What Does it Take to Change?

A Qualitative Evaluation on
the Fight Against Prescription Drug Abuse
in Southern West Virginia

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July 2004

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What Does it Take to Change?
The Fight Against Prescription Drug Abuse
In Southern West Virginia

In February 2003, Purdue Pharma, manufacturers of the prescription drug OxyContin, gave the WV Prevention Resource Center $125,000 to help implement a prescription drug abuse prevention effort in three southern West Virginia counties. The effort focused primarily on the rising use, or misuse, of OxyContin. The three pilot counties, Mingo, Logan, and Wyoming, were chosen for two primary reasons: (1) they have experienced significant problems with prescription drug abuse over the past several years, and (2) communities in each of these counties have mobilized around the issue and are currently active in developing responses to the abuse problems with which they are faced. This report, which covers a 13-month study, is an account of the pilot region's experiences, obstacles, and efforts surrounding the prescription drug abuse epidemic.

Methodology
A Note from the Author

This report is based on interviews, conversations, and observations I made over a 13-month period. I visited all three pilot counties, attended local meetings, spoke to community members, law enforcement, doctors, and addicts. I reviewed literature, watched news programs, listened to radio programs, and attended prescription drug abuse conferences. I heard heart wrenching stories of personal loss and was uplifted by ordinary citizens seeking solutions for their communities. The prescription drug abuse problem is overwhelming, and at the close of this study, there are still more questions than answers. I am not a counselor or a drug expert; I am a writer and researcher. This report is based on my limited perception and experience. It is my hope that I have accurately portrayed the people and communities that this report represents and that it will serve as a glimpse into the full scope and depth of the prescription drug abuse crisis.

Purdue Pharma, L.P.

The Purdue Frederick Company was established by two doctors in New York City in 1892. In 1952, with annual sales of $22,000, it was purchased by its present owners, Dr. Raymond Sackler and Dr. Mortimer Sackler, and began selling laxatives (Senokot®) and antiseptics (Betadine®). In 1972, Contin®, controlled drug release system, was developed, and in 1991 Purdue Pharma was formed. The company's primary business focus is on the development of long-lasting medicines, particularly controlled-release opioid analgesics, to relieve pain for both cancer patients and patients with moderate to severe chronic pain. A privately held company headquartered in Stanford, Connecticut, with branch facilities in the U.S. and independent associate companies worldwide, Purdue has about 3,000 U.S. employees and exceeds $1 billion in annual sales.

OxyContin – An Overview

In December 1995 Purdue Pharma introduced OxyContin, the brand name and registered trademark for oxycodone hydrochloride controlled-release, an opioid analgesic agonist prescribed for moderate to severe pain in humans. Oxycodone, a cousin of morphine, is also sold under the registered brand names of Percodan, Percocet, and Tylox, and all of these opioid drugs, including heroin, hydrocodone, and codeine, are derived from opium, which is extracted from the opium poppy. Hippocrates, "The Father of Medicine," prescribed opium to his patients in 470 B.C. The first recorded use of opium as a recreational drug occurred in the 17th Century.

OxyContin ("Oxy"), one of the strongest pain relievers on the market, is distributed in 10mg, 20mg, 40mg, 80mg, and originally, 160 milligrams, although this dosage was pulled from the market in May 2001. It is a Schedule II narcotic, meaning it is a federally approved drug with a high potential for abuse. Taken orally, the dissolvable coating on OxyContin allows it to be released into the body over a 12-hour period, making it the longest lasting oxycodone available. Opiate agonists, the term used for this family of synthetic (man-made) drugs, rapidly attach themselves to opioid receptors in the brain and spinal cord, altering the limbic system, which controls emotions; then they block pain messages from the spinal cord to the body, causing relief from pain associated with cancer, arthritis, lower back problems, and other diseases and disorders. OxyContin is a single entity agent, meaning it is a pure opioid that is not combined with other drugs, like Tylenol or aspirin, reducing the risk of gastric problems or liver damage associated with these combination drugs.

OxyContin was developed in response to the estimated 50 million Americans who live with chronic pain and the additional 25 million who live with acute pain. When released, Oxy was considered to be a breakthrough drug for pain management. As the good word spread, doctors began prescribing more OxyContin, and sales began to rise, from $125 million in 1997 to $1.35 billion in 2001.

As sales were rising, so was the illegal use of the drug, which began to appear across the nation shortly after Oxy's release. Users discovered that if the time-released coating were destroyed by crushing the pill and the remains were inhaled or injected, all of the oxycodone normally spread over a 12-hour period could be experienced at once, causing euphoria and sometimes death. Because of its time-release component, OxyContin contains a higher dosage of oxycodone than other narcotic painkillers, reducing the number of pills legitimate patients must take, while increasing the risk for abuse among abusers looking for a greater high. Soon after Oxy's abuse potential became known, Purdue Pharma came under attack for not formulating the drug to prevent misuse.

When OxyContin is misused, addiction can occur alarmingly fast. Pills in the higher milligram strengths are meant for opioid tolerant individuals only, not first time opioid users, thus recreational use of the drug is highly dangerous. Because of its potency when misused (it is up to 16 times stronger than similar medications), it is relatively easy to

overdose on OxyContin. Depending upon the degree of dependence or addiction,[1] withdrawal symptoms can be excruciating. About six hours after the last dose, nausea occurs in conjunction with abdominal cramps, diarrhea, sweating, insomnia, body shakes, leg aches, runny nose and eyes, and a sensitivity to sound. Often addicts trying to get off of the drug cannot withstand the withdrawal process and return to the drug for relief from symptoms, creating a vicious cycle that has caused overdose deaths and reported cases of suicide. Overdose symptoms include slow, shallow breathing, pinpoint pupils, a very slow heart rate, low body temperature, seizures, and coma. If not treated immediately, death occurs from respiratory depression. The number of deaths directly tied to OxyContin is an on-going controversy. Contributing factors that make numbers hard to come by include oxycodone's fast, five hour metabolization, no autopsy, medical examiners not being told to test for certain drugs, first responders failing to secure the scene, and more than one drug being used at the time of overdose.

Due to the higher dosage of oxycodone contained in OxyContin, the drug's price is higher than other narcotic painkillers. At the pharmacy, 60 OxyContin pills at 40 milligrams per pill sell for 240 dollars. Patients with insurance or Medicaid coverage can receive this prescription for as little as one dollar. On the street, however, the average price of an OxyContin tablet is one dollar per milligram, or forty dollars for one 40 milligram pill, or 2,400 dollars for the same prescription purchased at the pharmacy for one dollar.

OxyContin has been termed "hillbilly heroin" because of its exploding use in Appalachia, where dangerous work associated with coal and timber industries produce a high rate of job-related injuries. OxyContin legitimately works for these occupational ailments, so it is often prescribed. In addition, black lung and smoking contribute to high rates of cancer, for which OxyContin is the most effective pain medication. And finally, poverty and high unemployment in the area induce people who have legitimate prescriptions to sell to drug dealers in order to improve their financial situation, thus contributing to the spread and accessibility of the drug. These contributing factors helped to lay the groundwork for the prescription drug epidemic in southern West Virginia.

[1] Opioid users can develop a tolerance for the drug, requiring a higher dosage to achieve the same pain relief. Dependence takes place when, without the drug, withdrawal symptoms occur. A person is labeled an 'addict' when they become obsessed with obtaining the drug for its effect, without needing it for any kind of therapeutic purpose.

S.T.O.P. – Strong Through Our Plan

In the summer of 2000, Debbie Trent, a licensed professional counselor and social worker, was working at a mental health center near her hometown of Gilbert, WV, a small community of about 500 people located in the coalfields of Mingo County, population 28,000. Debbie, a bright-eyed, upbeat blonde, noticed that "too many people from my area" were being referred to the center, "and that's when I first heard about OxyContin," she wrote, in a local publication entitled *Perspectives*. Around the same time, Debbie started hearing about robberies and break-ins, unusual in a town where residents didn't bother locking their doors. Then several young people died from apparent suicides. Toward the end of the summer, Debbie got a call that a friend had been in an auto accident. She rushed to the hospital, but her friend had died instantly after being hit head on by a car filled with young men who were high on OxyContin, track marks evident on their arms. At the hospital, trying to comfort her deceased friend's son, she noticed that he had lost a substantial amount of weight. Later, the son acknowledged that he, too, was addicted to OxyContin, and he needed treatment.

The pastor of Gilbert Presbyterian Church, Rev. Wil Smith, came to the hospital as well that day. He and Debbie started sharing their concerns over the local drug situation and decided that something had to be done, although they didn't know what they could do. Debbie decided to talk to Dr. Wayne Coombs, who was supervising a postgraduate program that she was taking. She knew that Dr. Coombs was director of the WV Prevention Resource Center (WVPRC) and thought "perhaps they would have a solution to 'fix' Gilbert's drug problem."

On October 18, 2000, Debbie Trent and Rev. Smith organized their first meeting in Gilbert with about 20 community members in attendance, including Dr. Coombs, who brought several professionals from the WVPRC. Debbie said, "The people at that first meeting were ready to vent. They told how drug addiction was affecting their families, schools, and neighborhoods. I heard about a place commonly known as "Pill Hollow" and was amazed to find out that it was less than half a mile from my home." While the WVPRC agreed to offer support and technical assistance, it became clear that a quick fix was impossible, and the community itself would have to work toward its own solutions. But the community appeared up to the challenge. The second meeting grew to 40 people, and soon the numbers grew so large that the meetings had to be moved to the local community center. Thus began the Strong Through Our Plan, or STOP, organization.

STOP continued to meet regularly, and key players with different perspectives and backgrounds began to materialize within the group. A mission statement was developed, and problems and target areas were identified. Meetings spread to neighboring Logan and Wyoming counties and included guest speakers like law enforcement, treatment professionals, experts on prescription drug abuse, a doctor who had started a petition to ban OxyContin, and representatives from Purdue Pharma.

As STOP's activities increased, so did the media attention. They attracted county and state politicians and were picked up by local and state newspapers, *The Associated Press,*

New York Times Magazine, *London Guardian*, CBS's *48 Hours*, MTV, and HBO. "Our goal," said Debbie "is to reclaim our communities from the stranglehold of drugs and addiction." But some residents in Gilbert thought that all the attention was giving their community a black eye. Debbie and others felt that the community had been in denial for too long, and in order to heal itself problems had to be faced. They sought support from area churches, who distributed STOP newsletters that said "STOP's not Stopping," and implored church leaders and congregations to get involved with the effort, and to pray that God use their community as a model for change that can occur when people and churches work and pray together.

By the end of their first year of operation, STOP had made huge strides in mobilizing and educating their communities, and they did so on less than $800 in donations, and two $500 mini-grants, one of which was spent on applying for and receiving 501(c)3 non-profit status. "STOP's finances (or lack of) illustrate that it does not take major funding to get a project up and running," said Debbie, who added that, since that time three years ago, no significant financial changes had occurred.

During those three years, however, STOP gradually started losing some of the momentum it had built. Rev. Smith, President of STOP, was reassigned to another church outside the area, and Debbie Trent, the Executive Director, though still involved with STOP, was forced to focus her attentions on other job responsibilities. And the community itself seemed to lose interest. Meeting attendance dwindled from over 100 to just a few. Rev. Beverly Birchfield, a member of STOP, explained:

> The disagreement about the type of attention we had drawn, plus the time it took to educate ourselves, took a toll on our attendance. Impatience worked on many who had taken on the work, and our meetings dwindled as interest waned. At a public fundraiser for another situation, one of the local pastors used the podium to blast an accusation. He accused us of not getting anything accomplished aside from sitting around pushing papers about. After that, we watched as pastors and churches withdrew their support.

Nonetheless, those that remained persevered, and STOP continued its efforts on an abbreviated scale.

When Purdue Pharma gave monies to the WVPRC, Dr. Coombs felt that STOP would be an ideal candidate for utilizing and maximizing the funds. He contacted STOP, and members of the organization agreed to renew their efforts with help from the WVPRC. Strategies for the Prescription Drug Abuse Prevention Capacity Building Program were developed, along with a plan for implementation.

With encouragement and direction from the WVPRC, it was decided that, as STOP continued to work in the community, it would also focus its attention on internal stability and growth. This meant creating a formal board of directors, which had not been done previously. "We have no direction," said one member; "we're like loose cannons shooting in all directions." Another female member suggested that "the chairperson

should be a man. In southern West Virginia, men can get doors open, and a woman might be a handicap." Generating funds was also a focus for reorganizing STOP. "We have $492 in the bank," said the acting treasurer, "not including the $90 that hasn't been deposited from the bake sale." In total, ten people, representing Logan, Wyoming, and Mingo counties, were elected to the board, headed by a male chairman. Committees were formed for Prevention Education, Public Relations and Policies, Recovery, which would research fellowship homes and half-way houses, and Finance. Finally, with Purdue funds, an AmeriCorps VISTA (Volunteers in Service to America)[2] volunteer was recruited for each of the three counties. Given a small stipend, their goal was 'to facilitate the connection of needed community resources to build community capacity to assist in the prevention of substance abuse and promote a drug free lifestyle.' Each of the VISTAs chosen were natives of their county.

Wyoming County – Debbie Dunford is soft spoken and neatly dressed. She carries an 8x10 framed photograph of her son and shows it to people at the STOP meeting she has organized in Oceana, WV. He is handsome and bears a resemblance to his father, who is also at the meeting. One year ago, at age 19, the young man in the photograph died from an accidental overdose of OxyContin. "I never thought this could happen to me," Dunford tells me. "It's taken me a year since his death to get my mind focused on doing anything." Dunford has taken the VISTA position for Wyoming County, where she was born and raised and where she raised her children. "If I can help some other mother from going through this pain that I'm going through, or if I can stop another young person from dying, that's my goal. That's why I'm in this program."

A panel of local law enforcement experts are the focus of the Oceana STOP meeting, held at a United Mine Works Association union hall. David Thompson, the prosecuting attorney for Wyoming County, explains to the audience of about 15 people the difficulties associated with drug enforcement. "The drug community is fairly sophisticated in terms of how to avoid law enforcement and what's needed to get convictions," he says. "One of the greatest impediments is lack of manpower and money." The prosecuting attorney's office participates on several levels of collaboration with the police but usually get involved and begin working up cases *after* an arrest is made. Contraband confiscated during an arrest is sent to Charleston for testing to make sure it meets the code for conviction. Charleston is the only drug lab in the state where evidence is verified. One lab covering the entire state has resulted in extreme backlogs and a *one year* turnaround time. Defense attorneys are able to move hearing dates around due to lack of physical evidence or certification from Charleston, and since the evidence is not forthcoming, convictions are plead or let go. Convicts post bond and are back on the street. According to Chief Deputy Randall Aliff, it is harder to catch dealers the second time around, because informants, who are often used in the first arrest, are expended, and the dealers are more cautious of whom they do business with. If,

[2] AmeriCorps is a network of national service programs that engage more than 50,000 Americans each year in intensive service to meet critical needs in education, public safety, health, and the environment. See http://www.americorps.org

however, offenders are arrested a second time while still on bond, a petition can be filed to revoke the bond.

Debbie Dunford has spent the last year educating herself in an attempt to try and figure out why her son died. "I hear that the reason a lot of people overdose is because, when they're coming down off that high, they don't want to feel that withdrawal or pain, so they either shoot up or snort more, and they don't realize how much is getting in their system and how strong it is. Some of my son's friends, knowing that my son died of an overdose, it wasn't intentional, it was accidental, because my son loved life, but they're still doing the drug. What does it take to change?"

A few weeks after the Oceana meeting, I traveled to the county seat of Pineville, population 1,200, to talk further with Chief Deputy Aliff. Outside the Wyoming County courthouse in Pineville, coal and logging trucks moved endlessly down the town's main street, a narrow two-lane road that housed a furniture store, a portrait studio, an abandoned diner and law office, a few small businesses, and an Army Recruiting Center. Beside the gothic courthouse was the jail where Chief Deputy Aliff talked to me about prescription drugs in Wyoming County, population 27,000. He said that prescription pills are a "tremendous problem," and that OxyContin is the most serious, causing the most deaths. "You get people from 18 to 50, rich, poor; there are no boundaries. Very few families are unaffected, and we don't have an answer for parents who want help. There is no evidence that anything we do is working." Chief Deputy Aliff reiterated that more manpower would be helpful. There are only two officers assigned to drugs in Wyoming County, one full-time and one part-time. The Sheriff and 17 officers cover the entire county; starting salaries are around $17,000 a year, and raises are available only if the county can afford it. "You have to want to do it," he said. Aliff has a problem with the court system too, restating what was said at the Oceana meeting: even after arrests are made, convictions are hard to come by. "I wish I had answers," he said. "It stays on your mind a lot."

Logan County – Gail Bowen, a fiery red head and registered nurse from Lorado, one of 16 small communities that comprise Buffalo Creek, survived the Buffalo Creek Flood that killed 125 people in 1972 when a sludge pond, owned by the Pittston Coal Company, burst, releasing millions of gallons of water. After the flood, Gail remained in Lorado and said that Buffalo Creek was "a wonderful place to raise children." One of her sons is now a missionary and one is an OxyContin addict. "I know how my children were raised; I know their values. I know it was a good home," she said; so when a large sum of money disappeared from her checking account and she learned that her son, over a period of time, had stolen it to buy OxyContin, she was shocked, angry, and hurt. Moreover, she was frightened for her son. "Knowing who he was and the heart he's got in him, my big question was: what is this thing that is so powerful it would make a good kid do this?" She started looking for answers. "I wanted to find help," she said. "When my pastor asked me to help organize a community coalition, that's how I got involved with all of this, with STOP." Gail was one of the first community members to join STOP, and when the VISTA position arose, she accepted it for Logan County.

Since 1987, the Logan County Circuit Court has been analyzing trends in felony offenses. The statistics have remained relatively constant over the years: over 90 percent of felony cases in circuit court are linked to drugs and alcohol. According to Circuit Court Judge Eric O'Bryant, "We saw a run on OxyContin over a two-year period, which appeared to be the drug of choice, but it is not as prevalent now in the court system." He attributes this fall in Oxy cases to several factors: (1) doctors are being more selective about prescribing the pills; (2) major illegal dealers have been busted and sent to prison; and (3) a lot of people using OxyContin have been diverted to methadone clinics.

Another Logan County study revealed that the average age of offenders in the Logan County Circuit Court was late twenties to early thirties, that there were more men than women, and most offenders had less than a high school diploma. "Out of 500 people who plead or were found guilty, 96 percent could link drugs or alcohol to their legal entanglements," said Charles Brown, a Logan County probation officer. "Out of those 500, only four people had college degrees." Three of the four people with degrees were lawyers, some of whom were indicted for trading marijuana for prescription drugs, and two of whom are now deceased from drug related deaths.

Judge O'Bryant has seen cases where Oxy offenders have started out with legitimate access to the drug, having been given a prescription for an injury, for instance. A dependency on the drug develops, the doctor takes them off the medication, or compensation runs out, and, unable to obtain the drug legally, they seek it illegally. He has also seen a number of cases where patients with legitimate access to the drug sell it for extra income, or trade it for guns or other drugs. He said that sources outside the state contribute to Oxy's availability. For example, dealers from North Carolina and Tennessee obtain the drug and bring it into areas of West Virginia where they know it will sell.

Drug cases are "cyclical," said Judge O'Bryant. "Availability is the key." Many of his cases are property crimes – theft, breaking and entering, but he says that the crime rate depends on the economy. When more people are working they have less time to get into trouble; they're happier overall. When out of work, people worry about not meeting their bills, they grow unhappy, and, with too much time on their hands, they turn to alcohol or drugs, and crime starts to rise. "When you have got people out there selling their kids into prostitution [to feed their drug habits], and I know for a fact it's happened," said Probation Officer Brown, "there's no doubt that crime rates go up."

There is a general consensus among area law enforcement officials that drug offenders tend to return to the drug life after being incarcerated, and prison does not seem to work. For illegal possession of Schedule II drugs, be it one pill or 1,000, West Virginia sentencing guidelines require not less than one year or more than 15 years in jail, and up to a $25,000 fine. (Federal sentencing guidelines differ, as they are based on the amount of drugs confiscated.) Circuit judges determine where to place offenders (i.e., on probation, house arrest, or in jail for no less than a year). The amount of time offenders actually spend in jail or prison is determined primarily by their behavior inside. For

every good day of behavior, one day is taken off of the sentencing time, thus a 15-year sentence could actually be fulfilled in 7.5 years. While Chief Deputy Aliff in Wyoming County would like to see a five-year minimum sentence for drug offenses, he doubts that it would do much to deter recidivism; nonetheless, he says that a five-year sentence is five years in which offenders would be off the streets. In terms of preventing recidivism, Charles Brown said, "I don't think the prison system is doing what it can do." To this end, in January 2004, a Day Reporting system was started in Logan County as an alternative to sending drug offenders to jail. It is for non-violent offenders and offers rehabilitative services, counseling and treatment, and educational services for help in getting a GED. STOP sought funding for a similar project they wanted to implement called H.E.A.R.T. (Health Education and Recovery Training), which would work with nonviolent substance abusers on home confinement. However, funding efforts for HEART have been unsuccessful, but STOP and the WVPRC are now working with the Day Reporting system to help encourage its success.

"Jail is not a good rehab place," said Gail Bowen, who ended up getting acquainted with law enforcement after her son was sent to regional jail for shoplifting in order to pay for his drug habit. Classic scenarios of supporting a drug habit usually begin with writing bad checks, often stolen from a parent or spouse, stealing money from family members, or stealing items from the home. Gail discovered her possessions in a pawn shop and was forced to buy them back. Once family resources have been exhausted, shoplifting, breaking and entering, prostitution, and more serious crimes start to occur. Gail explained her experience with the cycle of addiction she encountered with her son:

> You go through all these different phases. I mean nobody is happy if they have a drug addict in the family; everyone suffers. The addict that is out of control suffers through their cycles of guilt, self-disgust and despair. Family members suffer as they try to function while being tossed back and forth through different phases of denial, shock, anger, fear, constantly praying for a miracle and seeking help to end the cycle. But a big deal with parents is they don't want to be the ones to have their own children arrested, even though they have stolen from them. I wanted to intervene somehow, even though I knew he had to do the work, and he had to be ready for it and want it for himself. After multiple attempts to get him into rehab and forever waiting on long waiting lists with no results, I thought to intervene might be the spark he needed to start making changes. Unfortunately, he ran the whole gamut and ended up in jail anyway.

While her son was in jail, Gail demanded that he be drug tested. "He was not clean," she said. "I'm tired of hearing how there's not a clean jail or clean rehab, and you can just expect it. No, I don't have to expect it. I can deal with the reality that it might be true, but I don't think that I should expect it."

For Gail, the bottom line always returns to the same question: How do I help my son? She still searches for answers, not only for herself but for other parents like her, and for her community. "Being a survivor of the Buffalo Creek disaster and having that kind of trauma, I feel like the OxyContin plague is a flood coming at us, and it's not stopping,

and we have a lot of debris left over from all that's going on and all that's still yet to come."

Mingo County - "I knew nothing of the drug situation that surrounded me," said Florence Lester, a life-long resident of Gilbert, who, with her husband of 30 years, raised two daughters successfully, without the worry over drugs. Florence, unpretentious and, admittedly, tenderhearted, represents a segment of people in her community who have been relatively untouched by the storms brewing around them, because they have been fortunate enough to avoid direct experience. Newspaper articles revealed a problem, and it was a shame, but it was happening to someone else. When Debbie Trent suggested to Florence that she become Mingo County's VISTA, Florence accepted the offer. Her youngest daughter had left home to attend college, and the timing seemed right. The community had been a good place for Florence and her family; it was home, and she wanted to give something back. Within weeks Florence said she was "amazed" and "bewildered" at the epidemic ravaging her community. "It looks dismal," she said. "It seems like an abyss. I feel like I'm just such a small part, and I know so little of what to do to try to turn it around. There seems to be few facilities in our area; there are none for treatment, and I just feel like it's enormous. I really don't know where to start."

Florence was not the only person who felt overwhelmed, but she and the other VISTAs and members of the STOP organization began doing what they could, implementing plans, working on the committees they had created, trying to generate community support through phone calls and visits to schools and businesses, and meeting monthly to go over problems and progress.

STOP's ten board members are a varied group, from a recovering addict to a female minister. They are earnest and sincere and largely outspoken. Most members have full-time jobs but still make time for STOP, often donating monies, meeting places, and other resources. Some have been touched directly by drug abuse, and some simply want to help improve the well-being of their communities. They are a likable group, and while their business is serious in nature, laughter is often present. Meetings are usually started with a prayer; agendas that have been put together by Florence are distributed, and the group gets down to business. Invited guest speakers have talked about funding opportunities, fellowship homes, treatment centers, and underage drinking forums.

One of the board members, Minness Justice, an articulate, energetic, and straightforward electrical mine inspector, invited me to attend a private meeting he had arranged with the Chief Safety Director from one of the areas largest coal producers. Minness wanted to provide to the coal company, free of charge, a seminar for middle management on recognizing and dealing with substance abuse in the workplace. From the Safety Director I learned that, during a random drug testing at the coal company, five employees tested positive for drugs and were later discharged. "Some of the people we had to terminate were our best people," said the Safety Director, adding that marijuana and cocaine were the most prevalent substances found, and that the average age of those testing positive

was between 30 and 45. He also said that addicts carry materials off job sites to pay for their habits, and once they're fired sales go up.

Like Gail Bowen, Minness Justice was one of the first community members to become involved with STOP because of drug abuse within the family. His daughter became involved with a high school football player, and they both developed a drug problem that eventually escalated into OxyContin as the drug of choice. "It was really detrimental to her health, the family security, the family shell," he said. "It destroyed it all." Minness had already suffered a "devastating blow" when his son was killed in a car accident at age 18. "He was a good kid," said Minness. "He experimented with drinking a little bit, but to my knowledge he never used drugs. They were at a party, you know, and the people at the party let him drive. Him and a friend had an accident, and he was the only one that was killed; the other one was injured, but he survived. That was in 92, and I quit drinking anything. I haven't had a drink of alcohol since 92. I just don't do it."

Minness's experiences, particularly, in this instance, with his daughter, offers a glimpse into the reality of drug addiction, not only for the addict, but for the entire family unit:

> Anytime a child deviates from a normal upbringing -- and normal is, they experiment, they do things you don't like, but they come back to the middle -- when they don't come back to the middle then it affects you in every possible way. It has an impact on your attitude toward dealing with work, and you're very concerned about their welfare, their health. How are they going to survive this? It'll devastate your finances. [Professional help], keeping her from going to jail for bad checks, these things jump tremendously, and the numbers get very high. I have a good income, and I was able to assume some of these things, but I work with people that do not have that kind of resource, and they cut the child loose very early in the drug stage, very early, because they are financially devastated. They don't have the emotional, or the intelligence, to go seek help; they just shun themselves for it. Throw the child away is basically what they do, turn them out. And I think a lot of these kids you'll find are the ones that are on the street selling theirselves, ending up in jail. It's a painful experience. It's devastating, but it's your child, and no matter what they do, I think we have an obligation to do as much as we can for as long as we can before you turn them out.

DOES TREATMENT WORK?

Perhaps Tim Gibson, a STOP board member and chairman of STOP's Recovery Committee, best characterizes the process of addiction and treatment. His story, while lengthy, provides insight into a process similarly described by many addicts.

A big man, tall and broad shouldered, Tim is 37, gregarious, with a wife and three children. Born and raised an only child in Man, WV, he and his family also survived the Buffalo Creek flood. Shortly after the flood his grandfather died, and his grandmother moved into his house. Tim's father was a coal mine superintendent who made good

money but was often required to be away from home. "Essentially I grew up with two mothers, and my grandmother had nothing better to do with her money than give it to her grandson," said Tim. In school, with money, Tim became the person people came to "to get a couple cases of beer or a bag of weed," and it became his tool for fitting in. While still in high school, Tim started experimenting with drugs like crystal meth, crank, cannabinol tea, speed, and acid. In college, working part-time at a dog-racing track, Tim was introduced to cocaine. "That part of my life was pretty laid back. I mean my roommates and I, we got high, we went to school, we went to work; you know, we were functioning addicts." But soon the cocaine started taking away from the tuition money, and Tim gave up on college. By this time he had met and fallen in love with his future wife. "I've always had a real strong moral background. I knew right from wrong, and I wanted to marry this girl, but I didn't have enough money to do it," he said, "so I decided to join the Army. I knew that I could get money for college; I knew I could get a paycheck, and I knew I could see some places. I wanted to make a better life for me and her." After basic training, Tim married and was sent to Korea, where his wife later joined him. During his four years in the Army, Tim was drug free. "Couldn't do drugs, never thought about doing drugs. Drugs were not an option. But alcohol, you know, a fifth a day, it was common." After Korea, Tim's next duty station was in California, where he and his wife, and by now his children, remained after he got out of the Army. Tim got a job with a major electronics company and one day, while golfing at Pebble Beach, his boss pulled out a joint. "My mind is thinking, marijuana, I remember you. So I get introduced to pot again, which is okay. You know I'm holding a steady job making good money, and so is my wife. Babies are fine. We're really doing well." Then, at the office Christmas party, Tim and a couple of co-workers stepped into the parking lot to smoke a joint, and they invite a newly hired secretary to join them. She handed Tim a crack pipe. "I took a hit of it. I got sick, but I liked it." The secretary explained that everybody gets sick the first time; you just have to wait a few minutes and try again. "It constricts all the organs in your body instantly and makes you sick, and it has to go one of two directions," Tim explained. After vomiting, he tried another hit. "I like how it made me feel. For lack of a better word, I was revitalized, charged batteries. I'm a big guy. I do nothing fast. I have a motivation problem. I've got lots of things I want to do, but it's hard for me to just get the adrenalin, to get up and go do it. It's instant adrenalin." After the second hit, Tim said he was high and had energy for what seemed like hours. "I was funny. I was all over the party. The next day I wanted more."

Over time, Tim became addicted to crack. Unlike alcohol, marijuana, Percodans, Percocets, powdered cocaine, or any other drug he had used, Tim never saw himself losing control until he used crack, and, unlike previous drugs, he did not want to share crack with anyone. He became expert at keeping his addiction hidden from his wife and friends, but his boss recognized he had a problem after he started missing work. "She tried to help me but said this is the only chance I'm going to give you. Of course I messed up, so I lost the job." Tim drifted through four more electronics companies. "The crack use got more expensive, from $20 a day to $50 a day. The last 14 months of my full-blown addiction, I was spending anywhere from $1,200 to $1,500 a day. I found myself in places that a 6'4" white guy from West Virginia had no place being. I was dealing with Puerto Ricans and black dealers and white dealers, and they were like, he's

not a cop; he's just a big old country dumb ass that's hooked on crack. For a long time I thought that it heightened the sexual experience, but even sex wasn't important anymore, just the buzz. I became educated on it. I read what endorphins were, how it affected your body and what cocaine does when it's released into your system, and I knew I could never catch that same buzz that you get after a good night's sleep and eating a meal. But you know it still didn't stop the chase. I would tell my wife on a Friday that I didn't get paid, that I'd pick up the check on Monday, and I would do over $700 worth of drugs over the weekend. I always had some voice in my head telling me, you know this is wrong, but I couldn't stop myself. One night I was out of money, had nothing of value except a TV, and I knew that when my kids got up in the morning before they got ready for school, they'd want to watch a few minutes of cartoons. I knew this. I took it anyhow, telling myself I'm going to be in trouble for this in the morning, the whole time I'm carrying it off."

After four years of drug abuse, Tim's wife was fed up. He had been caught in lies more than once. "Seeing her frustration and pain, feeling the hurt it was causing my parents back home, because my mother unknowingly was supporting some of my drug habits by sending me money; I really used her to death – at the coaxing of my wife, I went into rehab; I started the help process." Tim entered a treatment facility in Pacific Grove, California, a few blocks away from the beach. "It was beautiful. An old Victorian house, had about 40 rooms, 24-hour counselors and a cook in the house. You had your own room. We had meditation walks and things like that; we went down to the beach and meditated. My wife complained to me, 'you're on vacation being pampered, and here I am taking care of the kids and working.'" The cost of this 28-day program was $33,000. Blue Cross/Blue Shield insurance paid for all but $1,600. "That was probably the best rehab that I've ever been in," he said. "I've been in four." 40 days after leaving the Pacific Grove rehab, Tim was back to using again, and his wife kicked him out of the house. "She was very, very, very bitter, and not very supportive." His wife simply wanted him to snap out of it. "You don't have enough backbone [she would say]; be a man; deal with it. [It made me feel] weak, challenged, afraid to go home and feel her wrath."

Tim begged his wife for a second chance. He told her, "let's find another place to help me; I need to find someone to make me better." She gave him another chance, and they tried an out-patient clinic for six weeks. Hours were from nine to five, a urinalysis test was given every Wednesday, and, according to Tim, "It was a nice place, very educational, a lot of classroom stuff, one-on-one sessions, and things like that. Toward the end of the six weeks, probably around week four, I was going home of the evenings and using till Tuesday and drinking gallons upon gallons of water so I would flush. That got me through, but my heart wasn't in it. I tried another rehab house; I wasn't there but a few days. I was in full relapse for a few months, and my wife just had all she could take." During this period, Tim created an elaborate lie to make his wife think he was working. He told her he had gotten a job at Target. "We even went to Target and got me a shirt that said 'Target' and a pair of shoes. Every night I would leave at midnight, get home at 8:00 in the morning. Of course, she was in bed by 11:00 and left by 7:00. This

went on for like six weeks. That was probably one of the last straws she could take. She was really looking forward to a Target discount card," he joked.

Not knowing how to admit to his wife that he had lied about the Target job, and after being gone for an entire weekend without calling home, Tim returned to his house to find his bags packed and on the porch. He knocked on the door, but his wife wouldn't let him in. "So I threw my bags in the truck, and I pulled out, and it was night, you know, there's nowhere to go. I had no money for a hotel; I done smoked all my money. I had no money for cigarettes or food, and I was probably in this parking lot for a week in my car. My dad wouldn't take my phone calls; he wouldn't allow my mother to take my phone calls. Hunger is a real big motivator. Hunger and humility. I would go up to the front of the store and snag cigarette butts out of the ashtrays and go back to my truck. Just sit in the parking lot, that's all I did. I finally got my father to take a phone call from me and I told him, I said, I've had enough. I want to get better, but I can't do it here. He said, 'well, I'll give you one more chance. There's a plane ticking waiting for you at San Jose airport.' He didn't know it was 68 miles away. I said, 'well, I don't have no gas to get there.' He said, 'find a way,' and he hung up on me. So, I started trotting." Tim left his truck in the parking lot of Lucky's Grocery Store, and for the next two days walked and hitch-hiked to the San Jose airport and the rest of his life.

Tim returned home to West Virginia and, because he's a veteran, went to a VA clinic. He had to wait five days to get into a rehab home, so he locked himself in the house. The 28-day program was strict. "You had to make your bed, be at breakfast, do your homework. If you neglected it, if you didn't get along with other clients, you got demerits, and three strikes in the program and you're out for six months. My first week there I got two strikes, and my counselor told me no one ever graduated this program getting two strikes the first week. I said you're looking at the first person that will, and I did. I wasn't using, but my heart wasn't in it, not until that first week when I made a decision to turn my will and my life around. I wanted to be done with it. I wanted to live."

Since that time four years ago, Tim has been drug free. His wife forgave him, again, and returned to West Virginia with the children. If Tim has a cold, he monitors his cough syrup. "Part of my recovery pulled me toward wanting to help other people," he said, "get the message out there that there is help. And my assumption with STOP, when I first heard about it, was that it was to help people that are not familiar with the disease in its full blown form. Maybe they are used to alcoholics, old school drunks, but they haven't seen what I have been through."

So, does rehab and treatment work? The short answer is yes. The long answer seems to be: you have to want to do it. "I have had people that I think are real success stories through rehab efforts," said Probation Officer Charles Brown, pointing out that successes are almost always attributed to patients who *want* to go into rehab. He has seen other people go into treatment 10 to 15 times, and it never helps. "Prognosis for people truly addicted to drugs and alcohol is poor, but that does not mean we should not get them treatment. If seven out of ten don't work, three still get help, and they change the lives of

people around them. I think treatment does work with the right mind set. The big challenge is in knowing which group of people to send into treatment." If five slots are available and there are 20 people to choose from, Brown said he would (1) assess if the person is going into treatment because it is being forced on them, or are they sincere? (2) If sincere, what are the reasons for their sincerity? Is it family? My wife is leaving me? Find out what is driving their motivation. (3) What kind of support system do they have in place after treatment is over? "If and when challenges begin, and they will, are they going to be surrounded by people that are going to help, or people that are going to enable?"

At one point Minness was spending about $900 a week in professional help for his daughter. "It didn't work," he said. "She explains to me that it's a craving, a feeling that you absolutely cannot believe; you have to have it. And I believe her. For the kids to do what they do to their parents, their grandparents, their relatives, the community they live in, and to themselves, it has to be something that's absolutely overpowering. From talking to my daughter in depth about how she feels and what the appeal is, once the drugs are in the system and the body becomes addicted to it, I really believe that it's impossible for them to stop without some kind of help. Not totally impossible; there are exceptions to everything. Some people have the ability to stop; some don't."

After 30 years in the business, Charles Brown still does not understand the motivation for people to go back to drugs. "I've interviewed them after treatment and asked, why can't you stay away? But generally they cannot verbalize why." Brown believes that many professionals focus only on the drug they're researching, without looking at the bigger picture. "Nothing happens in a vacuum," he said. "Usually it's a dysfunctional family, or there's been neglect, or abuse, or low income." Brown allows that addiction occurs in affluent families as well, but says, "A rich drug addict doesn't stay rich for long."

"The recovery rate in Gilbert is pathetic," said Debbie Trent, while Chief Deputy Aliff in Wyoming County said, generally, "Rehab programs don't work. You can get more drugs in rehab than on the street. Very few stop." This suggests that traditional approaches to treatment may need to be re-thought and new methods developed or explored. One such controversial method called Rapid Detox, meant to kick opiate addictions, involves giving patients a general anesthesia and a non-addictive drug called Naltrexone, a narcotic antagonist that blocks the opiates from attaching to receptors. Patients are put to sleep and detoxified, and by the following afternoon are usually ready to go home, with clean, opiate-free receptors. Patients continue to take Naltrexone daily for several weeks to two years, and ongoing psychological counseling is strongly recommended. According to a May 2003 article in *Health South*, a consumer health network magazine, practitioners estimate there are about a dozen rapid detox centers around the country. One center, Florida Detox, which detoxed about 400 patients in six years, reported that 75 percent of their patients stayed drug-free for six months, and 50 to 60 percent stayed clean for one year or more. The Coleman Institute, with offices in Richmond, Virginia and two in southern California, advertise a three-day out-patient program with a 99 percent success rate, stressing the importance of an aftercare program. "The more work they do in the early months; the more likely they are to be successful," Coleman literature

states. "We almost never see someone relapse who completes ninety AA [Alcoholics Anonymous] or NA [Narcotics Anonymous] meetings in ninety days. Most patients, unfortunately, are under the false illusion that they will be different and they don't need to work quite as hard on their recovery. This is a mistake." [3] The cost for Rapid Detox starts at around $3,200 and is generally not covered by insurance.

Methadone – Addiction as Treatment

Methadone is a synthetic narcotic that has been used to treat opioid addiction for more than 30 years. The federal Office of National Drug Control Policy (ONDCP) states that, "Methadone is a rigorously well-tested medication that is safe and efficacious for the treatment of narcotic withdrawal and dependence."

Methadone is effective in opioid addictions only, not other drugs of abuse. Opioid drugs release excessive amounts of dopamine into the body, and users continuously need more of the drug to occupy the opioid receptor in the brain. Methadone occupies this receptor, relieving opioid withdrawal symptoms and reducing opiate cravings, allowing addicts to change their behavior and discontinue using heroin, OxyContin, or other opioid drugs. Methadone blocks the high from these drugs, but it does not provide a euphoric rush. Taken orally once a day, it suppresses withdrawal for 24 to 36 hours.

According to the ONDCP, under supervised treatment "Methadone does not impair cognitive functions. It has no adverse effects on mental capability, intelligence, or employability. It is not sedating or intoxicating, nor does it interfere with ordinary activities such as driving a car or operating machinery. Patients are able to feel pain and experience emotional reactions." Furthermore, the ONDCP asserts that long-term methadone treatment causes no adverse effects. Since methadone treatment costs about $13 a day, it is considered a cost-effective alternative to incarceration, and research has shown that methadone treatment significantly decreases the rate of HIV infection used by sharing needles, hepatitis B and C, tuberculosis, and sexually transmitted diseases.

Two months after Minness Justice's daughter became pregnant, she entered a methadone clinic, which had been advertised as the safest treatment for an opioid addict who is pregnant. "It worked well for her," said Minness. "It took her through the pregnancy with minimal problems. The baby was born, a little girl, and she went through a two or three week stay in the hospital to withdraw her from the methadone. She's healthy; she's happy. The baby has absolutely no problems that can be detected now, at 16 months old. The only problem we have is that my daughter is still taking the methadone at a reduced rate, and we're not so sure that the clinic is actually pushing her to get off of it. We're concerned; we would like for her to eventually come completely off of this."

Methadone itself is highly addictive. The trade off is that, while the patient ultimately remains physically dependent on the opioid, with methadone he or she is freed from compulsive and disruptive behavior and can lead a relatively normal life, without turning to crime in order to support their habit. The ONDCP says that withdrawal from

[3] See www.thecolemaninstitute.com

methadone is much slower than that from heroin. As a result, it is possible to maintain an addict on methadone without harsh side effects, and many patients require continuous treatment, sometimes over a period of years.

Prior to 2001, West Virginia had no methadone clinics; since then, however, seven clinics have opened statewide, with another eight pending approval. The clinics are for-profit, and six are operated by CRC Health Group, a California-based company and the nation's largest provider of methadone treatment, treating an estimated 20,000 methadone patients daily. Heretofore, West Virginia has not regulated its clinics, nor has it required clinics to submit information, like number of patients, success rates, or how long patients are kept on methadone. In Ohio, for-profit methadone clinics have been banned, and clinics must be either non-profit or government run. "The idea is that for-profit clinics have less incentive to ever wean addicts off methadone," reported Tara Tuckwiller in the *Charleston Gazette*. Merritt Moore, the Adult Treatment Services Coordinator at the Division on Alcohol and Drug Abuse (DADA), which acts as the state methadone authority, said that methadone clinics must go through layers of regulations before being granted a license and, once a license is granted, clinics must abide by federal regulations already in place. The Office of Health Facility Licensure and Certification, a division of the Department of Health and Human Resources, performs oversight visits to each clinic once every two years, or when the need arises.

"The knowledge I have is all second hand from people who go to the methadone clinic and tell me about it," said Tim Gibson. "The problem I have with the methadone clinic is that they don't mandate enough from their clients. You're taking care of the desire physically, but addiction is a lot more than a physical thing. Opiates, they do affect you physically. You hurt when you don't have them. They should be mandating that their clients are attending at least three support group meetings a week, and they should have to sign papers that they're going. And they should have some sort of counseling that's more than just 15 minutes to say 'how are you doing?' Cause I'm going to tell you exactly what you want to hear in such a way that you'll believe me. That's my problem with methadone."

In February 2004, the *Charleston Daily Mail* reported on a Boone County man who, addicted to OxyContin, entered a methadone clinic in Charleston. Over a reported three years and $25,000 later, he was examined by a doctor just once, had gone six months without speaking to a counselor, and was never encouraged to lower his dosage. "(Methadone) manages a disease for which there is not a cure, like high blood pressure," said Phil Herschman of CRC Health Group, which operates the Charleston clinic. "How often does a physician suggest you stop insulin?" (The article reported that CRC plans to introduce a "methadone-to-abstinence" program in 2004, which will take an addict two to three years to complete.) Desperate to come completely off the methadone, the Boone County man underwent Rapid Detox at the Coleman Center. "It's unbelievable how I'm doing," he told the *Daily Mail*. "It's indescribable to wake up and not feel like I have to depend on something to function.… What aggravates me, at the [methadone] clinic, they

say they are a treatment center. And they call you a patient. I don't think I'm a patient. I'm a client. I'm buying drugs from a legal drug dealer."[4]

While Probation Officer Brown is not a substance abuse specialist, his experience has led him to believe that methadone is trading one demon for another. "At face value it looks good; maybe it'll make them quit stealing, or get them out of the criminal system," but he adds that there is not enough effort to wean people off of the drug. "If you give a drug addict a choice: you can do heroin and steal, or you can try this methadone and do that for the rest of your life, or you can go cold turkey, which do you think they're going to choose?"

In the meantime, methadone deaths are on the rise, from Florida, where it has been called "the fastest-rising killer drug" by the Florida drug control director, James McDonough, to Maine, where methadone has killed more people than any other drug in the past five years.[5] Reported overdoses have occurred when inexperienced drug users mix too large a dose of methadone with alcohol or other drugs and when OxyContin or heroin addicts who have switched to methadone believe they can achieve the same high by increasing their methadone intake.

Because of the continuing controversy over methadone clinics and the rise in the number of clinics, from zero to a possible 15, in a short span of time, the state Health Care Authority placed a moratorium on the opening of new clinics until June 22, 2004, or until state health plan standards are developed. The legislature recently approved an advisory committee, headed by the DADA, to develop emergency rules and regulations for the clinics. The regulations are not expected to be ready until Fall 2004, but once complete will be enacted without waiting for the next legislative session. Merritt Moore, who serves on the advisory committee, said DADA serves as a clearinghouse for complaints against methadone clinics, and that his office has received few complaints overall. He said that there are about 3,500 patients statewide currently being served by the clinics.

FINDING SOLUTIONS

No one sets out to become a drug addict or an alcoholic. I have been told by doctors that addiction is genetic, and not just drug and alcohol addiction, but sex and gambling and other addictions, too. At a prescription drug abuse conference I attended in November 2003, an addictions doctor told me that addicts are, "born this way. There are people who have never had a drink who are alcoholics." He and other professionals insist that perceptions, both by the public and the government, need to shift so that people understand substance abuse addiction is "a chronic, relapsing, deadly disease." This could explain why recidivism after incarceration or treatment occurs so frequently.

Changing perceptions can be a slow and arduous process, but getting the ball rolling in that direction is an important first step. Professionals recommend that people contact

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[4] *Charleston Daily Mail.* "Treatment or Illegal Drug? Boone County Man Speaks Out, Officials Defend." Therese Smith. 2/17/2004.
[5] *The Sunday Gazette-Mail.* "Methadone: Medicine or Menace?" Tara Tuckwiller. 5/04/2003.

their legislators and relay stories about residents in their district, and insist that legislators look at this problem not simply as a social issue but as a public health issue, too.

Once the cycles of addiction begin they become increasingly harder to break. The best case scenario, of course, is to never get started in the first place, thus it is vital to become better educators and messengers of prevention.

When treatment becomes necessary, rehabilitation facilities and half-way houses should be available and affordable. Long waiting lists and facilities far from home, which was the case in this pilot study, worsen an already difficult situation. When help is needed immediately, there should be some place to go. Community support groups should be available every night of the week, not just for addicts but for family members who suffer as well.

Doctors and treatment specialists, through continuing education, should be made aware of the latest pain medications and their propensity for addiction. As reported to me during this study, no doctor should believe that prescribing OxyContin for menstrual cramps is up to standard.

If incarceration is not deterring drug offenders, perhaps more focus and funding should be spent on programs like Logan County's Day Reporting system, which offers a more comprehensive rehabilitation system, a system that mirrors Probation Officer Charles Brown's suggestion that a more comprehensive approach to treatment is necessary, not just a focus on the drug itself, but the overall life of the addict.

While the prescription drug epidemic is overwhelming and possible solutions seem like mere drops of water in a vast sea, it is crucial to do whatever is possible, however small, to begin turning the tide. There is hope. Judge Eric O'Bryant has seen a reduction of OxyContin cases come through his courtroom in Logan County. Purdue Pharma is in the process of reformulating the OxyContin pill so that it is abuse-resistant. Early reports from the Day Reporting system look positive. And the STOP Organization has procured enough funding to renew VISTA positions and hire an Executive Director. Now they have set their sights on establishing a community fellowship home. Perhaps the story and the people of STOP can teach us all how to be agents of change, to be proactive and lead by example, courageously share our stories, refuse to live in denial, reach out to the community, work together, listen, learn, set goals, grieve together, heal together, and above all, persevere.