Women's Commission on Alcohol and Drug Issues of Oregon

WWW.WCADIO.ORG SPRING / SUMMER 2016

Open Invitation to Join WCADIO
Your Support Is Needed
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WCADIO's Mission

To increase public awareness of women's alcohol and drug abuse issues and to promote services related to women throughout the state of Oregon. This means ALL women who are affected by their own alcohol or drug use or that of their family or friends.

Visit us at www.wcadio.org

WCADIO Board

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Jail is Not a Death Sentence! The Risk of withdrawing from Heroin in Jail

Madaline Pitkin, age 26, died April 24, 2014, at the Washington County Jail. Pitkin, a heroin addict, had spent seven days detoxing at the Washington County Jail before she died.

The Oregonian reports that Pitkin had made four written pleas for help which the jail's health care contractor Corizon Health "mostly discounted or mishandled." (Washington County commissioners have since changed the jail healthcare provider from Corizon to NaphCare, another national correctional healthcare company.)

Pitkin detailed her intensifying weakness on jail forms and twice wrote that she felt near death. Yet the medical staff repeatedly ranked her withdrawal symptoms as mild. Even when nurses did become concerned about Pitkin in the later stages of her jail stay, they failed to track her low blood pressure. They did not send her to the hospital. They did not administer medication by injection when she couldn't keep food or medicine down. After 7 days, she was found unresponsive in her jail cell and could not be revived.

(As reported by Rebecca Woolington, The Oregonian/ Oregon Live, 4-10-16)

(See **Withdrawal…** *continued on page 2)*

WCADIO Seeks Nominations for 2016 Counselor of the Year

Since 1987, the Women's Commission on Alcohol and Drug Abuse Issues of Oregon (WCADIO) has been an advocate for the needs of substance abusing and dependent women and their children throughout the service delivery system in Oregon.

WCADIO will present its annual Counselor of the Year Award at the 2016 Native American Rehabilitation Association Conference in August, 2016.

We invite you to make nominations of counselors who treat women for alcohol and drug issues to the board by July 15, 2016.

Please write a brief summary of why the counselor excels in her counseling with women with addiction.

You can either mail the summary to: WCADIO at PO Box 14495, Portland, Oregon 97293, or email to weil.rm@frontier.com. ❖

Are You a Member of WCADIO...?
Want to get involved in the good works we do? WCADIO membership application is on the last page and is also available on our website at www.WCADIO.org.
We encourage you to join and have a voice!

Withdrawal… *(Continued from front page)*

Heroin Withdrawal

Symptoms from heroin withdrawal usually begin within 3 to 12 hours after the last use and can become severe after 24 hours. Symptoms include body aches, tremors, runny nose, yawning, gooseflesh, nausea, vomiting, diarrhea, irritability and drug cravings. While opiate addicts going through withdrawal can be miserable for days, withdrawal is typically not life-threatening. However, it can become dangerous if symptoms aren't controlled early—life threatening dehydration is a major concern. For example, if a person can't keep anything down or has serious diarrhea, they may need fluids and medication administered intravenously.

Managing Drug Withdrawal in a Jail Setting

Health care in jails can be provided through contracts with health care companies that specialize in custody settings, as it is in Washington and Clackamas Counties. It can be provided by the county health department, as it is in Multnomah County. Other jails may hire or contract with health care providers directly to provide health care services to inmates in custody.

Medical detoxification is considered the standard of care for individuals with opiate dependence in jails. Opiate withdrawal is rarely considered dangerous except in medically debilitated individuals and pregnant women. A typical withdrawal protocol might include medications for anxiety, vomiting, pain, and/or diarrhea.

The drugs that produce dangerous and potentially life threatening syndromes for individuals who are physiologically dependent include alcohol, sedative/ hypnotics, and anxiolytics. These drug withdrawals are often managed by medication, such as a short-term taper of Librium, valium or a barbiturate.

Standards of Practice

The Federal Bureau of Prisons has published detailed clinical practice guidelines for managing the withdrawal from addictive substances for federal inmates. Those standards recognize that the intensity of withdrawal cannot always be predicted, and thus recommend frequent clinical assessments along with treatment adjustments as indicated. The standards call for "every effort to be made effective to ameliorate the inmate's signs and symptoms of alcohol and drug withdrawal," with frequent reassessments being made. Drug regimens to manage withdrawal, including the use of medications to assist those addicted to opiates, are recommended.

The National Commission of Correctional Health Care (NCCHC), which accredits in-custody healthcare programs, publishes standards for how to treat opioid and alcohol withdrawal in correctional settings. For opioid withdrawal, the NCCHC advises that all inmates be carefully evaluated when they enter the jail; those that test positive for withdrawal risk should be treated with methadone or buprenorphine, both FDA-approved drugs for detoxification.

A 2005 study found few jails that provide the medical standard of care recommended by doctors for patients at risk of withdrawal. The survey included information from 500 jails across the country; 49% of them had no procedures or support for withdrawal at all. (Fiscella, Moore, Engermant, Meldrum; 2005; Management of Opiate Detoxification in Jails; Journal of Addictive Diseases; 24(1))

The tactic of complaining of another physical condition, even including intentionally falling and injuring oneself in the corrections facility, was repeated by others as a way to receive medical treatment for withdrawal.

In Oregon, any standards for managing drug withdrawal in jail are held confidential by the Oregon State Sheriff's Association (OSSA). There are many standards for jail management promoted and enforced by this organization, however these standards are considered proprietary and are not shared with the public. If there are standards of care for managing withdrawal in Oregon jails, those standards are not known by anyone outside the local sheriff's office and the OSSA. In a 2009 presentation on safe detox in jail settings given by Gail Hill and Nancy Wolf, it was reported that many Oregon county jails had protocols only for alcohol withdrawal. It is not known if that situation has changed over the past 7 years.

Incarceration and Opioid Withdrawal: The Experiences of Methadone Patients and Heroin Users

Both heroin-addicted individuals and methadone maintenance patients are likely to face untreated opioid withdrawal while incarcerated. In a 2009 study, 53 opioid dependent adults were interviewed in an investigation of withdrawal experiences during incarceration. Whether dependent on heroin or methadone, one of the most frequently mentioned aspects of incarceration was experiencing withdrawal in jail, often with limited medical care.

According to one female study participant who was still incarcerated at the time of the study: "This is one of the worst kicks I've ever had in jail. It gets to the point where, I mean, they don't give you anything here for withdrawal, but I was so sick that I managed to drag myself to the doctor here and tell him that I was an alcoholic. I had the shakes that bad from the drugs that they actually gave me Librium that they give alcoholics that come in here."

The participant's comment indicates that in order to receive assistance with her heroin withdrawal symptoms she believed she had to attribute them to alcohol dependence. The tactic of complaining of another physical condition, even including intentionally falling and injuring oneself in the corrections facility, was repeated by others as a way to receive medical treatment for withdrawal. Another male study participant with a 30-year heroin habit reported receiving medical care for his heroin withdrawal only after having a heart attack while going through withdrawal during a previous incarceration experience.

Some participants reported receiving treatment for their withdrawal symptoms, including the administration of muscle relaxants, narcotic pain relievers, sedatives, anti-nausea medications, or Clonidine. Often, people had to wait several days and experienced severe symptoms before receiving care. Others stated that they were denied any medical treatment and so either bought sedatives or other drugs from their cell-mates or were limited to over-the-counter medications such as Tylenol and/or aspirin which they purchased from the dispensary.

(Mitchell, Kelly, Brown, Schacht Reisinger, Peterson, Ruhf, Agar, and Schwartz; Incarceration and opioid withdrawal: The experiences of methadone patients and out-of-treatment heroin users ; Journal of Psychoactive Drugs; 2009 Jun; 41(2)).

Conclusion:

Deaths in jail from withdrawal reactions are completely preventable with appropriate medical care. Medical services are available in every jail. Safe protocols for managing withdrawal from any drug, including alcohol, are published and easy to find. The common and recommended drugs for managing withdrawal—methadone, lorazepam, clonazepam—are available for a dollar or less per dose.

No one should die in jail from drug withdrawal. A jail sentence is not a death sentence. This must never happen again. ❖

Peer Delivered Services in Addictions Treatment Now Covered by Oregon Health Plan

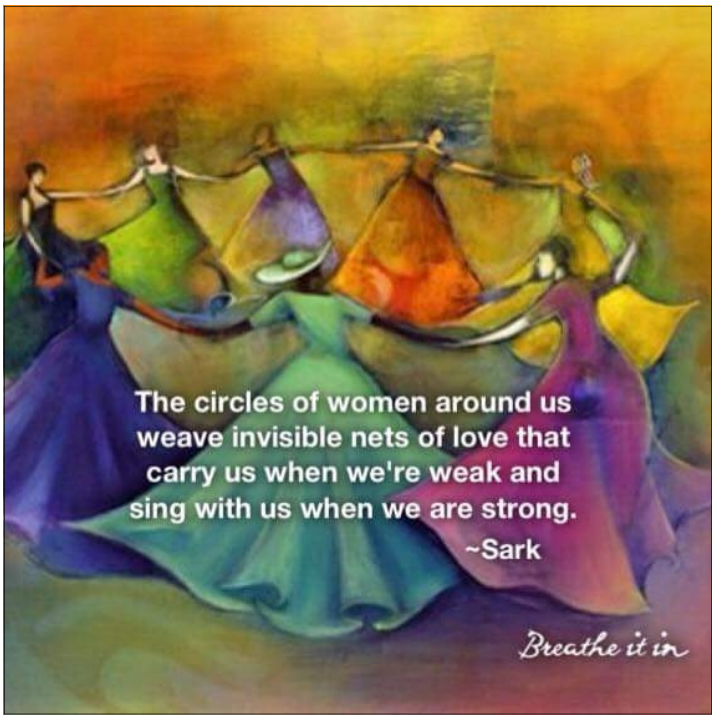
There is good news for the 2015-2017 biennium! The legislature made new investments in mental health and addictions treatment and the Oregon Health Authority set aside $1.5 million of those new dollars for peer-delivered services to be included as part of addictions services. Previously, peer-delivered services were not funded by the Health Plan although they have been an important component of the addictions treatment system for women and their families.

Peer delivered services encompass an array of services and supports to individuals or family members with similar lived experience. They are designed to support the needs of individuals and families as they progress through various stages in their recovery from substance use disorders. Peer delivered services include emotional support through peer mentoring, peer coaching, and peer-led support groups. Emotional support is essential for women seeking recovery because of the power and influence relationships have in women's lives. In addition, peer support helps address the shame and stigma women addicts are often struggling with.

Peer Delivered Services can provide a variety of benefits, including:

1. Outreach - Build personal relationships with people experiencing behavioral health challenges

(See **Oregon Health Plan…** *continued on next page)*



Oregon Health Plan… *(Continued)*

and support motivation to seek help

2. Build Community - Support people to become socially involved with others who will support ongoing health and recovery
3. Information—Sharing knowledge, information, and skills such as life skills, job skills, and health and wellness information
4. System Navigation - Help people access needed community services including child care; plan for appointments and keep appointments
5. Recovery and Resiliency Promotion – Peers in recovery model a healthy recovery lifestyle
6. Family Support – For family members with relatives who are in recovery from substance use disorders, help families develop and maintain positive relationships, increase understanding of recovery processes, and build connections among family members for mutual support

A list of Peer Support and Wellness Specialists Training Programs approved by the Oregon Health Authority can be found at this link:
http://www.oregon.gov/oha/amh/pd/Pages/approved-training.aspx

The Oregon Health Authority will fund projects throughout the state intended to build regional capacity for these services. ❖

2016 Oregon Legislature passes Laws that will Benefit Women and their Families

Minimum Wage is Raised

Governor Brown signed the landmark minimum wage bill into law on March 2. The bill creates three geographical minimum wage tiers — Portland, rural counties and "everywhere else" — and raises the minimum wage in those tiers slightly each year for six years. By 2022, the minimum wages will be $14.75 in Portland, $12.50 in rural counties and $13.50 "everywhere else." The first wage increase takes effect July

Affordable Housing

A package of bills passed that address the state's affordable housing crisis, caused by soaring rents and home prices in many Oregon communities. Oregon legislators reached agreement on bills aimed at boosting the construction of affordable housing.

The four bills would lift the statewide ban against requiring developers to include affordable housing as part of major construction projects, provide a new tax source for lower-income housing and provide new protections to renters. In addition, one of the measures would also allow developers in many cases to annex their property to cities without having to get voter permission.

House Bill 4143: Provides new tenant protections, like banning rent increases during the first year of month-to-month tenancies and requiring 90-day notice for other rent increases. Before that change, rents could be raised with a 30-day notice for tenants renting on a monthly basis.

House Bill 1533: Lifts the longstanding ban on inclusionary zoning, a practice where municipalities require developers to build or sell housing at below-market rates in exchange for incentives like property tax breaks. Cities can now mandate that affordable housing units be included in some new developments, thus increasing the supply of more affordable homes. In addition, the measure would also allow local governments to levy a 1 percent tax on new residential, commercial and residential construction that would help pay for the construction of lower-cost housing.

Two other bills make changes in the state's land-use system. *Senate Bill 1573* would largely prohibit public votes on voluntary annexations inside of urban growth boundaries. And *House Bill 4079* would allow two cities to conduct pilot programs allowing 50-acre developments of affordable housing outside the urban growth boundary. (Cities in the Portland area would not be able to

If you have not yet paid your dues for 2016 please do so soon. See last page for membership application.

Visit us online at
www.WCADIO.org

To submit something to this publication please send to Editor Ginger Martin
gingersnapmartin@gmail.com

What Opioid Hysteria leaves out: Most Overdoses involve a mix of drugs

By Chelsea Carmona
Reprinted from
www.theguardian.com

The rising opioid death rate is alarming, but it's time they didn't take sole blame for fatalities

Drug overdose is now the leading cause of accidental death in the United States, with opioid-related deaths driving much of the increase. This alarming statistic has gained widespread attention and led to a national conversation demonizing opioids and the people who use them. But a critical predictor of overdose has remained absent from this conversation: opioid-related overdoses, both fatal and non, almost always involve at least one other drug.

Mixing drugs is generally much more dangerous than single-substance use, and certain combinations are particularly lethal. Taking opioids with alcohol, for instance, or benzodiazepines, dramatically increases the potential for fatal respiratory depression, as all three drugs depress the central nervous system. A person's blood-morphine concentration needs to be significantly higher to cause death in an opioid-only overdose than in an overdose where alcohol or benzodiazepines are present. These drugs are frequently noted in autopsy reports for opioid-related overdoses.

But autopsy reports and death certificates do not always capture the true reasons behind a person's death, especially when drug use is a factor. Kenneth Anderson, CEO of the Hams Harm Reduction Network, scoured death certificate data on opioid overdoses, and found stark state-by-state differences in regards to drug mixing. While there are surely some differences between individual communities, the more likely explanation for this variation is the subjectivity of individual physicians, medical examiners and coroners.

One coroner might attribute an opioid-related overdose death to heroin alone when in fact the death resulted from a combination of heroin and a legally prescribed, low-dose benzodiazepine. Another could attribute the death of a known drug user to overdose, when in fact the death resulted from dehydration, pneumonia or another health condition. Researchers have pointed to this and called for more thorough reporting of drug-related overdose in death certificates, as they provide the basis for our understanding of public health trends and consequently shape research and public policy.

Our current obsession with opioids is just the latest trend in a long history of scapegoating single drugs: alcohol in 1830s and 40s, opium in 1870s, marijuana in the 1950s and 60s, crack cocaine in the 1980s and 90s, methamphetamine in the 1990s and early 2000s and now, opioids like heroin, Oxycontin and Fentanyl. The problem of multiple-substance use has remained absent from much of this conversation – and from the education of users and health practitioners – despite the fact that drug mixing is both dangerous and pervasive.

The vast majority of opioid-related overdose death is accidental – and entirely preventable. Drug mixing and tolerance changes are the primary predictors of overdose. Graduates of 28-day abstinence-based rehabs are over 30 times more likely to die of a heroin overdose than untreated addicts using on the streets. These programs should be held legally responsible if they choose not to distribute overdose antidote naloxone, and they should be required to run regular trainings on tolerance, drug mixing and safe-use practices.

In order to continue receiving federal funding, public schools and universities should be required to implement a standardized drug education and overdose prevention program covering the dangers of drug mixing.

Amid mounting concerns around heroin, intravenous drug use and the spread of infectious diseases, the cultural tide seems to finally be shifting in favor of harm reduction services that have been proven to work. The federal government has called for more access to medication-assisted treatment programs and lifted the nearly 30-year ban on allocating funding to needle exchange programs.

Many states have passed good samaritan laws and made naloxone available without a prescription. Some have proposed bills that would establish safe-injection sites and others have decriminalized marijuana. But none of these measures will prove effective if we cannot keep users – be they addicted, dependent or dabbling – alive.

By fixating on fearing opioids, we are missing the more culpable factors that lead some people to keep using drugs despite negative consequences. Opioid use on its own is not dangerous, and it's time we stop demonizing it. Instead, we must implement a national overdose education strategy targeting the immediate factors of opioid-related overdose: drug mixing and tolerance changes. ❖

Counselor of the Year Nominations
Don't forget to nominate someone for Counselor of the Year! See front page.

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