

# Beneath the Surface

## The Opioid Epidemic in Northwest Connecticut

**“It has not been in the pursuit of pleasure that I have periled life and reputation and reason. It has been the desperate attempt to escape from torturing memories, from a sense of insupportable loneliness and a dread of some strange impending doom.”**

*—Edgar Allan Poe*

**“Loving an addicted child is like grieving his death and fighting for his life at the same time ....”**

*—Sandy Swenson*

This publication is made possible by generous contributions  
from the following individuals and organizations:

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**DEDICATION:**

**To Frankie, G., Joslin, Sean and  
the Yard Family (Tara, Charlie, Chuck, Mary, Sarah).**

Thank you for trusting your stories to us. Thank you for allowing us to publish them,  
so we might better understand addiction and the struggle to break free.

We honor your strength and courage.



## Dear Friends,

*Beneath the surface* of beautiful, rural Northwest Connecticut, is a battle being waged by many of our friends and neighbors, healthcare providers and the substance abuse service community that is the opioid epidemic. This epidemic is ravaging families and damaging our communities. It is a little known fact that almost 20 years ago fatal overdoses surpassed motor vehicle accidents as the leading cause of accidental death in Connecticut. Motor vehicle accidents decreased due in large part to proactive multi-level community efforts. However, there was no apparent equally focused community effort with respect to fatal overdoses. Since little attention was paid to the mounting number of fatal overdoses over the past 20 years, it comes as no surprise that with increased media attention on the opioid epidemic, it is easier for us to see what should have been obvious all along – that hundreds of people are dying of opioid overdoses every year in Connecticut.

Many of you are aware of the widespread and deadly impact of addiction, and in particular, opioid use and abuse but are you aware of how deeply it has impacted our communities? The only way to truly combat this epidemic is to model an approach that has been used to address other public health crises, and to study and adopt best practices in use by other communities.

All successful interventions that involve behavior change require community-wide, multi-level interventions that promote prevention, early intervention, treatment and recovery support. These interventions need to be targeted at individuals, as well as the communities where they live and work. Interventions include programs to increase knowledge, build new skills, and change attitudes and behaviors. These intervention programs are critical, but they must be accompanied by creating or changing policies that can impact all of these areas as well as influence increased access to services while limiting access to negative factors including the drugs themselves.

As part of our response, the Northwest Connecticut Community Foundation, the Foundation for Community Health, Berkshire Taconic Community Foundation, and the McCall Center for Behavioral Health are pleased to provide you with this report on the opioid epidemic and its impact on Northwest Connecticut. In addition to producing this report, our organizations are committed to applying our collective resources and strengths to work together to support current and ongoing efforts to address this epidemic.

We hope that this report will provide you with information you may need to do your part in joining us to combat this epidemic. No part is too small. Whether it is sharing what you learned from this report with someone else, or deciding to join a local coalition working on addressing this epidemic, or funding one of the resources listed in this report. Any and all actions you take or inspire will bring our community one step closer to turning the page on this problem.

Sincerely,

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*\*Because most data are reported at the county level, statistics specific to Litchfield County will be noted as such. Where data exist at the individual town level, they have been aggregated and reported as Northwest Connecticut data.*



Opioid abuse is ravaging families and damaging our communities. Deaths caused by heroin and other opioids have almost tripled in the past five years despite efforts to rein in prescriptions and introduce more treatment resources. It is a complicated issue involving assumptions about addiction and those who become addicted, about what law enforcement should be doing and the responsibilities of the medical and pharmaceutical professions.

## By the Numbers

**On average, two people die of an opioid overdose every day in Connecticut.<sup>1</sup>**

**Statewide, fatal overdoses have overtaken motor vehicle accidents as the leading cause of accidental deaths.<sup>2</sup> Since 2013, Connecticut has surpassed the national death rate for drug and opioid overdoses.<sup>3</sup>**

**Researchers and health officials now call the problem “an epidemic.”<sup>4</sup>**

Because of inconsistent standards for reporting cause of death, hospitalizations, treatment center admissions and re-admissions, and arrests across multiple agencies, it is difficult to truly measure the extent of the problem. Given the volume of recent media reporting on the opioid epidemic, information from a variety of news outlets has been reviewed and incorporated as appropriate.

Despite the inconsistencies and lag time in reporting the most up-to-date figures, the best available data at this time include statistics from the Community Case Manager based at Charlotte Hungerford Hospital, insurance payments, arrest reports, opioid-related treatment admissions to programs offered by the Department of Mental Health and Addiction Services, and autopsy results.

### Community Case Management

In December 2013, community stakeholders joined together to form the Litchfield County Opiate Task Force. Its biggest initiative to date has been the creation of a community case manager position to serve Litchfield County. Emergency department doctors begin by filling out an electronic order to alert the community case manager to patients who are addicted to opiates. The community case manager then meets with each patient face to face, or makes a call within 24 hours, to talk about treatment options.<sup>5</sup>

In the first four months after the position was created, 58 patients were referred to the community case manager, and 33 percent were successfully connected to treatment, such as a detox center, or enrolled in a residential facility for substance abuse counseling.<sup>6</sup>

As of October 2016, the community case manager had processed 121 referrals, and 52 percent were connected to a detox center or a residential substance abuse facility.<sup>7</sup>



## Insurance Payments

Nationwide, from 2011 to 2015, insurance payments to hospitals, laboratories, treatment centers, and other medical providers for patients with a diagnosis of opioid dependence or abuse grew from \$32 million to \$446 million.<sup>8</sup>

Fair Health, a nonprofit databank that provides cost information to the health industry and consumers, recently released a study detailing the stress that opioid dependence or abuse places on the health care system.

**On average, insurers spend \$3,435 per year on an individual patient, but for those with an opioid dependence or abuse diagnosis that amount jumps to \$19,333 per year.**<sup>9</sup>

The Fair Health study also reported a **3,200%** increase in the volume of insurance claims related to opioid dependence diagnoses between 2007 and 2014.<sup>10</sup>

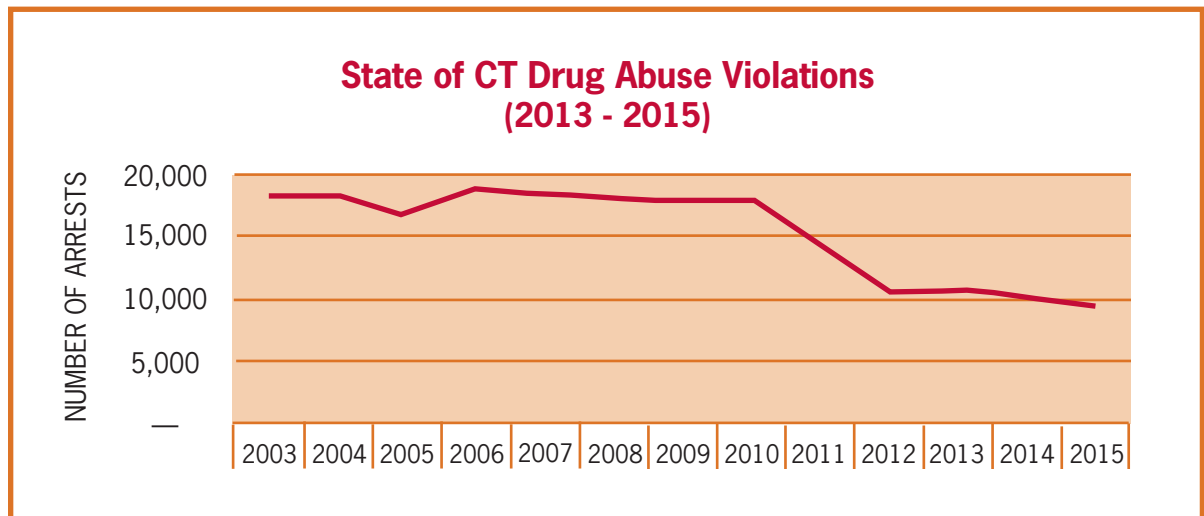
## Arrest Reports

The most comprehensive source of crime-related data is *Crime in Connecticut*, an annual report that employs the FBI's Uniform Crime Reporting Program categories. Unfortunately, there is no separate category for opioid abuse, and raw data are not readily available for analyzing crimes solely related to opioid abuse.

The closest category is "Drug Abuse Violations." Drug abuse violations are defined as state and/or local offenses relating to the unlawful possession, sale, use, growing, manufacture, and making of narcotic drugs, including opium or cocaine and their derivatives, marijuana, synthetic narcotics, and dangerous non-narcotic drugs such as barbiturates.

The only other category that captures opioid abuse is "Driving Under the Influence" – again, a less-than-precise measure of opioid abuse since, by definition, it includes being under the influence of alcohol and/or any narcotic drug.

Despite this inherent imprecision, the data show that arrests for Drug Abuse Violations have declined 50% from 2003 through 2015 in the state.



Source: *Crime in Connecticut 2015*, Annual Report of the Uniform Crime Reporting Program, State of Connecticut, Department of Emergency Services and Public Protection Crimes Analysis, September 2016.



Arrest figures by town are available in the Connecticut Uniform Crime Reports (“CT UCRs”); however, the categories are not directly comparable to the *Crime in Connecticut* report.

CT UCRs use two relevant but broad categories:

“*Drug/Narcotic Violation*” (unlawful cultivation, manufacture, distribution, sale, purchase, use, possession, transportation, or importation of any controlled drug or narcotic substance); and

“*Drug Equipment Violation*” (unlawful manufacture, sale, purchase, possession, or transportation of equipment or devices utilized in preparing and/or using drugs or narcotics, including cases involving drug paraphernalia, equipment, chemicals, illegal labs, etc.)

Using the available data despite the categorical differences, the only overlapping timeframe to compare the state figures and the town-by-town Northwest Connecticut figures is 2007 to 2010.

From 2007 to 2010, statewide arrests for Drug Abuse Violations declined by 3.3 percent, but **arrests in Northwest Connecticut for Drug/Narcotic Violations and Drug Equipment Violations increased by 23.5 percent.**

*Every town* in Northwest Connecticut reported arrests for Drug/Narcotic Violations and Drug Equipment Violations.

## Opioid-Related Treatment Admissions

Data are available for the number of admissions and individuals served per year in treatment programs funded or operated by the Connecticut Department of Mental Health and Addiction Services (DMHAS), where the primary drug at admission was an opioid. While these data do not reflect all individuals who have participated in an opioid-related treatment program since they only consider programs funded or operated by DMHAS, the town-by-town breakdown makes it possible to get an idea of the extent of the problem in Northwest Connecticut.

There has been a dramatic increase in the number of people affected by opioid addiction in Northwest Connecticut.

	2012	2013	2014	2015	2016	
<b>State of CT</b>						
Number of Admissions	21,127	22,875	24,332	27,535	27,773	<b>+32%</b>
Number of Unduplicated Clients	13,027	14,422	15,189	16,713	16,312	<b>+25%</b>
Average # of Admissions Per Client	1.6	1.6	1.6	1.7	1.7	
<b>Northwest Connecticut</b>						
Number of Admissions	679	884	1,065	1,280	1,425	<b>+110%</b>
Number of Unduplicated Clients	387	509	598	771	736	<b>+ 90%</b>
Average # of Admissions Per Client	1.8	1.7	1.8	1.7	1.9	

The figures are slightly understated because the state excludes data in any year where the number of admissions or unduplicated clients for any town is more than zero and equal to or less than five to protect the identity of individuals, or missing client’s town of residence.

Source: [data.ct.gov/Health-and-Human-Services/Opioid-Related-Treatment-Admissions-by-Town](http://data.ct.gov/Health-and-Human-Services/Opioid-Related-Treatment-Admissions-by-Town)

## Autopsy Results

Dr. James Gill, the chief medical examiner for the State of Connecticut, reports a **more than 50 percent increase in autopsies in the past two years, primarily attributable to the spike in accidental drug overdoses.**<sup>11</sup>

According to the chief medical examiner's records, in 2012, there were 357 accidental overdose/intoxication deaths. By 2015, that number more than doubled to 723 deaths. In 2016, there were **917** deaths.<sup>12</sup>

In 2014, there were 307 opioid overdose deaths in the State of Connecticut; 273 involved heroin. Heroin is the leading contributor but fentanyl deaths have also surged. There were 14 overdose deaths in 2012 involving fentanyl. In 2016, there were **479**. Fentanyl is a powerful synthetic opioid analgesic that is similar to morphine but is 50 to 100 times more potent.<sup>13</sup>

When Gill took the job as chief medical examiner a few years ago, only 63 percent of Connecticut's drug-related deaths had specific drugs listed on the death certificate. Today 99 percent do.<sup>14</sup>

"I found that the doctors here, a lot of them were certifying the deaths as acute or multi-drug intoxication," said Gill. "And I said, 'No, we need to spell out what the drugs are that are causing the death.' So, it would be 'acute intoxication due to the combined effects of heroin, diazepam, and alcohol' — and that's how we certify the deaths now. We're very specific about what we're finding in the toxicology."<sup>15</sup>

**Over half the towns in Northwest Connecticut have reported opioid-related deaths.** The following towns have been affected: Barkhamsted, Hartland, Harwinton, Morris, New Hartford, North Canaan, Salisbury, Sharon, Torrington, Washington, and Winchester/Winsted.

The substances involved in those deaths include benzodiazepine, cocaine, ethanol, fentanyl, heroin, hydrocodone, methadone, oxycodone, oxymorphone, and tramadol. Many of the deaths involved multiple substances.





# How Did This Start?

## A Tale of Two Sources – From the Doctor’s Office to the Street

Founded in 1951, The Joint Commission on Accreditation of Healthcare Organizations (“The Joint Commission”) is an independent, not-for-profit organization that evaluates and accredits nearly 21,000 health care organizations and programs in the United States. It is the nation’s oldest and largest standards-setting and accrediting body in health care.<sup>16</sup>

In 2001, The Joint Commission released its Pain Management Standards, which helped spread the idea of pain as a “fifth vital sign” in addition to blood pressure, heart rate, respiratory rate, and temperature. It required healthcare providers to ask every patient about their level of pain, given that the perception at the time was that pain was undertreated.<sup>17</sup>

At the same time, a heated debate was taking place in the medical community centered on whether or not opioids were addictive. A theory was advanced that pain counteracted the euphoric effect of opioids, thereby reducing the risk of addiction. The American Pain Society (APS), formed in 1977 as a multidisciplinary community comprised of a diverse group of scientists, clinicians, and other professionals, claimed that the risk of addiction was low when opiates were used to treat pain. The APS further claimed that pain acted against the tendency of opiates to stop the lungs from breathing; therefore, withholding opiates because of respiratory concerns was unwarranted.<sup>18</sup>

The APS position that opioids were less addictive than commonly believed and posed little risk for abuse was reinforced by very persuasive and extensive marketing campaigns by major drug manufacturers. Many doctors who previously shied away from opioids due to fears of addiction and abuse started aggressively prescribing them.

Opioids were advertised mostly to primary care physicians who had little pain-management training and high caseloads – that is, doctors who did not have enough time in their day to conduct the in-depth assessment necessary to accurately diagnose and treat chronic pain patients.<sup>19</sup>

Starting in 1996, the rate of opioid use accelerated rapidly, fueled in large part by the introduction of OxyContin in 1995, which was manufactured by Purdue Pharma. Between 1996 and 2002, Purdue Pharma funded more than 20,000 pain-related educational programs through direct sponsorship or financial grants and launched a campaign to encourage long-term use of opioids for chronic non-cancer pain.<sup>20</sup>

In 1997, opioid distribution through the pharmaceutical supply chain was the equivalent of 96 mg of morphine per person. **By 2007, it was approximately 700 mg per person.** 700 mg of morphine per person is enough for everyone in the United States to take a typical 5 mg dose of Vicodin every four hours for three weeks.<sup>21</sup>

However it cannot be emphasized enough that *the risk of addiction is still quite high even for occasional or infrequent users.*

**“This was not a cartel from Mexico kind of pushing drugs in our community, this was basically, an epidemic generated by the over-prescribing of prescription medication within our medical community.”**

— Michael Botticelli, White House  
Director of National Drug Control Policy  
(2014 – 2017)

**“[This is] about America and Mexico, about addiction and marketing, about wealth and poverty, about happiness and how to achieve it.”**

— Sam Quinones, *Dreamland: The True Tale of America’s Opiate Epidemic*

**DIVERSION OF PRESCRIPTION PAINKILLERS IS THE SINGLE MOST COMMON ROUTE TO ADDICTION:**

**Source of Pain Relievers for Most Recent Nonmedical Use**

Users Age 12+

<b>Free or bought from friend/relative</b>	<b>61.5%</b>
<b>Took from friend/relative without asking</b>	<b>4.4%</b>
Prescribed by one doctor	22.1%
Drug dealer/stranger	4.8%
Other	4.1%
Prescribed by more than one doctor	3.1%

Source: Lipari, Rachel N., Ph.D., and Hughes, Arthur, M.S., "How People Obtain the Prescription Pain Relievers They Mis-use," The CBHSQ Report, www.samhsa.gov, January 12, 2017

In 2007, Purdue Pharma pled guilty to misleading the public about the risk of addiction with OxyContin. It paid a \$634.5 million settlement as part of the plea deal that included an additional payment of \$19.5 million to 26 states and the District of Columbia to settle complaints that it encouraged physicians to overprescribe OxyContin.<sup>22</sup>

OxyContin was reformulated in 2010 in an attempt to deter abuse, but many users switched to heroin, which was cheaper. Studies have noted that efforts to reduce nonmedical prescription opioid use and overdose have coincided with reports of increased rates of heroin use (both injection and non-injection) and deaths from heroin overdose. Some researchers have suggested that the very policies and practices that were designed to address inappropriate prescribing are now fueling the increased rates of heroin use and death.<sup>23</sup>

In 2003, Siegal et al. were among the first to suggest the pathway from nonmedical use of opioids to heroin use.<sup>24</sup>

They found that in Ohio, 50 percent of people age 18 to 33 who recently started using heroin reported opioid abuse (primarily OxyContin) before initiating heroin use. A larger study involving young urban people who used injected heroin in New York and Los Angeles in 2008 and 2009 showed that 86 percent used nonmedical opioids before using heroin.<sup>25</sup>

The data residing within the Connecticut Prescription Monitoring and Reporting System can only be accessed by doctors, pharmacists, and law-enforcement officials, and there is no known study of opioid prescribing trends compared to opioid abuse and overdose statistics for Northwest Connecticut.

**94% of respondents in a 2014 survey of people in treatment for opioid addiction said they chose to use heroin because prescription opioids were "far more expensive and harder to obtain."**

Source: Opioid Addiction 2016 Facts and Figures, American Society of Addiction Medicine



**People with a prescription opioid addiction were 40 times more likely to be addicted to heroin.**  
**People with a cocaine addiction were 15 times more likely to be addicted to heroin.**  
**People who use marijuana were 3 times more likely to be addicted to heroin.**  
**People who use alcohol were 2 times more likely to be addicted to heroin.**  
— National Survey on Drug Use and Health



### **Heroin use has been on the rise in the United States for the past 10 years.** <sup>26</sup>

South American heroin was introduced in the eastern United States in the 1980s, along with cocaine. Mexican black tar, which is especially cheap to make, began showing up in the western United States about the same time, and the price of heroin dropped dramatically. The proximity of Latin America to the United States allowed for a more competitive product that essentially pushed aside Turkish and Asian heroin.<sup>27</sup>

The price of retail heroin decreased from \$2,690 per pure gram in 1982 to **\$465** in 2012. <sup>28</sup>

**A typical heroin street purchase is anywhere from \$5 to \$12.**

The level of opioid abuse in rural and suburban communities continues to take many people by surprise. While some portion of the blame could be attributed to the historic lack of prevention funding in public health, for example, or the lack of resources that could have been devoted to combating certain socio-economic issues, it would have been extremely difficult to gain any advantage against the millions and millions of dollars spent by drug manufacturers to ensure that doctors were comfortable with continuing to prescribe generous quantities of opioids.

In addition, it is challenging to counteract dealers who not only have street smarts, but remarkable business savvy. Certain operators within the drug trade recognized that rural and suburban America represented an untapped market, and they proceeded to exploit those markets with a much more affordable product moving through a different kind of entrepreneurial retail distribution system.<sup>29</sup>

When competition threatened profits, they learned the importance of branding and marketing, emphasized customer service, offered discounts, the convenience and safety of home delivery, and good-quality product. They gave away free samples to clients coming out of methadone clinics. They focused on midsize metro areas, and stayed away from territories controlled by other established competitors. They expanded quietly and quickly throughout the United States using the power of small-scale, free-market capitalism while avoiding the violence and police attention associated with their competitors. <sup>30</sup>

## SEAN LAFFERTY

Sean Lafferty is a hard-working, very personable young man. He is an accomplished motocross racer, but modest when asked about his accomplishments. He is open and forthcoming telling his story – blunt, to use his own word. He tells it like he sees it. Sean's recovery includes medication-assisted treatment with Vivitrol, going to 12-step meetings and seeing a therapist. He currently lives in a sober house and was asked to describe his experience with addiction and medication-assisted treatment.

*I grew up in Harwinton. I had a great childhood, didn't really have any issues. I played with machines instead of playing in a sandbox. I always liked things with motors.*

*I never had to do homework in high school because the teachers liked me. I conned them into saying that I had ADD which I didn't, and I never had to get a doctor's note. I'm not good at stealing, but I'm good at manipulating.*

*I was kind of the "anti-drug kid." I didn't like smoking pot. I really didn't like drinking. I mean I did experiment. I did coke a couple times, I smoked pot, I drank but I didn't really take it to the next level like any other kid in high school. The cool kids in high school do (drugs). It's everywhere. It's hard to explain. There are kids I went to school with that were in line to be valedictorian, never drank, never did drugs, (seems like) half of them died.*

*I destroyed my foot in motocross when I was 17. I couldn't walk or do anything after I got my cast off, so they kept feeding me pills. They hadn't done an MRI to see if anything was torn. They just thought because I shattered the ball of my ankle it was ankle pain. They didn't know my Achilles tendon was torn so they just kept feeding me pills.*

Despite having multiple surgeries over a number of years for a variety of injuries including hand surgeries, hernia repair and the ankle reconstruction, Sean will say that physical pain doesn't really bother him, but the psychic pain of depression does.

*I didn't know what I wanted to do, and I was kind of depressed so I kept taking Vics (Vicodan). I was on Vics for three or four months for pain, and then I got off of them and I was getting sick. So then I did my own thing for a few months.*

To get money, Sean sold his Suboxone pills and conned people including his parents. He went to detox and relapsed two weeks after getting out. He got back on Suboxone and that worked well for about six months. He says he planned to relapse, and ended up getting high with a friend.

When asked about the first time he tried heroin, Sean replied, *I think when I was 18. I passed out from Xanax and pills and somebody shot me up. I woke up with a track mark. I didn't like it and so I didn't do it again until I was 23.* Sean knew the person who shot him up, and knew that person's goal was to give out free bags of heroin to get people hooked and have a steady supply of customers.

*I did pills off and on for six months then wouldn't do them for a while. And then I was 23, I kept having nightmares from a childhood trauma, so I tried shooting up again. I sniffed dope, didn't like it at all, it was a complete waste of time, then shot up, didn't like it, then finally shot up and actually did enough to get a rush. I have a really high pain pill tolerance. So then, that's how that went. I'd get messed up for a little while then stop, get messed up for a little while and stop. I'd still work. My paycheck would be gone by Friday.*

*The week before I came in for treatment, I overdosed four times in six days.*

Sean was treated with Narcan each time, twice by his mother and twice by his girlfriend.

*Getting Narcan sucks. Feels like you got hit by a train, it's terrible. You wake up pretty much withdrawing, and it feels literally like you got hit in the head with a sledgehammer. It really really hurts. Especially if you get Narcan multiple times. Then I just stopped caring, I just didn't care.*

Asked what kept him going back to drugs even after overdosing four times in a week.

*Grief and shame. You're already doing it, what does it matter, everyone knows you're getting high. You don't really care if you're living or dead. To be honest, the last few years of my life are a blur. I don't remember much. I was on Subs (Suboxone) for eight and a half years. The only thing I can suggest is Vivitrol. Suboxone or methadone aren't any good for me. Vivitrol's a lot better.*

Reflecting on rehab, Sean said, *Rehab's easy, you're told what to do. It's a great way to get drugs out of your system and reintroduce you to people who are clean. You feel great after rehab because you have no drugs in your system. You're arrogant and then you walk out the door and everything hits you if you don't have a place to go. You're just going to end back up right where you were. If I went from in-patient to a sober house where I could do whatever I want, I probably would be doing way worse.*

When asked what was most important after detox and rehab, he remarked, *I think pushing after-care.*

*It's work. Quick fixes mean you're quicker to relapse. I wouldn't change anything right now. I mean, some days suck, don't get me wrong. But I have people in my life who are there and I have a house where I can go home and don't have to worry about walking in to somebody drunk or getting high or walking into family and getting stressed out.*

Sean was fortunate enough to spend several months at McCall House, an intermediate residential facility that is part of the McCall Center for Behavioral Health.

*It's good – it teaches you how to live normally again which I don't know how to do, and I'm learning. It taught me to get up and go do things. It reintroduces you to society but if you mess up, you don't mess up and then just keep messing up every day, it teaches you how to live. Rehab's not a cure. Keep going to different programs and sober houses. Everybody's different.\**

\*Sean Lafferty passed away on June 2, 2017.



# What Are Opioids?

**Opioid or opiate drugs (full agonists)**, are derived, either naturally or synthetically, from the opium plant. They act on receptors in the brain to produce morphine-like effects. Certain opiate drugs such as heroin are illegal in the United States, but many others are available by prescription from pharmacists. Opioids are often prescribed to treat pain, but many are also effective in treating persistent coughs.

Methods of administration for opioids that do not come in pill or liquid form include injection, snorting, sniffing, and smoking.

<u>OPIOID DRUGS</u>	<u>COMMON BRAND NAMES</u>
Codeine	Robitussin, Pedituss, Nalex, Antituss
Fentanyl	Duragesic, Actiq, Sublimaze
Heroin	N/A - illegal in the United States
Hydrocodone	Vicodin, Lorcet, Lortab, Vicoprofen, Norco
Hydromorphone	Dilaudid, Exalgo
Meperidine	Demerol
Morphine	Avinza, Duramorph, Kadian, MSContin, MSIR, Roxanol, RMS, Infumorph
Oxycodone	OxyContin, Percocet, Percodan, Roxicodone, Tylox
Oxymorphone	Opana
Propoxyphene	Darvocet, Darvon

An **opiate antagonist** is a medication that blocks the opiate receptors, which effectively blocks the effects of the opiate. Antagonists such as **Naloxone** (common brand name Narcan) are used to immediately reverse overdoses. Antagonists such as **naltrexone** (common brand names Revia and Vivitrol) are used to treat a patient's addiction over time. They effectively block the receptor, and prevent the body from responding to opioids and endorphins.

**Naloxone** (Narcan, Evzio and other brands of naloxone) is a medication approved by the U.S. Food and Drug Administration to immediately reverse overdoses by opioids such as heroin, morphine, and oxycodone.

There are **363 pharmacies in CT** authorized to prescribe naloxone.

There are **14 pharmacies in Northwest Connecticut** authorized to prescribe naloxone. Half are located in Torrington and Winsted.

**Partial opioid antagonists** activate the opioid receptors in the brain, but to a much lesser degree than a full agonist. Buprenorphine is a partial antagonist (common brand names: Butrans, Subutex, Belbuca, Probupine), and is used in treatment programs. **Buprenorphine** blocks other opioids while allowing for some opioid effect of its own to suppress withdrawal symptoms and cravings. It is considered less addictive than methadone, with fewer side effects, and is more accessible.

**Methadone** (common brand names: Methadose, Dolopine), like heroin, is a full agonist. People who are dependent on high doses of opioids are better suited to treatment with a full agonist such as methadone.

# Who Is Affected?

Nationally, those who overdose on prescription opioids are generally:

- Poor, white men from rural communities between the ages of 20 and 64
- People with mental illness
- People using prescription opioids long-term, usually for chronic pain
- People who do not have a prescription or a medical need <sup>31</sup>

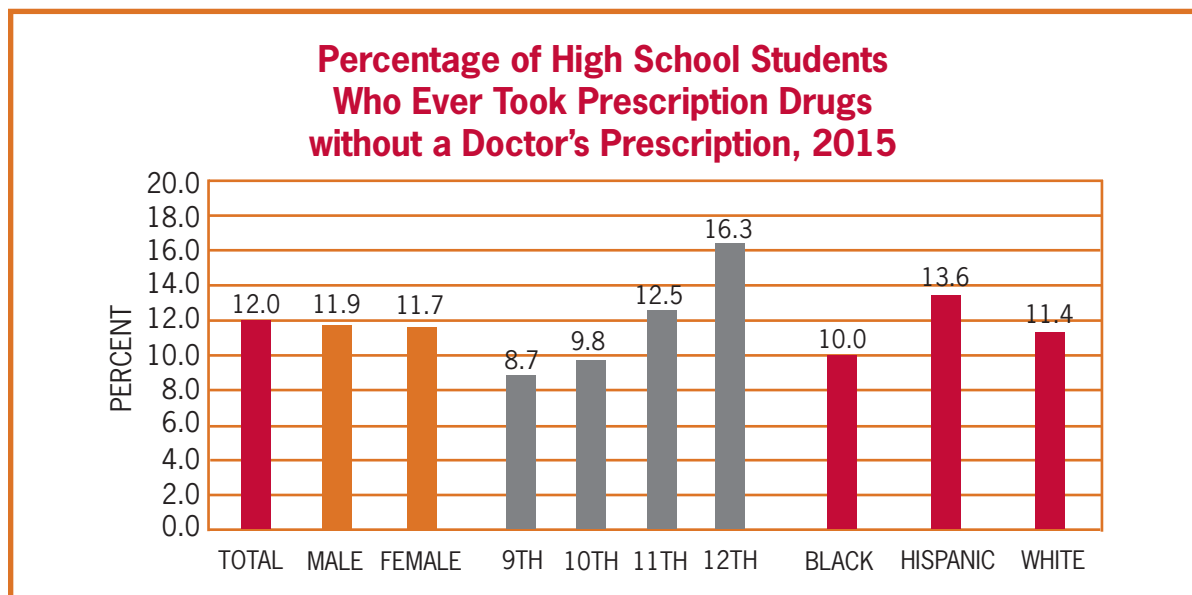
In Connecticut, those affected by opioid addiction tend to be white, male, and suburban. There appear to be a greater number of deaths during young adult years — especially between the ages of 22 and 32, and again between the ages of 40 and 50. <sup>32</sup>

Using the number of arrests for Drug Abuse Violations (as defined above) for Litchfield County from *Crime in Connecticut* for the year 2015, **the typical drug abuser was age 25-54, white and male, with the largest concentration of arrests at age 25-34.**

In 2015, Torrington was the only Northwest Connecticut town with reported Drug Abuse Violations for residents under the age of 18, accounting for **56 percent** of under-age-18 arrests for Drug Abuse Violations in Litchfield County.

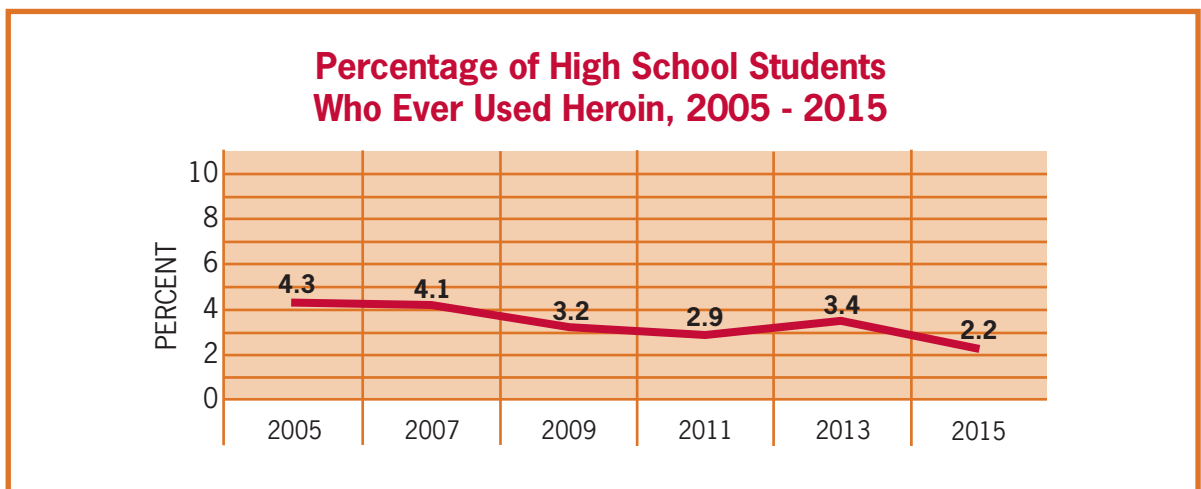
Sociologists at Penn State University studied the 2011 and 2012 National Survey on Drug Use and Health, a poll of 32,036 teens focusing on misuse of prescription opioids. The researchers found that **teens between the ages of 12 and 17 living in rural communities were 35 percent more likely to have abused prescription painkillers.** Teens living in small cities were 21 percent more likely to have abused prescription painkillers than teens in larger cities. The most commonly abused painkillers included OxyContin, Percocet, and other morphine-based opiate drugs. <sup>33</sup>

The 2015 CT School Health Survey reported that 12 percent of high school students had taken prescription drugs without a doctor’s prescription to get high one or more times in their lives. Most teens get prescription drugs from friends and relatives, sometimes without the friend or relative even knowing about it. Students in grade 12 reported the highest percentage of prescription drug use compared to students in grades 9, 10, or 11. <sup>34</sup>

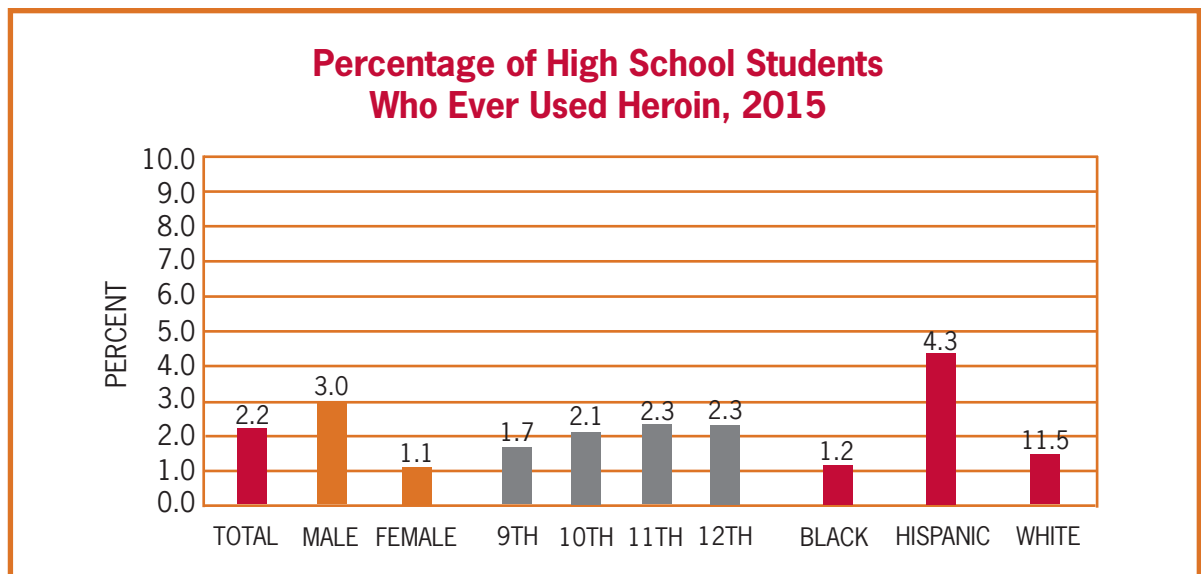


Connecticut Department of Public Health, CT School Health Survey, 2015

In general, heroin use is decreasing for Connecticut high school students. However, **almost 30 percent of high school students have been offered, given, or sold illegal drugs on school property.**<sup>35</sup>



Connecticut Department of Public Health, CT School Health Survey, 2015



Connecticut Department of Public Health, CT School Health Survey, 2015



# Addiction

*Everyone affected by this heartbreaking nightmare asks “Why?”*

*Why did you ever touch that stuff?*

*Why do I keep taking it?*

*Why can't you stop?*

*Why am I doing this to myself?*

*Why can't you see how this is affecting our family?*

No plant has been studied more intensively for its medicinal properties than the opium poppy. Hundreds of drugs have been derived from the opium poppy, all containing the morphine molecule or variations of it. According to Andy Coop, chair of the department of pharmaceutical sciences at the University of Maryland in Baltimore, what gives the morphine molecule its immense power is that it evolved to fit into the receptors that all mammals have in their brains and their spines. The receptor combines with endorphins to produce a very intense euphoria, an end to physical pain, along with drowsiness and constipation.<sup>36</sup>

**Looking back over the past 14 years of research, I've come to believe that addiction, like violence, poverty, and inequality, is one of the greatest societal challenges we face today. There is not a single person reading this right now who is not affected by addiction. You may not be the one who is or was addicted, but I guarantee that someone you love, work with, or is important in your life is struggling. It's a pandemic that's destroying families.**

Source: Brown, Brene, *Rising Strong: The Reckoning. The Rumble. The Revolution.* Spiegel & Grau, 2015

In the human body, most drugs readily break down into water-soluble glucose, which is then expelled by the body.

Inexplicably, the morphine molecule resists being turned into glucose, so the drugs stay in the body.<sup>37</sup>

“We still can't explain why this happens. It just doesn't follow the rules. Every other drug in the world—thousands of them—follows this rule. Morphine doesn't,” Coop said. “It really is almost like someone designed it that way—diabolically so.”<sup>38</sup>

Although drug addiction was described as a disease as long ago as the 1700s, addiction medicine has been neglected by the medical system according to a 2012 study by the National Center on Addiction and Substance Abuse at Columbia University.

Addiction changes the brain in fundamental ways. It disturbs a person's normal hierarchy of needs and desires and substitutes new priorities connected with obtaining and using the drug of choice. Despite the negative consequences, the resulting compulsive behaviors continue to weaken impulse control and are remarkably similar to hallmarks of other mental illnesses.<sup>39</sup>

Many people who are addicted to drugs also are diagnosed with other mental disorders and vice versa. For example, compared with the general population, people addicted to drugs are about twice as likely to suffer from mood and anxiety disorders, with the reverse also true.<sup>40</sup>

Drug use disorders and other mental illnesses are considered developmental disorders, since they often begin in the teen years or even younger—periods during which the brain experiences dramatic developmental changes. Early exposure to drugs of abuse may change the brain in ways that increase the risk for mental disorders; and early symptoms of a mental illness may indicate an increased risk for later drug use.<sup>41</sup>

## G.

G. is an engaging, eloquent young man in recovery. He has an undergraduate degree from a prestigious university, and is currently pursuing a masters degree. He relays his story in a quiet, thoughtful way. His serious and deeply analytical demeanor is balanced by a dry wit and a great sense of humor. He relies on regular attendance at AA meetings for recovery support.

*Something that wasn't clear to me growing up, but which I know now, is that my mother's father was an alcoholic. He was dead before I was born. All three of my father's sisters are alcoholics. I knew one was because she was spectacularly so. But the other two, I'm not even sure if quite frankly my father knew that until very recently.*

*When I look back at my experience with addiction, I think there is a fundamental sense of "not ok-ness" that maybe everybody experiences, but I think people who have a psychological predilection for addiction are probably experiencing it more acutely or more unremittingly than other people are. And in combination with whatever genetic risk factors exist, looking back, I think my path into addiction started a lot earlier. The older I get, the more I think about it, the more time I've been clean, the earlier it seems to me like I was essentially an addict.*

*I don't think I actually had my first drink until I was 15 or maybe 16. I spent a substantial portion of my life feeling anxious, feeling sad, feeling essentially like I wanted an external source of validation to replace a missing internal locus of self-worth. I always had an ulterior motive in relationships which was that I wanted validation of myself that was basically absent internally.*

*I wasn't happy in high school but I was very successful. I was successful in sports, I was successful socially and I was very successful academically.*

*That I wasn't happy was ok because I felt that it was probable that I would be happier in college. When that didn't happen, I'd be happier in grad school. Or if I wasn't happy in grad school, I'd be ok because I'd be happier when I got a job. And if I wasn't happy when I had a job, I'd be happier when I retired. And if I*

*wasn't happy when I retired, I'd be happier when I was dead. Whatever it is, because I think I know a lot of people who live their lives that way.*

*When I got to college I started to drink socially. For me that was very effective medication for my depression and anxiety. My experience with progressive alcoholism in college was not drinking in the morning, drinking around the clock, blacking out on a regular basis. It wasn't like that. My experience of drinking in college was the experience of becoming more social over time.*

*After college I went to work in New York City. I wasn't there long when I became consciously an alcoholic. I drank on a daily basis. I blacked out, essentially, on a nightly basis. I would be rarely able to eat. I would go to work, I always went to work. While I was there I developed a stomach issue that resulted in my being hospitalized for about a week. Because they initially thought it was appendicitis and were intending to operate, they didn't feed me. They just put me on IV fluids and Percocet. When I left the hospital, I used the Percocet as prescribed for a couple of days, and then used what was left to kill a rat that was in my apartment. I didn't abuse the first prescription for opiates I'd ever received but I knew with absolute certainty that at some point in the future, I would take that substance again. And I did.*

*After that, my life went in a lot of directions. Six months after (being hospitalized) I was simultaneously addicted to alcohol, cocaine, heroin, benzodiazepines, and ketamine.*

*I ended up getting in trouble with the law. After being summoned to court, I couldn't sleep. I spent probably 36 consecutive hours trying to find the appropriate potpourri of lies that would explain how I'd ended up in this circumstance I was in. And it was only in exhaustion and after 36 hours of working on it that it occurred to me that I could tell the truth. Which I did and reluctantly.*

*I went to treatment. I absolutely, unequivocally did not ever want to drink or use drugs again. I went to all my groups. I listened. I did everything that was assigned to me. I more or less followed the rules to the*

best of my ability. I got out of treatment, I went home. The first place I went to was a meeting. The second place I went to was a liquor store.

Things got worse than they had been before I had first gone to rehab. I was living in an apartment, basically on a couch. The room I lived in was full of bottles of urine and I could not bathe despite having a fully functional bathroom 15 – 20 feet away because I couldn't get off the couch. I would put plates and silverware in the sink and not clean them. After a couple months the place would start to smell so I opened the window. At some point, I determined that I needed to go back to treatment.

The distinction between the first time I went to treatment and the second was the distinction between conditional and unconditional surrender. The first time I went to treatment, I surrendered conditionally. There was a lot about the way I thought about the world and about myself and about other people that I was unwilling to put on the table. I wanted to negotiate a life in recovery or in sobriety without having to expose my belief system to scrutiny.

The second time I went to treatment, I did things differently. The virtue that I brought to rehab the second time was not that I was more honest than other clients, it was not that I was more intelligent or harder working or more compassionate or more diligent, (it was) an utter and complete disgust for the way my own brain operated. I wanted anybody else to make decisions for me to absolve me of the responsibility and risk that came from making decisions on my own.

And that's as important as anything gets when it comes to talking about addiction. It's a disease of information processing and the way that people make decisions. The decision to drink, the decision to use drugs, was always the correct decision because what could not change was the correctness of the decision to drink and so my brain had to manipulate the way it processed information to keep that decision always correct.

The miracle of recovery from addiction is that a person whose decision-making process is so spectacularly sickened that they could actually believe something

like using intravenous heroin is a reasonable decision can now have an easy time deciding whether or not to use heroin, like deciding what they want to eat for lunch, whether to stop for gas, something like that. That is a miracle, and what a 12-step program is about really is about making sure that decision remains easy. Decisions have consequences and part of what's so important about that is the step one stuff about not lying to one's self about the nature of his or her relationship with addiction and with substance.

Why was I not successful my first time? I hadn't fully surrendered, sure. But the honest truth is that I lacked faith in my own ability to do what was necessary to get better. I knew people were capable of change but those were better, stronger people with better character than I. I didn't really lack faith in the program, I lacked faith in myself.

I had exceedingly little understanding of the degree of control I exerted over my experience of life. I felt lazy because I knew I was lazy some of the time. I felt that I was dishonest and I knew that I lied some of the time. What I didn't see is how capable of fundamental decency I was, and how capable of compassion I was, I just did not see that.

One of the questions in the minds of almost everybody I know who is in early recovery, is whether or not they are capable of doing it. And the evidence on the basis of their own life experience would demonstrate that, no, they are not. Because all of them have attempted to moderate or to stop or to change and have proven wholly incapable of doing that. By the time they get to treatment they have a heavy dose of suspicion that they are simply not capable of beating it.

When I got out the second time, and went to a sober house in West Hartford, I was no less anxious, I was no less scared, I was no less depressed, in some ways no less pessimistic, but I had a modicum of faith in my own ability to progress. The first time around, I was like "This is terrible. Possible options: drink." The second time I felt like I had the option of enduring. I was fortunate enough to be surrounded by people who could help me with that.

continued on page 18

G. continued

*How do people end up relapsing when they leave rehab? I think people need to know that they're worth something, that they are valued in some way. People are looking for value and when they can't ever find enough of it externally to replace what they're missing internally, they forgo purpose and motivation, and they just go straight to chemistry and that is drugs. People talk about more need for case management, that's true. People talk about more need for therapy and psychiatry, and that's true. I'm an AA person. I go to Alcoholics Anonymous, and probably advise anybody who's dealing with addiction to do so. But in the long run, people are going to depend on things like employment and comradeship and social supports, and I do not know that there's an effective way to substitute those.*

*I think a month to 45 days of in-patient intensive treatment is (about right). Long-term treatment is great and I wish there was more of it. It's probably more economically efficient in the long run rather*

*than cycling in and out (of detox and rehab). I think the half-way house model is a very interesting one, where there is more structure, more accountability. Where there is some core functionality within a person's life that is professionally administered and professionally overseen and professionally designed and where the people have continued access to professional care.*

*But if you ask me now if I think that I'll end up really enjoying and cherishing my life, I would say absolutely yes. I know that I can be relied upon most importantly by myself, and I know that I have a borderline insanely high degree of confidence that I am going to get out of my life what I want to, the things that are important to me. And a small portion of that is a healthy amount of ego about myself and the work that I do and things like that. A much bigger portion of that is that I've been unfailingly surrounded by people who absolutely have helped me find what I'm looking for.*



## Substance Abuse and Trauma – How Trauma Affects the Brain

There are hundreds of articles and studies linking increased risk of substance abuse to trauma, brain injury, domestic violence, exposure to family substance abuse, PTSD, sexual abuse, and so forth.

Below are some of the specific effects on different areas of the brain:

The **amygdala** (the brain's threat-detection center) can become overactive, engaging in a constant program of looking for, seeing, and assessing threat. This will cause feelings of intense anxiety, vulnerability, and fear.

The **hippocampus** (the brain's center for processing memories) can become underactive. Rather than consolidating and then placing memories in the outer layer of the brain for long-term storage, memories get hung up in a present-day loop. The result is repeated experiences of intrusive, disturbing, and uncomfortable recollections.

The **cortex** (the brain's center for executive control) becomes interrupted by survival-oriented instincts. These instincts overrule logical thinking, diminish cognitive processing, and decrease the ability to inhibit behavior – even addictive behavior.<sup>42</sup>

**“Addiction is like driving your car, and you see a kid in front of your car and you want to stop, but the brakes don’t work.”**

– Dr. Gail D’Onofrio, Professor and Chairwoman of Emergency Medicine, Yale University School of Medicine



## JOSLIN TABER



Photo by Julia Scharnberg

Joslin Taber is a vibrant, intelligent young woman in recovery. She radiates strength and purpose. Her eight-month old son, Elijah, sits in her lap, quietly feeding and teething as she relays her story – a story rife with trauma from a very young age. Joslin's recovery support includes 12-step meetings and weekly sessions with a therapist who specializes in EMDR (Eye Movement Desensitization and Reprocessing), which is a recognized therapy that is an effective form of treatment for trauma and other disturbing experiences. She is set to start studying environmental science in college and is really looking forward to that experience.

Her teenage birth parents struggled with addiction. Joslin and her younger brother were given up for adoption when she was about two years old. Joslin's birth mother used drugs throughout the pregnancy. She says her first memory was seeing her birth mother hit her adoptive mother and the police taking her birth mother away.

Joslin says her story really starts when she was in fourth grade.

*My grandmother was murdered by my aunt. She was pushed down the stairs and beaten with a hammer. She was in a coma and didn't die until six weeks later. My adoptive parents took me and my brother to say goodbye to her. I don't really know why they did that. To this day they regret it. Seeing someone's head bashed in like that at nine years old was very traumatic. That's when my whole life changed. I wasn't a normal nine year old girl anymore. I wasn't allowed to tell anyone at school, but of course I did. I didn't know how to handle it. We were dealing with reporters. The murder happened in Georgia and in tiny Salisbury, CT we were getting reporters. We weren't allowed to answer the phone anymore. We weren't allowed to answer the door. It was a very scary time.*

*I started fifth grade, and my mom started drinking really heavily. And my dad, he was still working. He was never around. I remember going over to this girl's house once for a playdate, and when she came home, her mom gave her a hug, made us snacks, was really loving with her: "How was your day? What happened today?" And that sticks out so much in my mind because I never had that. I would come home and my mom would be drinking.*

*She was just very cold, emotionally abusive. I didn't know how to act. My brother didn't know how to act. The only way I could get my feelings across was to hit her and say "Stop! Stop saying this stuff to me." I think one of the hardest things was that my Dad didn't believe me. No one would listen. I went to counselors at school. They would just call my parents and ask "What's going on?" And of course my parents said "No. This isn't happening. She's making it all up." I learned at a very young age that numbing your feelings and not dealing with your problems was acceptable.*

*I got pretty good grades and played a lot of sports. Sports was my outlet for a while. That was my escape from reality until I started getting all these injuries and I couldn't play as much as I wanted to. And that's when more emotional problems started coming through, and I really didn't have an outlet.*

*Around age 14 is when I had my first drink. There was a family party at my house and I was the only one drinking. I had my first blackout. I didn't remember anything I had just done and thought that was pretty cool. I started cutting a lot, burning myself, and this was how I handled my emotion on the outside I still upheld this façade that I was ok. And I obviously, definitely, wasn't ok.*

*I drank on and off until I was about 17, and I was sent to a therapeutic boarding school. The hard part about being there is that I was surrounded by some very very sick kids. I thought I was bad? One of my roommates would cut so bad I wouldn't be allowed in my room until they cleaned all the blood up. Or they would wet the bed. Or they'd have electric shock therapy. So I was even more traumatized. I saw kids get restrained every day. But on the other hand, I did learn how to express myself and exert myself better and express "I" statements and how I feel. And that it's ok to say "No." It's ok to say that somebody's bothering me or making me uncomfortable, so I did find my voice there.*

*I ended up going to Mitchell College. I got into their Division 1 Sailing program so I was really excited about that. But I had just graduated from high school on August 12 and I was expected to be at college on August 22. So I had 10 days from complete lockdown to complete freedom. I had no idea how unprepared I was. I didn't do a single homework assignment junior or senior year (in high school). So then I go to college, and I go to my first class, and I wasn't capable of any of it. I'm supposed to be working at a college level with all these kids that are so prepared, so ready. So I went to about a week's worth of classes and then I stopped going. It was too overwhelming. I was partying and I thought I was having the time of my life. I was kicked out after just a few months. But when I got home, I was really depressed. Home always felt like a punishment.*

*My first experience with opiates was when I had gallstones. I was about 18, shortly after I got home after leaving college, had a gallbladder attack. My pediatrician told the surgeon, "DO NOT give her*

*opiate pain medicine." And they didn't listen. They gave me a prescription for Percocet. I had surgery the next day and they gave me another prescription for Percocet. Within two weeks, I was fully dependent on Percocet. I'd wake up in the morning, and a pill bottle would be under my pillow. I remember the morning I realized I had a problem. I woke up and couldn't get out of bed to use the bathroom before doing any lines. That morning I ended up calling rehab, and going that night. I did 30 days there and did pretty well, that's where the seed was planted for me. Then I went into a sober house.*

*Around the same time, I had a medical procedure that brought back memories of being raped. I remember them rolling me over and starting to go under and it brought it all back. That was the first time I tried heroin. That night I called a friend and told her I want to try heroin. So we met on Dixwell Avenue right by the police station in a Port-A-Potty and she shot me up for the first time.*

*That was the beginning of the end. I don't remember a whole lot between then and May 2014. I do know that I had been arrested for stealing from my parents.*

*Joslin entered detox, and from there entered inpatient rehab treatment for 30 days. She could not get into her preferred intermediate care center after rehab due to lack of capacity. At that point, she entered another sober house.*

*I ended up relapsing from there. I was in and out for a while. I'd get three months here, four months there, two months here, a few weeks there. I had no motivation. I didn't see where my life was going. I didn't have a purpose. I didn't love myself and I didn't have any respect for myself. We're so used to go go go, always going to get drugs. It's an everyday, all day thing.*

*Then (my best friend) Sergio died. I went to his wake, and his Mom said to me, "Stay strong for Sergio. It's what he would have wanted for you." Those words stuck with me. And two weeks later, I checked myself into the sobering center (in Danbury).*

*continued on page 22*

*Two more friends of mine had died, and I was overwhelmed. I packed all my stuff and left. I went to the sober house in Danbury and I stayed sober for about two months but ended up relapsing. I lived in a homeless shelter, and then I lived with a couple who paid their rent with crack. From there it spun out of control really fast. I started selling crack, smoking a lot of crack, selling dope, shooting dope and I was miserable. And I couldn't take it anymore so I moved into my car.*

*November 11, 2015. I'd just done the rest of my dope and I was sitting outside of Stop & Shop, sitting in my car and I was crying. I was thinking "I don't want to live anymore. I don't want to live like this anymore. (My son's) father happened to call me. I told him how I was feeling. He said "Call your parents." So I called my parents and said "Mom, I need to come home. I need help." And she said "Ok."*

*My sobriety date is November 12, 2015. I just didn't want to get high anymore and I didn't want to live like that. My willpower was stronger than my desire to use again. So I started to go to meetings, and then I ended up getting pregnant at three weeks sober.*

*I couldn't really get a job because I was still on probation. I'd been on probation for two years and had a lot of drug tests during those two years but they never violated me. I ended up babysitting eight hours a day, four days a week for \$80 a week.*

Joslin did find a much better job that she loved and was good at. In April 2016, she and Elijah's father were about to sign a lease for an apartment, and she was scheduled to be in court.

*I was so excited, things were going so well for me. I had this great job, I was pregnant, I was six months sober. I went to court and they threw me in prison (because of) all my dirty urines over the two years that I had been on probation. Not once did they violate me (during probation). They violated me then. When things were finally looking up for me. They didn't even let my lawyer speak – threw me right in prison.*

*Elijah's father relapsed that day. He moved back to Hartford. I spent six weeks in prison and had to do a long-term Mommy and Me program. I was so frustrated because here I am, now seven months sober, six and a half months pregnant. I just had my life going for me and now I'm going backwards. It was so hard to go back to rehab while being sober.*

But she got through the program and moved into her own apartment.

*I started going to meetings. I go to meetings every day. The best feeling in the world is coming home to my own place to take care of my son. There's no chaos anymore.*

*When I was first getting sober, it was the hardest thing in the world, I couldn't imagine coming up on 18 months. It really is a simple program, just don't use one day at a time and you can get through any minute, any day, without using and I'm proof of that now.*

*People look down on addicts. We're not people to look down on, we need help.*



## What Is Different About Addiction in a Rural Area?

The opioid crisis disproportionately affects rural communities, in part due to the lack of outreach and treatment resources.<sup>43</sup>

For more than a decade, opioids have been a key component of a rural doctor's pain management protocol. Certain jobs that are more prevalent in rural areas, such as manufacturing, farming and mining, tend to have higher injury rates, which can lead to more chronic pain, and possibly, to more use of painkillers. Alternative treatments like physical therapy may not be available or convenient, so drugs are the primary option.<sup>44</sup>



"It's not a fundamentally rural problem," says, Tom Vilsack, who led the Obama administration's inter-agency push to curb opioid abuse in his role as secretary for the U.S. Department of Agriculture. "But it's a unique problem in rural America because of the lack of treatment capacity and facilities."<sup>45</sup>

**"The traffickers ... figured out that what white people—especially middle-class white kids—want most is service, convenience. They didn't want to go to skid row or some seedy dope house to buy their drugs. The guys ... would deliver it to them."**

—Sam Quinones, *Dreamland: The True Tale of America's Opiate Epidemic*

Some researchers think larger economic, environmental and social factors leave rural Americans at particular risk, says University of California, Davis, epidemiologist Magdalena Cerdá. After the 2008 recession, rural areas consistently lagged behind urban areas in the recovery, losing jobs and population. "You have a situation where people might be particularly vulnerable to perhaps using prescription opioids to self-medicate a lot of symptoms of distress related to sources of chronic stress — chronic economic stress," Cerdá says.<sup>46</sup>

Another potential contributing factor is an insufficient law-enforcement presence. In Northwest Connecticut, only Torrington and Winsted have dedicated police departments.

In 2015, Torrington had 76 sworn officers and 11 civilian employees, and Winchester/Winsted had 19 sworn officers and 4 civilian employees.

Some towns have contracts with the State Police to have dedicated Resident State Troopers. The following Northwest Corner towns employ Resident State Troopers:

- Barkhamsted (1 officer)
- Bethlehem (1 officer)
- Harwinton (2 officers)
- Litchfield (1 officer)
- New Hartford (1 officer)\*
- North Canaan (1 officer)
- Salisbury (1 officer)
- Washington (1 officer)

\*New Hartford cut back to one Resident State Trooper from two, effective 9/20/2013.<sup>47</sup>

The rest of the Northwest Connecticut towns rely on State Police Troop B (located in Canaan) or State Police Troop L (located in Litchfield) to cover a very large geographic area.

Troop B is assigned to 13 towns: Barkhamsted, Canaan, Colebrook, Cornwall, Goshen, Hartland, New Hartford, Norfolk, North Canaan, Salisbury, Sharon, Torrington, and Winchester/Winsted – a total of 514 square miles with 78,230 residents.

Troop L is assigned to 14 towns: Bethlehem, Bristol, Burlington, Canton, Harwinton, Kent, Litchfield, Morris, Plymouth, Thomaston, Warren, Washington, Watertown, and Woodbury – a total of 416 square miles with 160,015 residents.

An insufficient law-enforcement presence is particularly concerning because Litchfield County is surrounded by areas defined as High Intensity Drug Trafficking Areas (“HIDTA”) by the U.S. Department of Justice. According to the Justice Department’s “Drug Market Analysis,” Litchfield County is hemmed in by high-intensity activity in Fairfield, New Haven, and Hartford counties.

Drug distribution within the New England HIDTA is centered in two primary hubs: Hartford/Springfield and Lowell/Lawrence, Massachusetts.<sup>48</sup>

Route 44 and Route 8 provide convenient east/west and north/south travel routes for distribution to Northwest Connecticut out of the New England HIDTAs.

**The latest synthetic opioids being cut into or passed off as heroin include W-18, and carfentanil (trade name Wildnil). Carfentanil is approved as a general anesthetic for large animals, such as elephants and bears. Both W-18 and carfentanil are extremely potent and are causing a sharp increase in fatal overdoses.**

Violence among street gangs is increasing in the New England HIDTA region, particularly violence associated with disputes over drug territories, and street gangs are actively expanding their drug distribution operations into rural and suburban areas.<sup>49</sup>

To further complicate matters for first responders and healthcare personnel, drug abusers are being exposed to substances they do not intend to ingest, because street drugs are being cut with other deadly substances such as levamisole, fentanyl, and other extremely potent synthetic opioids.<sup>50</sup>



## Recognizing Teenage Opioid Abuse

Teenage opioid abuse is particularly dangerous, as the signs can be much less apparent than those associated with the abuse of other drugs such as alcohol, methamphetamine, and marijuana.

“Some parents don’t even know their children are addicted to painkillers because their kids are functioning well in everyday life,” said Shannon Monnat, assistant professor of rural sociology, demography, and sociology at Penn State. “Opioid abuse is different from drinking, for example, because parents can usually tell if their child is drunk, and it’s even different from marijuana use because there are behavioral differences that they may be able to notice if their kid is smoking weed.”<sup>51</sup>

Signs of opioid abuse include:

- Drowsiness, lack of energy
- Pinpoint pupils
- Inability to concentrate, lack of motivation
- Social behavioral changes
- Changes in appearance
- Increased secrecy
- Theft
- Poor decision-making

**“Addiction is a disease that in most cases begins in adolescence, so preventing or delaying teens from using alcohol, tobacco or other drugs for as long as possible is crucial to their health and safety.”**

–Susan Foster, the National Center on Addiction and Substance Abuse at Columbia University, Vice President and Director of Policy Research and Analysis

These signs can also be indicative of many other health concerns, including thyroid issues, Lyme disease, or depression, which can delay the confirmation of opioid abuse.

***“Teen substance use is our nation’s number one public health problem. Smoking, drinking and using other drugs while the brain is still developing dramatically hikes the risk of addiction and other devastating consequences.”***

–Jim Ramstad, Former Member of Congress (MN-3), the National Center on Addiction and Substance Abuse at Columbia University, board member and National Advisory Commission member

***90 percent of Americans who meet the medical criteria for addiction started smoking, drinking, or using other drugs before age 18.***

***25 percent of Americans who began using any addictive substance before age 18 developed an addiction, compared to 4 percent of Americans who started using at age 21 or older.***<sup>52</sup>

A study published by the National Center on Addiction and Substance Abuse at Columbia University notes that American culture actually increases the risk that teens will use addictive substances. A wide range of social influences subtly condone or overtly encourage use, including the acceptance of substance use by parents, in schools and throughout their communities; the pervasive advertising of products; and media portrayals of substance use as benign or glamorous, fun and relaxing. These cultural messages and the widespread availability of tobacco, alcohol, marijuana and controlled prescription drugs normalize substance use, and undermine the health and futures of teens.<sup>53</sup>

**72.5% of high school students have drunk alcohol**

**46.3% of high school students have smoked cigarettes**

**36.8% of high school students have used marijuana**

**14.8% of high school students have misused controlled prescription drugs**

**65.1% of high school students have used more than one substance**

Source: “Adolescent Substance Use: America’s #1 Public Health Problem,” the National Center on Addiction and Substance Abuse at Columbia University, June 2011



There is scant data on teenage substance use in Northwest Connecticut. What does exist is limited to three years of Youth Survey Reports for Torrington and Region 10 (Harwinton and Burlington), and a 2017 report titled “Developmental Assets: A Profile of Your Youth,” conducted in Region 1 (Canaan, Cornwall, Kent, North Canaan, Salisbury, and Sharon).

The Youth Survey Reports are intended to determine the prevalence and trends of substance use by youth, along with related perceptions and practices. The Developmental Asset study looks at how youth experience “40 Developmental Assets,” which are specific, basic building blocks of human development. The underlying assumption is that youth with high asset levels are less likely to engage in high-risk behaviors such as violence, sexual activity, drug use, and suicide.

Setting aside the Developmental Asset study due to its very different approach, the sample size of the Torrington and Region 10 Youth Surveys is small compared to the potential sample size of all Northwest Connecticut teenagers, and there are some differences between the two with respect to their survey forms. The Youth Survey Reports are best utilized by the studied communities only. They are not robust enough to draw any broad conclusions about teenage substance use in Northwest Connecticut or to compare to state or national trends. Expanding the Youth Survey Reports to all Northwest Connecticut teenagers would be helpful to uncover regional trends with respect to substance use, and also to provide baseline metrics for service providers to evaluate the impact of interventions.

# Access to Treatment

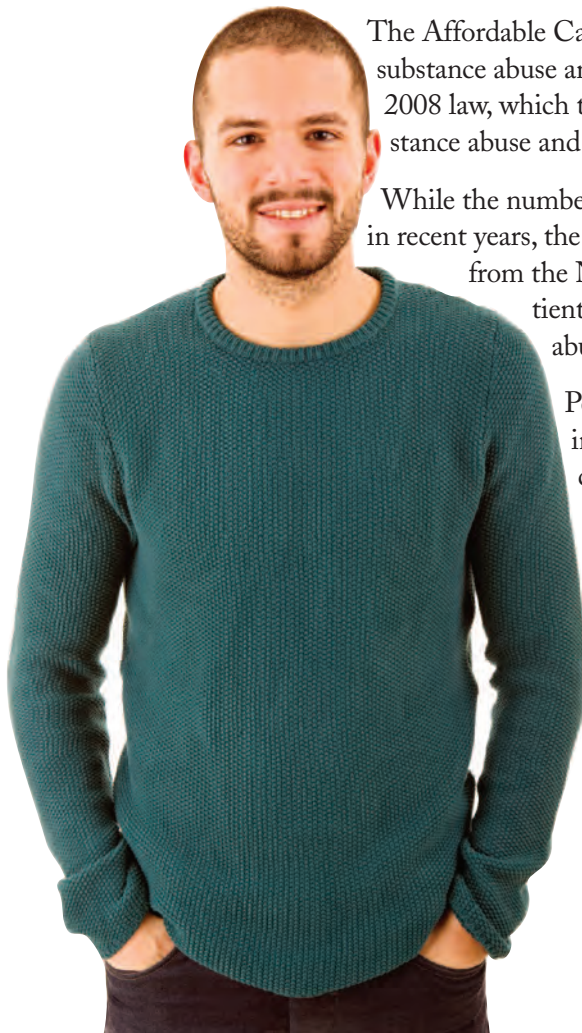
Only 11% of the 22.7 million Americans who needed drug or alcohol treatment in 2013 actually got it, according to the Substance Abuse and Mental Health Services Administration. While some of those who went without care did so by choice, at least 316,000 tried and failed to get treatment.<sup>54</sup>

A mother in the audience of the Opioid Awareness Forum held in 2016 at Goshen Center School who works as a healthcare professional detailed the drug-related death of her son, who became addicted to opiates following severe motorcycling injuries. “My son was one of the 355 who died in 2012,” she said. “He was 28 years old.” She said the system failed her son in many ways. “Drug treatment programs turned him away because he was on Medicare/Medicaid.”<sup>55</sup>

Medicaid programs in at least 17 states don’t pay for long-term methadone treatment, according to the Legal Action Center. In Connecticut, Medicaid does cover methadone and suboxone treatment, and there is one methadone clinic located in Northwest Connecticut. However, Medicare does not pay for methadone services, so individuals covered by Medicare would have to pay out of pocket for treatment.

**In 2010, the National Center on Addiction and Substance Abuse released a report that found 65 percent of all 2.3 million inmates in American prisons had substance issues or had committed drug-related crimes — a total of 1.5 million prisoners. In addition, the same report found that only 11 percent of those prisoners received any treatment for their substance abuse problems.**

Source: Bushak, Lecia, “Portugal’s Drug Experiment: Tackling Heroin Addiction by Decriminalizing Drugs and Focusing on Health,” [www.medicaldaily.com](http://www.medicaldaily.com), April 21, 2016



The Affordable Care Act currently requires that insurance plans include substance abuse and mental health treatment as essential benefits. A 2008 law, which took effect in 2014, mandates that insurers put substance abuse and mental health care on a par with medical treatment.<sup>56</sup>

While the number of people getting substance abuse treatment has risen in recent years, the new laws have not helped everyone. A recent report from the National Alliance on Mental Illness found that patients continue to be denied care more often for substance abuse than for other medical issues.<sup>57</sup>

People who need addiction treatment face a number of insurance obstacles, according to Kelly Clark, president-elect of the American Society of Addiction Medicine. Many insurance plans limit the doses of buprenorphine that patients can receive or the length of time that people can take it. Studies show that people with private insurance are three to six times *less* likely to receive addiction treatment than people with public insurance, such as Medicaid.<sup>58</sup>

Linda Ventura, a mother from Kings Park, NY, said her insurance company told her that her son, Thomas, would have to “fail first” in outpatient treatment before it would pay for inpatient treatment for his heroin addiction. “If you relapse, the insurance company says, ‘We paid for this before. We’re not paying for it again,’” said Ventura. “But if you come out of remission with cancer, do they say, ‘You had four treatments. We’re not paying?’”<sup>59</sup>

Insurance hassles are only one of the barriers facing families trying to get help for substance abuse, said Emily Feinstein, director of health law and policy at the National Center on Addiction and Substance Abuse at Columbia University. There is a shortage of trained health providers.<sup>60</sup>

According to Feinstein, many physicians have little to no training in treating substance abuse. Some health providers feel uncomfortable with patients dealing with addiction. Others would like to treat addiction but can’t afford to specialize in the field full-time because insurance reimbursement rates are so low.<sup>61</sup>

The United States spends a lot of money on addiction — nearly \$468 billion a year. But **only two cents of every dollar goes to prevention or treatment**; the rest goes toward hospital care, jails, and courts, according to a 2009 report from the Columbia University addiction center.<sup>62</sup>

Yet studies clearly show that **prevention and treatment pay off**, said Keith Humphreys, a researcher at the Department of Veterans Affairs and a professor of psychiatry at Stanford University Medical Center.<sup>63</sup>

**Every dollar invested in treatment saves \$4 to \$7 in reduced drug-related crime, criminal justice courts and thefts**, according to the National Institute on Drug Abuse.

Substance abuse treatment “is a really good deal for the taxpayer,” Humphreys said. “But, it shouldn’t have to be. We should do it out of humanity.”<sup>64</sup>



**One year of methadone costs \$4,700.**

**A year in prison costs \$18,400.**

# Treatment Options

According to the medical establishment, medication coupled with counseling is the most effective form of treatment for opioid addiction.

Standard treatment in the United States, however, emphasizes willpower over chemistry. Opiates, cocaine, and alcohol each affect the brain in different ways, yet drug treatment facilities generally do not distinguish among the addictions. Roughly 90 percent of treatment facilities are grounded in the principle of abstinence, thereby systematically denying access to Suboxone and other synthetic opioids for people addicted to heroin.<sup>65</sup>

The anti-medication approach adopted by the United States sets it apart from the rest of the developed world.

Dr. Mary Jeanne Kreek, a professor at Rockefeller University in New York City and head of the Laboratory of the Biology of Addictive Diseases, has been studying the brains of people with addiction for 50 years. In the 1960s, she was one of three scientists who determined that methadone could be a successful maintenance treatment for an opioid-addicted person.<sup>66</sup>

Abstinence-only treatment may have a higher success rate for alcoholics, but it simply fails opiate addicts. **“It’s time for everyone to wake up and accept that abstinence-based treatment only works in under 10 percent of opiate addicts,”** Kreek said. “All proper prospective studies have shown that more than 90 percent of opiate addicts in abstinence-based treatment return to opiate abuse within one year.”<sup>67</sup>

The U.S. Food and Drug Administration approved both buprenorphine (Subutex) and buprenorphine-naloxone (Suboxone) in 2002 for the treatment of opiate dependence. In Kreek’s ideal world, doctors would consult with patients and monitor their progress to determine whether Suboxone, methadone, or some other medical approach stood the best chance of success.<sup>68</sup>

**“The brain changes and it doesn’t recover when you just stop the drug because the brain has been actually changed,”** Kreek explained. “The brain may get OK with time in some persons. But it’s hard to find a person who has completely normal brain function after a long cycle of opiate addiction, not without specific medication treatment.”<sup>69</sup>

After buprenorphine became an accepted treatment in France in the mid-1990s, other countries began to treat people addicted to heroin with medication. Where buprenorphine has been adopted as part of public policy, it has dramatically lowered overdose death rates and improved the patient’s chances of staying clean.<sup>70</sup>

**In November 2004, Stanley Street Treatment and Resources, a nonprofit in Fall River, Massachusetts, introduced Suboxone into its mix of detox, short residential, and outpatient therapies.**

**In 2014, more than 300 people were enrolled in the program. Nancy Paull, the facility’s CEO, reports a relapse rate of about 10 percent.**

Source: Cherkis, Jason, “Dying to Be Free – There’s a Treatment for Heroin Addiction That Actually Works. Why Aren’t We Using It?” [projects.huffingtonpost.com](http://projects.huffingtonpost.com), January 28, 2015

For families, the treatment process is frustrating and can end up as an expensive failure. Dr. A. Thomas McLellan, co-founder of the Treatment Research Institute who served as deputy director of the White House's Office of National Drug Control Policy from 2009 to 2011, recalled talking to a despairing parent with an opiate-addicted son. The son had been through five residential treatment stays, costing the family more than \$150,000. When McLellan mentioned buprenorphine, the father said he had never heard of it. <sup>71</sup>

Federal waivers are required for doctors to prescribe buprenorphine products such as Suboxone. Those who obtain and continue to qualify for the federal waiver work under rigid federal caps on how many patients they can treat: 30 patients the first year, increasing to a maximum of 100 patients thereafter. Effective August 8, 2016, the U.S. Department of Health and Human Services put into effect new rules that allow 30 patients the first year, 100 patients the second year, and a maximum of 275 patients each year thereafter.

The Substance Abuse and Mental Health Services Administration has a "physician locator" feature on its website to find a physician who has the required federal waiver. The latest list of all physicians with a waiver in the state of Connecticut yielded 374 results, with several located in Litchfield County.

Neither Suboxone nor methadone is a miracle cure, but medical treatment does buy time for people with addictions to fix their lives, seek counseling, and allow their brains to heal. Doctors recommend tapering off the medication only with the greatest of caution. The process can take years, given that addiction is a chronic disease and effective therapy can be a long, grueling affair. <sup>72</sup>

**There are 214 Substance Abuse Care Facilities in the state; 14 are located in Northwest Connecticut.**

Source: [data.ct.gov/Health-and-Human-Services/Substance-Abuse-Care-Facilities/](http://data.ct.gov/Health-and-Human-Services/Substance-Abuse-Care-Facilities/)





# What Is Being Done Now to Combat the Epidemic

On May 27, 2016, Gov. Malloy signed Public Act 16-43, a comprehensive bill to combat opioid abuse. Some of the notable provisions are: limiting initial opioid prescriptions to a seven-day supply in most cases involving acute pain, requiring first responders to carry overdose-reversing drugs, prohibiting commercial health carriers from requiring prior authorization for coverage of naloxone, and making several changes to the state's electronic prescription monitoring program to help facilitate prescriber and pharmacist compliance.

In addition, Gov. Malloy announced the creation of a partnership between his office, the Yale School of Medicine, and Connecticut's insurance carriers to develop a strategic plan to guide the state's response to the opioid epidemic.<sup>73</sup>

In October 2016, Gov. Malloy adopted a three-year plan put together by the Connecticut Opioid REsponse (CORE) team. The CORE plan recommends the following broad strategies:

**Strategy 1.** Increase access to treatment, consistent with national guidelines, with methadone and buprenorphine.

**Strategy 2.** Reduce overdose risk, especially among those individuals at highest risk.

**Strategy 3.** Increase adherence to opioid prescribing guidelines among providers, especially those providing prescriptions associated with an increased risk of overdose and death.

**Strategy 4.** Increase access to and track use of naloxone.

**Strategy 5.** Increase data sharing across relevant agencies and organizations to monitor and facilitate responses, including rapid responses to "outbreaks" of overdoses and other opioid-related events.

**Strategy 6.** Increase community understanding of the scale of opioid use disorder, the nature of the disorder, and the most effective and evidence-based responses to promote treatment up-take and decrease stigma.<sup>74</sup>

The CORE team will continue to work with the Alcohol and Drug Policy Council, a state stakeholder group, to comprehensively address the opioid crisis in the long-term.

In January 2017, Gov. Malloy announced a series of legislative proposals intended to prevent opioid addiction and overdose. The proposals include: requiring physicians to prescribe opioids electronically rather than on paper, allowing visiting nurses to destroy unused medication, allowing patients to add directives to their medical files indicating that they do not want to be prescribed an opioid medication, requiring doctors to provide information about the risk of addiction when prescribing opioids, removing legal restrictions that can prevent state agencies from sharing information that could help track trends and how resources are being used.<sup>75</sup>

## FRANK KELLY

Frankie hales from New York and has a personality the size of the Big Apple itself. He is warm, gregarious, loud and funny. People are naturally drawn to him. Frankie moved to Connecticut several years ago with his wife and children. He had several years of recovery, had a well-paying job and, by all accounts, had achieved success. However, addiction is a chronic, recurring illness. After his marriage failed, Frankie relapsed, and ended up back in the cycle of pain, suffering and criminal behavior, which led to the McCall Center for Behavioral Health continuum of treatment. Today he is just past the one year mark in recovery, is a regular speaker at AA and NA meetings and has chosen to share parts of his life in an effort to help others.

*I had dyslexia when I was a kid. I watched while other kids excelled and I didn't...so I acted out. Alcoholism was in my family. I kind of found myself through drinking. I felt like I was part of something with the other kids in the neighborhood. I had fun and connected with others while using alcohol and pot. I would try to outdo the others so I could have that title. It progressed. I thought – okay I can handle this – I'm going to move to other things. So, you name it, I used it.*

*To me, an addict was someone who lived under a bridge. I couldn't identify with that...things weren't that bad yet. I was under the care and protection of my family...I was probably enabled. I started doing heroin at 18 but I was still in denial because I was snorting it. But it didn't take long before I was shooting it. I did start to feel bad at that point. I had always thought that was the lowest of the low...a junkie. Everything I had heard about and was disgusted by my whole life...I became. I found myself doing, seeing and being part of things I never ever thought I'd be a part of. I'd go anywhere – you go where the good heroin is. I shouldn't be here right now. I shouldn't be alive with everything I did.*

Frankie goes on to talk about recovery. He is a big believer in the twelve step traditions:

*My resistance gave way – I surrendered so that I could get to the altar of freedom. That probably sounds crazy if you don't know how the steps work. But what it means is that I'm able to take in and receive what's being given to me. To win you gotta surrender. I learned that I've got to allow other people to help me and not allow my ego to dictate who I am. Instead of being vulnerable – we prevent that from happening because we allow our pride to interfere. My ego, my pride and my anger cripple me.*

*Another realization is that we suffer to get well. We need to go through change and feel that suffering in order to get well – to get to the other side. We die to live. That's a beautiful paradox. It's about resurrection. Because it's in losing one's life that you find it. Hell was upon me. In the promise of the 9th step you will know a new freedom and new happiness but you will not regret the past nor wish to shut the door on it. The program didn't promise to open up the gates of heaven but it did close the gates of hell for me. You got me?*

*Today I'm conditioning myself to be a better person. It's about spiritual progress – not perfection. You've got to keep it away to keep it. I keep that freedom because I give it back, by helping any human being in need.*

## The McCall Center for Behavioral Health

The McCall Center for Behavioral Health (McCall) is a private, nonprofit behavioral health treatment provider located in Torrington whose primary mission is to provide comprehensive substance use disorder and mental health treatment in an integrated fashion. McCall has been serving Northwest Connecticut for 40 years.

McCall, together with Charlotte Hungerford Hospital and other community partners, was instrumental in launching the Litchfield County Opiate Task Force in December of 2013. Each month, this group of providers, court division representatives, Department of Mental Health and Addiction Services representatives (DMHAS), Department of Children and Families representatives, legislators, health care professionals, recovery house managers and people with lived experience gather at McCall to collaboratively strategize solutions to this crisis. As noted previously, this public health model response includes a community case manager embedded in the Charlotte Hungerford Hospital Emergency Department to more readily connect people in crisis with treatment.

The Task Force has been instrumental in increasing communication across disciplines, which has led to increased access to care and heightened accountability. The Task Force and the innovative solutions designed by that group have served as a model for the state and have been recognized by the National Organization of Rural Health and Connecticut's congressional delegation.

McCall has significantly increased the hours and availability of its psychiatrist, and now offers both buprenorphine and naltrexone as options for clients struggling with opiate addiction. Through a newly launched Substance Abuse and Mental Health Services Administration grant, DMHAS tapped McCall to be part of a Medication Assisted Treatment (MAT) expansion initiative. This will allow McCall to have a team of medical and psychotherapy experts in MAT to expand its capacity to serve those struggling with an opiate use disorder.

All curricula used in McCall's programming is evidence-based, gender-specific, trauma-informed, age-appropriate and tailored to the specific needs of each client. Recognizing the high correlation between unaddressed trauma and addiction, McCall is committed to research-based trauma healing treatment throughout its continuum of care. Treatment options include an acute inpatient setting, intermediate residential homes, and long-term recovery housing, as well as outpatient care.

McCall is a DMHAS-registered walk-in assessment clinic that can offer immediate evaluations to clients. Its clinical programs include a full mental health and substance use assessment, individual and group therapy, treatment for co-occurring disorders, relapse prevention, mental health, treatment for trauma and anger management, intensive outpatient treatment, psychiatric evaluation, medication evaluation and management.



## CHUCK YARD (1985-2016)

Tara Yard is a grieving mother. She is soft-spoken, sweet, fiercely loyal and loving, compassionate beyond measure. Her son, Chuck Yard, died of a heroin overdose at age 30. Tara and her husband Charlie, and Chuck's two sisters, Mary and Sarah, all carry the same picture of Chuck. It shows a happy, healthy young man. He was a handsome, nice, smart, funny guy.



Photo Courtesy of the Yard Family

Chuck's obituary was brutally honest. Unusually so, compared to obituaries of other overdose victims that typically say someone died suddenly or unexpectedly. Tara said they all felt the obituary should be honest along with the funeral service. It was important for them to have the service be comfortable for the people they knew would probably attend: people in recovery, people hoping to be in recovery, people who need to be in recovery.

*At the funeral (there were) older people he met at the gym and younger people, and people that you knew aren't clean and people that are clean. But Chuck's heart was open to everybody. And he understood everybody. He didn't judge anybody. I couldn't be prouder of him.*

In 6th grade, Chuck won the prize for the D.A.R.E. (Drug Abuse Resistance Education) program. After attending Botelle Elementary School in Norfolk he transitioned up to Northwestern Regional Middle and High School in Winsted. Tara said the transition was difficult for Chuck, and around the time he was in 8th grade, she and her husband were more and more uncomfortable with Chuck's new group of friends.

*He had some friends spend the night and they were camping outside. Charlie went out and pulled the flap back and they were all smoking pot. So we called the parents, had them pick the kids up. They had a bong and Charlie smashed it. We both have a history in our family of addiction, so we never had alcohol in the house. We really don't drink and we were so afraid of that, that we really didn't look at everything else.*

The day before his junior prom, the Yards had a meeting at school to make plans for Chuck's senior year, but were met with the news that school administrators were ready to expel Chuck. They suggested he go into treatment. The Yards drove Chuck straight from that meeting to a treatment center where Chuck spent the summer and half of the next school year.

*On his 18th birthday, we went to pick him up to celebrate his birthday and bring him home for the day. The treatment center administrators had a meeting with us. Chuck had been rooming with an older man who showed Chuck how to do speedballs (mixing cocaine with another drug like heroin or morphine) and he got caught. So he actually learned more from being there than maybe what he really knew before. And that started his experience with heavy drugs.*

Chuck graduated from high school and went away to college. Home on a break, he was out one night and got hit in the face with a wrench resulting in serious facial bone fractures.

*He was put into the hospital and had surgery. I stayed with him and they gave him continuous meds. He had free range with his pump. He was on super heavy drugs because they had to operate, peel his face back, put his face back together. He was in there for about a week and sent home with lots of opiates. And I think that really triggered something in him. He didn't go back to college. He went back for about a week, packed his stuff up and came home.*

The Yards took Chuck to another part of the state for detox. They spoke highly of the detox program, but said they did not think the rehab program at that particular treatment center was as good as the detox program.

*They are put in houses that are horrible. They're sneaking out at night and buying drugs. Chuck was actually even worse when he came home.*

*He hated being addicted, just hated it. We never blamed him for his addiction, never disliked him, never not loved him. We were so desperate to understand and help him. It's overwhelming. It's beyond people's control and he said that.*

*We moved him home to keep an eye on him. He said to me, "Mom, I know I'm not going to live a long life" when we were sitting on the porch one night. He said, "I'm not going to live to be old." And he felt it. I mean, I knew he knew it. I said "Chuck, you'd break my heart if that ever happened." But I knew it too. I could feel it and my husband could feel it. My daughters feared it.*

*And then the day we got the phone call. Chuck had been in the hospital for four days with kidney failure and he was in a lot of pain. I kept saying to (the doctors), "Whatever you do, don't give him any narcotics because he is in recovery." But he was in a huge amount of pain. He was discharged late in the afternoon and he went to a sober house.*

*The next day, I just had a terrible feeling all morning. I kept calling and texting his phone and he didn't answer. I called his girlfriend. I asked her if she could go check on Chuck, and she said, "Yes, I'm on my way." I kept calling his girlfriend's phone but she wouldn't answer. She finally picked up and I asked, "What's going on? Just tell me!" I started screaming and asked "Is he dead?" and she said "Yes."*

*And I just remember screaming all the way down there. When they let me in to see him, I climbed on the bed and I held him because I knew I wouldn't be able to touch him much longer. And I just held him and touched his face and I begged him to come back to me.*

*It's like my heart is empty. There were three children, three siblings, and now there are two and that's really hard for them. He was the one that made them laugh, and teased them. They could always count on him if they were upset. He was really important to them. And, at the same time, they spent a lot of their years growing up trying to save him too.*

*We all as a family lived with it from the time he was so young, through all those years, and it was constant pain. In hindsight we have no regrets because Chuck knew we loved him every minute of the day. We're all extremely lonely for him and miss him, and it's starting to sink in that he's not coming back.*

*I think as a parent, some of the things I'm disappointed with are trying to find things in the system. When an addict needs help, they need HELP. Right that minute when they are open to it. You can't say: we can't take you, how about in a couple weeks? There is such desperation when someone needs help, they really need it that minute.*

*I'm discouraged by sober houses. I think (sober houses) really need to be re-evaluated, some stipulations need to be in place. And maybe bringing more homeopathic, alternative or spiritual things in to help people cope. I think it is a matter of everybody working together, and right now nobody works together, everybody is in their own little silo.*

*We have to all talk. We have to all share information— it's not a dirty secret. And it's nothing to be ashamed of. We talk about cancer. We talk about AIDS. Why can't we talk about this? Because it's killing our kids quicker than anything else.*



Photo Courtesy of the Yard Family

# Best Practices – Effective Community Change Models

Promising Practices	Available in the U.S.	Available in Northwest Connecticut
Less emphasis on criminal prosecution and more on treatment (Portugal)	Emerging (examples include Gloucester, MA)	No
Decriminalize all drugs (Portugal)	No	No
Medically assisted treatment with buprenorphine and methadone (Portugal, France, Australia, Iran)	Yes (examples include Baltimore, MD)	Limited access, lack of funding for broad access
Medically assisted treatment with a 12-step program	Yes (examples include Missouri, Oregon)	Yes
Drug and needle turn in program tied to immediate access to treatment	Emerging (examples include Gloucester, MA)	No
Widespread training and use of naloxone (Narcan) to reverse overdoses by first responders	Yes	Yes
Widespread training and use of naloxone (Narcan) to reverse overdoses by front-line government employees in municipal buildings	Yes (examples include Worchester, MA)	No
Community Case Manager to handle immediate referrals to treatment/care	Yes	Yes
Public Education and Awareness Campaigns	Yes	Emerging
Medication Disposal Drop Boxes	Yes	Yes
Medication disposal via authorized individuals in Neighborhood Watch programs	Yes (examples include Worcheser, MA)	No

Sources: Bushak, Lecia, "Portugal's Drug Experiment: Tackling Heroin Addiction by Decriminalizing Drugs and Focusing on Health," [www.medicaldaily.com](http://www.medicaldaily.com), April 21, 2016; Cherkis, Jason, "Dying to Be Free – There's a Treatment for Heroin Addiction That Actually Works. Why Aren't We Using It?" [projects.huffingtonpost.com](http://projects.huffingtonpost.com), January 28, 2015; International City/County Management Association, "How One City Went 'All In' to Fight the Opioid Epidemic," March 14, 2016; Szabo, Liz, "Addiction Treatment Hard to Find, Even as Overdose Deaths Soar," *USA Today*, May 24, 2015



# How to Help – What You Can Do

## DO TWO THINGS RIGHT NOW

### 1 Safely discard all medication that is not being used to treat a current illness or condition.

#### Local Medication Drop Boxes

These boxes are located in the lobby of the police department, and are accessible any time the department is open. No questions asked, just drop the unwanted medications in the box and they will be safely and securely destroyed.

**State Police Troop B**  
463 Ashley Falls Road  
North Canaan, CT  
860-542-5249

**State Police Troop L**  
452 Bantam Road, #A  
Litchfield, CT  
860-626-7968

**Torrington Police Department**  
576 Main Street  
Torrington, CT  
860-489-2000

**Winchester Police Department**  
338 Main Street  
Winsted, CT  
860-379-2721

You may use Medication Drop Boxes for over-the-counter medications, medication samples, prescription medications, medications for household pets, medicated lotions or ointments.

You may NOT use Medication Drop Boxes for needles or other “sharps,” hazardous waste, thermometers, personal care products (shampoo, etc.).

#### Household Disposal

If you are unable to access a Medication Drop Box or an advertised annual Medication Take Back Day, the FDA recommends you mix medicines (do not crush tablets or capsules) with an unpalatable substance such as salt, ashes, saw dust, dirt, kitty litter, or used coffee grounds; place the mixture in a container such as a sealed plastic bag or food container; throw the container in your household trash; scratch out or wrap duct tape around all personal information on the prescription label of your empty pill bottles or empty medicine packaging to make it unreadable; place it inside another container such as an empty food container to ensure that the contents cannot be seen and use duct tape to seal it; then dispose of the container. Do not place the container in the recycle bin.

### DO NOT FLUSH OR POUR UNWANTED, UNUSED OR EXPIRED MEDICATIONS DOWN THE DRAIN

### 2 Lock up medications that must remain in your home.

Carefully scrutinize the labels of any over-the-counter medications and safely dispose of those containing an active ingredient that could be abused.

Do not keep a supply of over-the-counter medications “just in case.” Use non-narcotic, alcohol-free medications.



## Explore Other Options for Pain Relief

Volleyball star Gabby Reece insisted on no opioids when recovering from a total knee replacement. Dr. Scott Sigman, an orthopedic surgeon in North Chelmsford, Massachusetts, and team physician for the U.S. Ski Jump Team, said “I’ve been doing this for 20 years and I can’t say I’ve ever had a patient come in and say to me, ‘I want you to do my total knee replacement, but I don’t want any opioids.’” Reece and Sigman are raising awareness of alternative pain relief options, including oral and intravenous anti-inflammatory medications and pain-relief drugs that are injected into the surgical site. A new survey finding is that 1 in 10 orthopedic and soft-tissue surgery patients in the U.S. report becoming addicted or dependent on opioids after their operations. Sigman began emphasizing alternative options in his practice about two years ago and found that patients reported top-notch pain relief, they returned home sooner, and had reduced health care costs by avoiding opioid-related complications.<sup>76</sup>

After years of seeing too many veterans with chronic pain becoming addicted to opioids, the Veterans Health Administration (VHA) established multidisciplinary pain clinics. The clinics take a holistic view and include physical therapy, acupuncture, massage, swimming pool therapy, along with social workers and psychological counselors. The VHA currently has 70 of these clinics, two are located in CT.

Medical insurance companies are not as supportive of multidisciplinary care. The U.S. medical system is good at fighting disease and awful at leading people to wellness.<sup>77</sup>

## TALK ABOUT IT

**Break the stigma.**

**Share this information within your community.**



## Help Your Community Work Toward Systemic Change

### Insist on Comprehensive Education and Outreach

“Addiction is a family disease, so you can’t just treat the person with the substance abuse disorder” – Audrey Gladfelter, administrator of the York/Adams (Mass.) Drug & Alcohol Commission.

Other addiction experts agree that seeking education is one of the first steps families can take when they feel themselves being pulled down by a loved one’s addiction. Doing so can help families come to terms with one of the most distressing aspects of addiction: that recovery is a process – a lengthy and often difficult one.<sup>78</sup>

### Disrupt Nonprescription Abuse

A significant proportion of people addicted to opioids did not have a prescription for the opioid that killed them. The data suggest that efforts to prevent opioid overdose deaths should focus on strategies that target: (1) high-dosage medical users, and (2) persons who seek care from multiple doctors, receive high doses, and are likely to be involved in drug diversion.<sup>79</sup>



## Help Your Community Work Toward Systemic Change

### Advocate for Funding to Reach Northwest Connecticut

One of the provisions of the “21st Century Cures Act,” passed by Congress in December 2016 and signed by President Obama, provides for \$1 billion in grants over two years to help all states deal with opioid abuse, including:

- Expanded funding for state-operated prescription drug monitoring programs;
- Training to reduce opioid over-prescribing and encourage alternatives;
- Expanded access to quality substance abuse programs and behavioral health services (including medication-assisted treatment and mental health parity);
- Flexibility for states to use federal funds for other public health initiatives related to the opioid epidemic, including naloxone and first responder training.

Once federal funds are distributed to Connecticut, advocacy will be needed to ensure that funds reach Northwest Connecticut service providers.

### Push for Better Prescription Drug Monitoring

Massachusetts and New York State are easily accessible from Northwest Connecticut. Other New England states are no more than a two-hour drive. A study using data from the National Ambulatory Medical Care Survey covering the experience of 24 states over 10 years found that the launch of state monitoring programs was associated with a **30 percent reduction in the rate of prescribing opioids**.<sup>80</sup>

Under Connecticut law, information about all transactions for controlled substances dispensed in Connecticut must be reported to the Connecticut Prescription Monitoring and Reporting System (CPMRS). Pharmacies – both in and out of state – and dispensing practitioners must submit data at least once per week; that timeframe should be much shorter for all participants nationwide, preferably at the time each prescription is filled.

### Break the Hospital Evaluation/Reimbursement Rate Connection

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), the patient satisfaction survey required by the Centers for Medicare and Medicaid Services for all hospitals in the United States which is used to determine hospital reimbursement rates, contains three pain-specific questions: whether patients needed medications for pain, if their pain was well controlled during their stay, and if hospital staff did “everything they could” to help with pain. It has been suggested that linking reimbursements to patient satisfaction with pain treatment results in overprescribing of opioids.<sup>81</sup>

### Advocate for More Effective and Timely Data

It is difficult to note trends (either positive or negative) and for organizations to be in a position to act appropriately when data are several years old and are not consistent across agencies.

In addition, it is important to have a system to track individuals throughout the entire process, from entry (e.g., voluntary, court-ordered, or hospitalization), into the substance abuse treatment system and after treatment. Right now, the only way to pinpoint the fate of anyone who has been through the system is if they relapse, get arrested and seek treatment again, end up hospitalized, or end up at the Medical Examiner’s Office for an autopsy. It is also important to understand what happened to those who quit or were asked to leave treatment. People addicted to opioids are faced with an ongoing cycle of waiting for treatment, getting treatment, dropping out, relapsing and then waiting and returning for more treatment.

**“When your kid’s dying from a brain tumor or leukemia, the whole community shows up .... They bring casseroles. They pray for you. They send you cards. When your kid’s on heroin, you don’t hear from anybody, until they die. Then everybody comes and they don’t know what to say.”**

Source: Quinones, Sam, *Dreamland: The True Tale of America’s Opiate Epidemic*, Bloomsbury Press, 2015

**“We see recovery every day, but if we can prevent addiction? All of the heartache and pain and suffering that could be alleviated, that would never start — who wouldn’t want that?”**

Maria Coutant Skinner, McCall Center for Behavioral Health



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**For a medical crisis:**  
**Call 911 or go to the nearest Emergency Room**

**For a psychiatric crisis:**  
**Call Mobile Crisis 860-482-1560 or go to the nearest Emergency Room**

**If you are homeless or at imminent risk of homelessness:**  
**Call 211 or access the website [www.211CT.org](http://www.211CT.org)**

**To report anonymous tips:**  
**Torrington: 860-489-2065 (Narcotics Unit)**  
**860-489-1995 (Crime Stoppers)**  
**CT State Police recommend submitting tips through the**  
**U.S. Drug Enforcement Administration's website: [www.dea.gov/ops/submit.php](http://www.dea.gov/ops/submit.php)**

## **Substance Abuse and Behavioral Health Resources in Northwest Connecticut\***

Angelus House	158 Flanders Road, Bethlehem, CT	T: 203-266-5709
Catholic Charities, Inc.	132 Grove Street, Torrington, CT	T: 860-482-5558
Community Mental Health Affiliates	100 Commercial Boulevard, Torrington, CT	T: 860-482-8561
Connecticut Junior Republic (Adolescent)	550 Goshen Road, Litchfield, CT	T: 860-567-9423
Hartford Dispensary (Methadone Clinic)	140 Commercial Boulevard, Torrington, CT	T: 860-482-8783
High Watch Recovery Center	62 Carter Road, Kent, CT	T: 860-927-3772
MCCA/Torrington (Outpatient)	30 Peck Road, Torrington, CT	T: 860-482-2613
MCCA/Trinity Glen (Men's Center)	149 West Cornwall Road, Sharon, CT	
MCCA/Trinity Glen (Women's Center)	62-64 Kent Cornwall Road, Kent, CT	
McCall Center for Behavioral Health	58 High Street, Torrington, CT 83 South Canaan Road, Canaan, CT 469 Migeon Avenue, Torrington, CT 231 North Main Street, Winsted, CT	T: 860-496-2100
Mountainside Treatment Center	187 South Canaan Road (Rte 7), Canaan, CT	T: 800-762-5433
Newport Academy (Adolescent)	64 Double Hill Road, Bethlehem, CT	T: 888-934-1222
CNV Help Inc./Watkins Network (Outpatient)	21 Prospect Street, Suite B, Torrington, CT	T: 860-482-7242

**For a more complete list of resources visit: [www.authenticrecovery.org/resources](http://www.authenticrecovery.org/resources)**

*\*Selected locations based on state licenses and credentials as of 10/12/2016*