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Community Health and CCAT: Battling the Addiction Epidemic in Cincinnati

In all honesty, I had no idea that we would be taking trips down to the CCAT House when I signed up for Community Health. I was a bit intimidated by the thought of visiting a drug treatment center every week, and the fact that I would have to urinate in a cup in front of a stranger beforehand didn’t help with my nerves. That being said, I was excited about this kind of opportunity. Though I’ve done community service around Cincinnati before, and I’ve seen what kind of community lives around the University of Cincinnati, I still feel detached from those groups much of the time. Being in college, I have such a routine that even after doing those community service projects, I sort of forget about the community around us and about the struggles that they face every day. I have been lucky my whole life to not have to worry about money too much or doing well in school, and I have even been able to keep myself almost constantly employed since my senior year in high school. With that, I feel like I have more of a responsibility to connect with and help people who haven’t had the luck that I’ve had and have to face things like poverty and addiction every day. These visits to CCAT gave me a chance to do just that, and through this experience I feel like I have learned how important it is to take care of all members of your community simply because they’re part of the community, no matter how different their lives may be from yours.

Even with Miss Kante’s visit the week before we were supposed to start our visits, I had no idea what to expect from the CCAT House. I had never been in a drug treatment center before, and I wasn’t very aware of the drug problems in the Cincinnati community. After three weeks of awful winter weather that kept us from visiting, I was more anxious and eager than ever to start our work there. The only expectation that I had was that the observed drug test would be horribly embarrassing, and on that first day I found out I was wrong—it wasn’t nearly as bad as I thought it would be. The videos that we spent the first few days watching were funny, and admittedly somewhat insightful, but it was tough after waiting so long to even start our CCAT House visits to sit through them. As nervous as I was about it, I just wanted to start interacting with the patients and staff.

On the first day we had interacting with the patients, I was assigned to teach the educational group. We chose to discuss memory-strengthening activities, which made me a bit more nervous because I was given the topic of meditation—something that I’ve never even tried before. The biggest worry I had wasn’t about the presentation itself per se; it was about how the patients would react to it. Though Miss Kante told us that the patients were excited to have us visit each Tuesday, I wasn’t sure that they were necessarily looking forward to the educational groups, especially since they were mandatory. I felt that if I were them, I wouldn’t be interested in learning about healthy habits from a bunch of college kids, but obviously that was just an assumption. What I found out in my first two weeks doing the educational groups would be that we actually allowed for a much needed break in the daily schedule of the patients, something many of them would be grateful for.

Standing in front of the educational group on that first day was as nerve-racking as I thought it would be. It was odd to essentially switch positions as a college student and take the role that my professors play every day. The biggest challenge of our presentation on memory-strengthening activities was keeping the patients engaged through the presentation itself. As someone who has multiple lectures a day to sit through, I understood that keeping them interested through the actual information would be the biggest challenge. That was probably our biggest weakness that day too. The way we had the presentation structured, we gave all of the actual information first and then did the interactive activity. Had we integrated interactive activities into the presentation, they probably would have seemed much more interested, but we found that was difficult to do. I think the success of our game made up for the weakness of our presentation though. We showed them two slides with many pictures on them and told them to memorize as many as they could and then write their answers down in teams once time was up. I was surprised to see them so active and competitive over some picture collages. That’s when I realized that they truly were excited that we were coming to visit because it gave them a chance to break from their routine and have fun with one another.

I was a lot less nervous about my second week of educational group teaching, both because I already knew what kind of a group we had and because we were teaching about STIs. Although I felt a bit weird teaching about something that they probably know more about than I do, I knew that overall, the topic would definitely keep their attention. We made sure to have a very interactive presentation—with games to test their STI knowledge and some contraceptive props for them to look at—and I think that was our biggest strength. Even through the non-interactive parts, like my information on STI testing resources, they seemed very engaged and attentive. I’m definitely proud of our presentation that day. Even if they were only engaged because of how funny it can be to talk about contraceptives and STIs, I think they still took away a lot of new knowledge about STI prevention.

For our third week down at CCAT, I was assigned to be on the suboxone clinic. That Tuesday was a relatively slow day, and by the time we got there, most of the patients had already been seen, so we spent most of the time just speaking with the counselors about what they do every day. The counselor who I shadowed has been working in counseling for a long time, and spoke a lot about how important suboxone has been for the Cincinnati community. With heroin use on the rise here to epidemic proportions, it is vital to have a safe medication to wean users off the drug. He told me about how dangerous methadone has been as a treatment in comparison.

Instead of tapering down medication doses as a patient recovers from addiction, methadone doses must be increased over the years, so it becomes a life-long treatment, which ends up being extremely expensive and inconvenient. In this way, patients have no choice but to essentially become addicted to methadone and rely on it through their lifetime. On the other hand, suboxone is only a twelve to twenty-four month commitment, with doses tapered down as a patient progresses. This prevents them from becoming reliant on the drug, and keeps the treatment from becoming too expensive. Suboxone is also better than methadone because it is an opioid blocker, meaning it blocks the receptors that propel a user’s craving for opiates. Methadone, in contrast, has more of a numbing effect on patients and acts in a similar way on those receptors as the drugs themselves do, which means that a patient isn’t really recovering from their addiction, but replacing it with methadone.

Though the suboxone treatment is less expensive in the long run than methadone is, that doesn’t mean that it’s cheap. The cost is about $11 a strip or a pill, and each patient takes two a day. The worst part is that suboxone can’t be covered by insurance yet, so patients have to pay out of pocket for the treatment. That means it is still out of reach for much of the demographic that needs it, though CCAT is working to fix this through advocating for suboxone in the community. By raising awareness about the effectiveness and potential of suboxone as a treatment for opiate addiction, CCAT can help make it more available to those who need it but can’t necessarily afford it.

It’s also a bit difficult to be accepted into the suboxone treatment program. They find that only a certain type of patient is truly fit for the treatment, and even after being placed in the treatment program, patients have numerous goals that they have to complete to keep on the medication. Patients must be very involved in life, with careers and some sort of support system to help them keep going. They have to have a sponsor while in the program, and are required to attend different meetings through their treatment, with counseling meetings once every four weeks. Many patients don’t fit the criteria initially and are thus more fit for short-term rehabilitation than suboxone treatment.

For those patients who are eligible for suboxone treatment, it seems to be relatively successful, at least from the short time we observed at CCAT. I was able to sit in on one of the counseling sessions with one of the counselor’s most successful patients. She seemed very willing to share any struggles she was having and her accomplishments even with me there. She certainly had a lot of potential obstacles to recovery, so it honestly amazed me that she mentioned not ever feeling like using drugs lately. From my outside perspective, it seemed that the suboxone was able to take her mind off drugs and allow her to finally focus on the important things that addiction had forced her to put aside before.

The meeting only lasted a few minutes, which the counselor said was typical of returning patient appointments when there aren’t any new and important developments in their lives. The counselors spend each appointment going through a checklist to basically make sure that the patient is coping well with life and that they don’t have any new life issues or medications that they’re on. If a patient does well on all the checklist criteria, then they are fit to continue the suboxone program and will come back to counseling in another four weeks. New patient appointments take much longer, on average around three to four hours. The counselor has to determine how bad their withdrawal symptoms are and perform drug testing to determine what will be the best course of action for them. What takes probably the most time is inducing the patient with suboxone to see if they have any negative reactions to the drug before they start treatment.

The next two weeks, I was assigned to the North Unit, where I was able to speak with some of the staff about their experiences at the CCAT House. The first staff member I talked to was one of the Nursing Unit Supervisors, whom everyone calls Miss Dolores. She worked for the state as a psych nurse for 25 years then retired before she was diagnosed with cancer. After going through treatment, she decided to come back to work part-time, first at the Nova House in Dayton. When her hours changed, she decided to leave and instead call CCAT to see if they had any positions open. Her background in mental health helped get her a job, and she has since been at CCAT for three years. Her main jobs are to make sure the unit runs smoothly, resolve staff and client problems, and to perform admissions checks on occasion. She told me that she has had a really good experience with the patients at the CCAT House so far, and that her favorite part of the job is seeing the transformation that they go through from detox through the twelve weeks of aftercare. Once patients have completed aftercare, they participate in a graduation ceremony. Miss Dolores recently attended one of the graduations, and she told me that she hadn’t realized until then exactly how much of an impact she had on the patients.

She said the job isn’t always so rewarding though. The most frustrating aspect of working there for her is the “revolving door”. She said that she sees many people leave, relapse, and come back again, sometimes even over four times, which can be disheartening. She told me that many of them believe that they can just use one more time before quitting, and they are always chasing that first high that they can never get back. The important piece of this though—as she pointed out—is that they are actually making it back to CCAT. What is even more disappointing for her is when patients don’t live to even make it back to rehab, and never get much of a chance to fight their addiction.

She said she hopes that they continue to battle the heroin epidemic here in Cincinnati, which has led to patients coming in younger and sicker. She said many of the patients start off taking pain pills, and since heroin is cheaper than pills, they get heavy into heroin early on as a replacement. She said that these days, it isn’t surprising to have a lot of 18 and 19-year-olds admitted, and many of them spend their whole lives trying to treat their addiction.

I also was able to speak with one of the patient aides named Joe while on my second week at the North Unit. He gave a different perspective on drug treatment as a former addict himself. A native Pakistani, he used to work in the poppy fields where he became addicted to opiates. But Pakistan only has three drug treatment centers for their 6.7 million drug users, he said, and the treatment centers don’t have doctors or counselors. Because of the stigma against drug users, the treatment facilities are essentially composed of drug users helping other drug users. They lean on one another after quitting drugs cold turkey.

He has been in the United States for three years now and has spent two of those years working at CCAT. He said that one of the important parts of how he does his job is relating to patients and approaching them in a way that makes things easier for them. He mentioned how he knows that drug users face life problems with more weight than everyone else. Most people have struggles with money or family or other issues during life, but drug users have to tackle those problems with the weight of their addiction always on their shoulders. He said it’s important to make them feel comfortable, saying that’s because, “We’re all in the same boat here.” Since there is no cure for addiction, he said that it is vital to approach the issue in a human way instead of simply addressing it scientifically or medically. He mentioned how it is always nicer to come home than to come to a hospital, and that’s why they do their best to be less strict with rules, and implement more care and understanding at CCAT.

He is very proud of the strides that CCAT has made in the community and boasted about the 73% success rate of patients completing detox and short-term recovery. He said the 28 days in the program gives them stability from the battle with their addiction, while also helping build a foundation for a healthier lifestyle without drugs. But the most rewarding part of his job isn’t that they’re completing recovery, it’s seeing the transformation that the patients go through—a similar answer to that which Miss Dolores gave. He spoke about seeing men meeting their children again after treatment and watching them cry. Seeing the change in the patients and their renewed hope for the future helps him to heal as well.

The following week’s visit was time for our joint educational group about men’s and women’s health, and my subgroup chose to discuss pregnancy and contraception. The whole group also discussed cancer and nutrition/fitness. I think that overall, our presentation could have been stronger and the same goes for the interactive activity. The patients were definitely responsive to our portion of the project, seeing as we were discussing contraception again, but they didn’t seem that interested in the rest of it. It was tough for me because they were a totally different group than the one that I taught at the beginning of our visits. It also was a smaller group than I had expected, so they were quieter than the others. The game wasn’t all that bad, but it definitely wasn’t as organized as it could have been. Overall, the presentation was a tiny bit of a flop because it was a lot tougher to present with all nine of us there, and I think the disorganization that came with that was our biggest weakness.

I’m sad now to think that I probably will never go back to the CCAT House, and I will never know how treatment pans out for most of the patients. Miss Kante, the staff, and all of the patients made me feel welcome there, and taught me so much about what drug addiction truly is, and how they fight it at CCAT. I only wish we hadn’t had so many snow days, so we would have had time to speak with the patients more. It hit me pretty hard when Miss Dolores told me about how many young adults they see coming in for treatment these days. At age nineteen myself, I have never known much more than a life filled with education and opportunity. I am able to wake up and think about tomorrow without the hopelessness that it will be the same as today. The only troubles I have are with how overwhelming it can be to know the whole world as it is, while most of the patients at CCAT struggle with not seeing past their addictions and the small part of the world that immediately surrounds them. It’s a burden for me to have so much opportunity in some ways—and as an Environmental Studies major that burden stems from the fact that I know how much there is to fix in the world as a whole. On the other hand, many of the patients are burdened by a lack of opportunity and by feeling stuck knowing only the life that they have now. It goes to show that everyone encounters hardship, no matter where they are on the socioeconomic or demographic spectrum because we’re all human, and we all have a brain that sometimes needs outside help to make us feel better.

Having an experience such as this one has reinforced my belief that I shouldn’t judge anyone, whether I know them well or whether I haven’t had the chance to understand them yet. When I think about this, many of Joe’s words resonate with me. We are all in the same boat. Everyone deserves a chance to be happy, and the patients at CCAT deserve the chance to face every day without the extra weight that addiction puts upon them. As a member of the Cincinnati community—and honestly, just as a human being—I have the responsibility to help take care of people I know are having trouble taking care of themselves. I think that’s why it’s so important that places like the CCAT House are around. I hope I can still support them now that our visits are over because, knowing what I know now, it can take a whole community to fight against a problem as vicious and unwavering as drug addiction.