The New Heroin Epidemic

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Agenda

• Heroin overview and statistics
• Signs and symptoms
• Medication-assisted treatment
• Substance use among the emerging adult population
• Treatment implications: what works vs. what doesn’t work
• Strength-based approaches
• Overdose prevention
What is heroin?

• Heroin is a highly addictive opioid drug made from morphine, a mind-altering substance that occurs naturally in the resin of the opium poppy plant.
• Heroin can be smoked, injected or snorted.
What does it look like?

- Heroin can be white or brown powder or a black, sticky substance called “black tar heroin.”
People who are addicted to...

Alcohol are 2x
Marijuana are 3x
Cocaine are 15x
Rx Opioid Painkillers are 40x

...more likely to be addicted to heroin.
Where do you get these drugs?

Sources of Pain Relievers for Most Recent Nonmedical Use, ≥ 12 years

- Obtained free from a friend or relative: 56%
- Bought from friend or relative: 9%
- Took from a friend or relative without asking: 7.2%
- From one doctor: 18%
- Other, including bought on internet: 4.3%
- Bought from drug dealer: 5.4%
Heroin use has increased among most demographic groups

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<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2.4</td>
<td>3.6</td>
<td>50%</td>
</tr>
<tr>
<td>Female</td>
<td>0.8</td>
<td>1.6</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Age, Years</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12–17</td>
<td>1.8</td>
<td>1.6</td>
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</tr>
<tr>
<td>18–25</td>
<td>3.5</td>
<td>7.3</td>
<td>109%</td>
</tr>
<tr>
<td>26 or older</td>
<td>1.2</td>
<td>1.9</td>
<td>58%</td>
</tr>
<tr>
<td><strong>Race / Ethnicity</strong></td>
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<td></td>
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</tr>
<tr>
<td>Non-Hispanic white</td>
<td>1.4</td>
<td>3</td>
<td>114%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.7</td>
<td>--</td>
</tr>
<tr>
<td><strong>Annual Household Income</strong></td>
<td></td>
<td></td>
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<tr>
<td>Less than $20,000</td>
<td>3.4</td>
<td>5.5</td>
<td>62%</td>
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<tr>
<td>$20,000–$49,999</td>
<td>1.3</td>
<td>2.3</td>
<td>77%</td>
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<tr>
<td>$50,000 or more</td>
<td>1</td>
<td>1.6</td>
<td>60%</td>
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<tr>
<td><strong>Health Insurance Coverage</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>4.2</td>
<td>6.7</td>
<td>60%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>4.3</td>
<td>4.7</td>
<td>--</td>
</tr>
<tr>
<td>Private or other</td>
<td>0.8</td>
<td>1.3</td>
<td>63%</td>
</tr>
</tbody>
</table>
Figure 8. Heroin admissions, by gender, age, and race/ethnicity: 2012

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 10/17/13.
Signs and symptoms
Signs & symptoms

Physical/emotional

- Unexplained extreme mood swings, nodding off
- Increased aggression or anxiety
- Change in dress or appearance/hygiene
- Changes in sleeping habits
- Inability to focus
- Dilated or constricted pupils and bloodshot eyes

- Threats and attempts of suicide
- Nosebleeds/unexplained burns
- Loss of appetite, yet periods of binge eating
Signs & symptoms

Social

• Changes in friends
• Drug use by friends
• Engaging in risky behavior
• Avoids contact with concerned persons
• Loses interests in hobbies/activities
• Secretive and defensive regarding actions and possessions
Signs & symptoms

**Financial**

- Steals money or objects from family or friends
- Develops unexplained shortages of money
- Loss of possessions
- Increased amounts of alcohol/pills missing in the home
Heroin

Physical side effects

• Withdrawal is never fatal in otherwise healthy adults, but includes two to seven days of:
  – Restlessness and yawning
  – Cold flashes with goose bumps, diarrhea
  – Muscle and bone pain
  – Vomiting and insomnia
Heroin

Physical side effects

- Slowed breathing, slowed cardiac function
- Suppression of pain, clouded mental functioning
- Constricted pupils, droopy eyelids, slowed/slurred speech
- Constipation and nausea
- Nodding off
- Runny nose, needle track marks
National overdose deaths: Number of deaths from heroin
## Opioid receptors

<table>
<thead>
<tr>
<th>OPIOID RECEPTORS</th>
<th>Effects</th>
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</thead>
<tbody>
<tr>
<td><strong>Opiod receptor class</strong></td>
<td><strong>Effects</strong></td>
</tr>
<tr>
<td>Mu$_1$</td>
<td>Euphoria, supraspinal analgesia, confusion, dizziness, nausea, low addiction potential</td>
</tr>
<tr>
<td>Mu$_2$</td>
<td>Respiratory depression, cardiovascular and gastrointestinal effects, miosis, urinary retention</td>
</tr>
<tr>
<td>Delta</td>
<td>Spinal analgesia, cardiovascular depression, decreased brain and myocardial oxygen demand</td>
</tr>
<tr>
<td>Kappa</td>
<td>Spinal analgesia, dysphoria, psychomimetic effects, feedback inhibition of endorphin system</td>
</tr>
</tbody>
</table>
Opioid system before drugs

Circles = Mu Receptors
Triangle = Kappa Receptors
Purple Stars = Endorphins
Opioid system on drugs

- Circles = Mu Receptors
- Triangle = Kappa Receptors
- Black stars = opiates/heroin
Opioid system in withdrawal

Red Circles=Mu receptors in withdrawal
Pink Triangles=Kappa receptors in withdrawal
Medication-assisted treatment
Medically Assisted Treatment (MAT)

• Medication is used for different purposes while in treatment
• Medication is most effective when combined with counseling and other support
• Rosecrance uses medication in treatment to:
  – Treat symptoms of withdrawal
  – Prevent relapse and treat cravings
  – Treat symptoms of other medical conditions
Opioid system on buprenorphine

Circles = Mu Receptors
Purple Stars = Endorphins
Triangles = Kappa Receptors
Black stars = Buprenorphine
Buprenorphine

**Pros**

- Stops withdrawal
- Reduces cravings
- Longer treatment stays
- Eases chronic pain
- Helps brain repair
- Safe for pregnant women

**Cons**

- Potential abuse/diversion
- Still activates the opiate receptor
- Need to taper carefully
Buprenorphine in medical withdrawal and maintenance

Kaplan-Meier curve of cumulative retention in treatment (Kakko et al, 2003)
Opioid system on Naltrexone

Circles=Mu Receptors
Purple Stars=Endorphines

Triangles=Kappa Receptors
Teardrops=Naltrexone
Naltrexone

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No abuse/diversion</td>
<td>• Not as good at curbing cravings</td>
</tr>
<tr>
<td>• No activation of opiate receptor</td>
<td>• Not for pregnant women</td>
</tr>
<tr>
<td>• Injectable, only take once a month</td>
<td>• Injectable (Vivitrol) can be expensive</td>
</tr>
</tbody>
</table>
Extended Release Naltrexone

- Much evidence based on one large Russian study (Lancet 2009)
  - 2009, 250 patients, 13 sites in Russia
  - Double blind, placebo controlled
  - 24 weeks of study
  - Results
    - Confirmed abstinence – 90% vs 35%
    - Reported days drug free – 99.2 vs 60.4
    - Retention 168 days vs 96 days
Substance use among the emerging adult population
What is emerging adulthood?

- An additional life stage between Erickson’s stages of adolescence and young adulthood (Jeffrey Arnett’s theory)
- It generally applies to young adults between the ages of 18 and 30
- A period of life where there is much conflict, difficulty, confusion and consequently greater susceptibility to substance abuse
What is emerging adulthood?

• Shift in attitude about adulthood obligations (marriage, home and children) from pursuit to avoidance (Arnett, 2005)

• Less stable financial times causing young adults to remain in parents’ home longer, allowing for increased freedom from responsibilities (Arnett, 2005)

• A new period of development brought on by societal changes
Ripple effect

• Increased focus on education creates a later age for leaving parental dwelling and/or financial assistance and marriage
• Instances of substance use and abuse are likely related to the discomfort often associated with forming oneself
• Feelings of the “shoulds” are great as the individual tries to compare self to those in the next or previous stage
• Young adults are often searching for “who am I”
So, how do young adults cope with this?

**Distraction, distraction, distraction**

- Extreme risk-taking behaviors
- Binging behavior (food, shopping, sex, etc.)
- Focus on external image (societal cause)
- Drugs/alcohol
- Internet
- Friends
Why might young adults be more susceptible to substance abuse?

Psychological factors

• Coming to terms with self as a unique and independent individual
• Security/comfort base shifts toward internal
• Identity less peer based
Why might young adults be more susceptible to substance abuse?

**Social factors**
- Peer groups change drastically
- “Societal” expectations
- Acceptance by others vs. acceptance from self
- Sensation seeking
Why might young adults be more susceptible to substance abuse?

**Familial factors**
- Changing “role” in the family
- Boundaries
- Expectations
Why might young adults be more susceptible to substance abuse?

**Biological factors**

- Biological growth still occurring
- Emergence of mental health problems more refined and evident
- Lack of healthy stress responses
Implications

- Four times higher failure rates for high school
- Four times greater rates of unemployment or lack of enrollment in advanced education for 18 to 21-year-olds
- Three times greater risk of engaging in illegal activities
- Six times greater risk of being involved with youthful pregnancy
Implications

- Anorexia and other eating disorders become more prevalent among males and females.
- Suicide remains the 2nd leading cause of death in young adulthood; for every successful suicide, there are 40 failed attempts (nine times this amount “consider” killing themselves).
- Opiate use continues to rise to epidemic proportions.
Treatment implications: What works and what doesn’t
Treatment considerations for counselors

- View client as the expert
- Educate on developmental issues
- Involve community support systems
- Grow internal motivation
- Encourage self-exploration
- Accept client’s ownership in the counseling and recovery process (empowerment)
- Instill confidence in life skills
What doesn’t work

- Fear- or threat-based approaches
- Long, large groups
- Constant siding with family
- Focusing solely on consequences
- Attempts to control client progress
- Poor boundaries
- Anger
- Inconsistency
- Lecturing
Strength-based approaches
Core principles of strength-based practice

• An absolute belief that every person has potential and it is their unique strengths and capabilities that will determine their evolving story as well as define who they are—not their limitations (not, I will believe when I see—rather, I believe and I will see).
Core principles of strength-based practice

- What we focus on becomes one’s reality—focus on strength, not labels—seeing challenges as capacity fostering (not something to avoid) creates hope and optimism.
Core principles of strength-based practice

- The language we use creates our reality—both for the care providers and the children, youth and their families.
Core principles of strength-based practice

• Belief that change is inevitable—all individuals have the urge to succeed, to explore the world around them and to make themselves useful to others and their communities.
Core principles of strength-based practice

- Positive change occurs in the context of authentic relationships—people need to know someone cares and will be there unconditionally for them. It is a transactional and facilitating process of supporting change and capacity building—not fixing.
Core principles of strength-based practice

- Person’s perspective of reality is primary (their story)—therefore, need to value and start the change process with what is important to the person—not the expert.
Core principles of strength-based practice

- People have more confidence and comfort to journey to the future (the unknown) when they are invited to start with what they already know.
Core principles of strength-based practice

• Capacity building is a process and a goal – a lifelong journey that is dynamic as opposed to static.
Core principles of strength-based practice

- It is important to value differences and the essential need to collaborate—effective change is a collaborative, inclusive and participatory process—“It takes a village to raise a child.”
Overdose prevention
Overdose prevention

Importance of education on:

• Change in tolerance
• Danger of heroin in area
• Discussion of Narcan
• Importance of ongoing recovery support
• Importance of continuing with doctors if medication has been prescribed
Thoughts

• Treating young adults requires unique approaches and appropriate staff.
• Today’s young adults are not equipped with the same skill set of a generation ago.
• Providers should not get bogged down in traditional treatment while enacting many changes with minimal cost.
Thoughts

• Young adults succeed in peer-based groups with whom they can realistically identify.
• This age group is still coming to terms with itself, so providers who are willing to meet the young adult where they are will ultimately fare better.
• Rapport is everything. Be genuine!!
Key points

• **If in doubt, call** - Rosecrance is here to help, if you are not sure if someone you love is abusing heroin or any other substance, call us, we can help.

• **This epidemic is not going away** - This situation will not go away anytime soon and it will likely get worse before it gets better. We all will have to work together if we are to push this epidemic out of our community.

• **There is hope** - While the situation is not a happy one, success stories continue to occur. There is hope.
* Pictures of individuals in this presentation are for illustration purposes only. These pictures portray models and are not pictures of actual clients of Rosecrance. No inference should be made, or is implied, that the pictures used here are of individuals connected in any way to Rosecrance or to its affiliates or programs.