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Treating Heroin Addiction in Florida

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Heroin abuse is less prevalent than any other drug of choice used by those seeking relief from their physical or emotional pain. However, it has caused untold destruction on individual lives and community health because of its powerful addictive qualities. Despite its comparative numbers to other drugs of abuse, the current resurgence of use around the country and in Florida warrant comprehensive coordinated community responses. **There are effective evidence-based interventions and treatments available. These treatments will save lives, families and communities.**

Heroin has been at the center of several drug epidemics in the United States since the opioid analgesic was originally synthesized by English chemist C. R. Alder Wright in 1874. Wright changed the molecular structure of morphine (from a variety of poppy) and created heroin (diamorphine, diacetylmorphine or morphine diacetate). Heroin was supposed to be a great new painkiller especially for the Civil War soldiers who became addicted to morphine as they lived in pain. It turned out to be much more potent and addictive than morphine.

Today, heroin abuse is higher than it was just a decade ago. The Centers for Disease Control reported that between 2002 and 2013 the heroin overdose deaths in the United States increased 286 percent or 8,257 deaths in 2013.

One of the epicenters of the heroin surge is Florida. For the last decade, Florida was a front-runner in the "pain clinic" growth that led to millions of people becoming addicted to a mind-altering substance, many for the first time in their lives. The Trust for America's Health stated that Florida has the 11th highest drug overdose mortality rate in the country. As states and local communities cracked down on "pain clinics" and started Prescription Drug Monitoring systems, obtaining opiates became more difficult. The result was a resurgence of heroin availability**.** Exacerbating this is the cost; **heroin can cost as little as one-third the price of prescription drugs like oxycodone.**

Heroin is correctly listed as a Schedule 1 drug – *it has a great potential for abuse and there is no acceptable medical use in the United States*. Couple this with the fact that this central nervous system depressant acts as a direct agonist on brain receptors which makes its use highly addictive and difficult to treat. Rapid physical dependence, fear of the painful withdrawal symptoms and the progressive nature of opiates in general lead to increased need and ever more chaotic lives.

Health issues like exposure to HIV, and both hepatitis B and C are increased and the need for more money may rapidly lead to criminal activity to support drug habits. The cost to society for treatment of these and other health issues connected to heroin addiction will increase if we do not create a united

front on decreasing demand. That only occurs when effective evidence-based prevention and treatment is available.

Hidden costs multiply when one considers how addiction to drugs like heroin increase societal, health, work and family problems. Heroin is almost always cut with something; one of the most dangerous additives is fentanyl-laced heroin – (f*entanyl: 80-100 times more potent than morphine and 40-50 times that of pharmaceutical-grade heroin).* This practice has led to thefts of fentanyl patches in nursing homes and from the gravely ill or elderly who often depend on such drugs to make life tolerable. Once addicted, individuals will often steal pills and other painkillers from their loved ones. Heroin also can be cut with acetylated morphine, brick dust, talc, quinine, caffeine, procaine, lactose, dextrose, mannitol, etc. Some of these can also lead to health costs. Often a user may consume other drugs and/or alcohol in conjunction with heroin. One highly lethal combination occurs when heroin is used with benzodiazepines. This often leads to expensive emergency room visits or deaths. Neglect of occupational and family responsibilities increase those hidden costs as employers deal with the residue of employee drug use or child welfare systems become further burdened when parents neglect or abuse their children.

Along with increasing education and encouraging decision-makers to take action, there are several reliable evidenced-based treatments and a method to treat acute overdose until medical help can arrive.

Naloxone – medical intervention for opioid overdose. With record numbers of overdoses and deaths, experts are promoting the use of naloxone (brand names examples – NARCAN, Evzio). Police and

other first responders can carry doses so they can save a life while transporting the individuals to hospitals. Naloxone, a pure opioid antagonist, can be injected or applied nasally. It was used in the past to verify opiate addiction or opiate influence since it immediately stops the action of the narcotics. The use of naloxone increases the window of time after an overdose for emergency help to arrive. The cautions include understanding that overdose symptoms can return within minutes and so repeated doses may be required while waiting for EMTs; it does have an expiration date; and there could be conditions that contraindicate the use of naloxone such as a history of heart disease. This intervention requires very little instruction. **Naloxone, while not a treatment for compulsive use of drugs, will save lives.**

MATS - Medication Assisted Treatments – all of the treatments below are more successful when used with effective behavioral therapy and the development of a lifelong program of recovery.

- **Naltrexone** (Vivitrol, Revia, Depade) – these medications, typically marketed as a hydrochloride salt – naltrexone hydrochloride (Revia, Depade), reverse the effects of opioids and are usually used primarily in the management of alcohol and opioid dependence. A once-monthly extended-release injectable form (Vivitrol) has gained positive acceptance and several states are looking at using this extended injectable medication prior to inmate releases for those with opioid abuse histories.
- **Buprenorphine (**Subutex) – is a semisynthetic opioid derivative of thebaine. It is a mixed partial agonist opioid receptor modulator that is used to treat opioid addiction in higher dosages, to control moderate acute pain in non-opioid-tolerant individuals in lower dosages and to control moderate chronic pain in even smaller doses. It is available in a variety of

formulations. This drug can be abused and needs strict medical monitoring. It has been sold on the streets to people who wanted to avoid the painful withdrawal from heroin.

- **Suboxone-** a registered trademark — this combination of drugs (buprenorphine and naloxone) is used to treat opioid addiction. This drug can be abused and requires strict medical monitoring.
- **Methadone** (Dolophine) – this synthetic acyclic analog of morphine and heroin acts on the same opioid receptors as heroin and has a 45 year history of safety when closely medically monitored and when coupled with effective counseling. It is used to treat long term or chronic addiction. It is recommended for use with pregnant, opioid-dependent women in order to prevent miscarriage or premature births. This synthetic opioid is the most widely used treatment for opioid dependence. Methadone, because of its long acting quality (24-36 hours) and strong analgesic effects, is used medically for chronic pain management. Once a therapeutic dose is determined, methadone allows individuals to work and live normal productive lives. Methadone is on **the World Health Organization's List of Essential Medicines,** a list of the most important medications needed in a basic health system. Methadone can be sold illegally on the streets which can contribute to overdose or death.

Heroin and other opiate abuse is a difficult relapsing disorder that often takes months or even years to properly treat. There are effective evidence-based medical treatments that have helped millions to reach recovery. These vary greatly in price, availability and access. An individual's physical, mental and emotional issues coupled with knowledge of their addiction history are key considerations when choosing treatments. People often begin their opiate addiction because of acute or chronic pain. This cannot be ignored when addressing heroin or other opiate abuse. Addiction is a brain disorder that

requires a holistic treatment approach. These effective medical treatments should be coupled with on-going monitoring, education, therapies such as cognitive behavioral, trauma-informed counseling and, when appropriate, medication and therapy for other co-occurring mental disorders. When those with addictive disorders have a chance at effective treatment, millions of lives are saved and families are restored which makes a safer and healthier Florida.

Conflict Of Interest

I declare that I have no proprietary, financial, professional or other personal interest of any nature or kind in any product, service and/or company that could be construed as influencing the position presented in, or the review of, the manuscript entitled: *"Treating Heroin Addiction in Florida"*.

About the Author

Ms. Hamilton has spent the past 39 in the behavioral health care field with concentration in substance abuse, mental health and co-occurring disorders. Ms. Hamilton uses her expertise in treating families exposed to substance abuse, mental illness and trauma, especially women, adolescents and children (particularly those with pre and post-natal exposure to substances) in hundreds of workshops, trainings and webinar, including several publications. Ms. Hamilton also has many years as a therapist, program director and ultimately the President and CEO of a very large comprehensive behavioral health agency with over 500 employees who work in over 40 programs in seven counties in the western mid-coast of Florida. For over twenty years Ms. Hamilton has been the agency connection to research, especially research done with pregnant, post-partum and parenting women and adolescents and their families. She has been on the NIDA Clinical Trials Network (CTN) and the University of Miami Florida NIDA Node Alliance Steering Committee for over 15 years and is currently on the Executive Committee of the NIDA CTN Network where she has served as co-Chair. Among her publications she is the primary

author of a manual for family intervention (Family Support Network) testing in the Cannabis Youth Treatment Study (funded by SAMHSA); this manualized therapy is used in many agencies and states and is listed in the NREPP list of programs. Ms. Hamilton has participated in many clinical trials over the years; Cannabis Youth Treatment Study (co-PI): NIDA Peri-Natal 20; SAMHSA/CSAT PPWI; NIDA CTN Buprenorphine Study in Detoxification; Seeking Safety; NIDA CTN ADHD Study and many more. Ms. Hamilton is an international and national trainer in several evidenced based protocols and practices. She served on the Florida Learning Systems Advisory Board for the Department of Children. She currently serves on the SAMHSA GAINS Center Expert Panel and was a long time member of the Florida Governor's Drug Policy Advisory Board. She has served currently serves on the SAMHSA GAINS Center Expert Panel and was a long time member of the Florida Governor's Drug Policy Advisory Board.