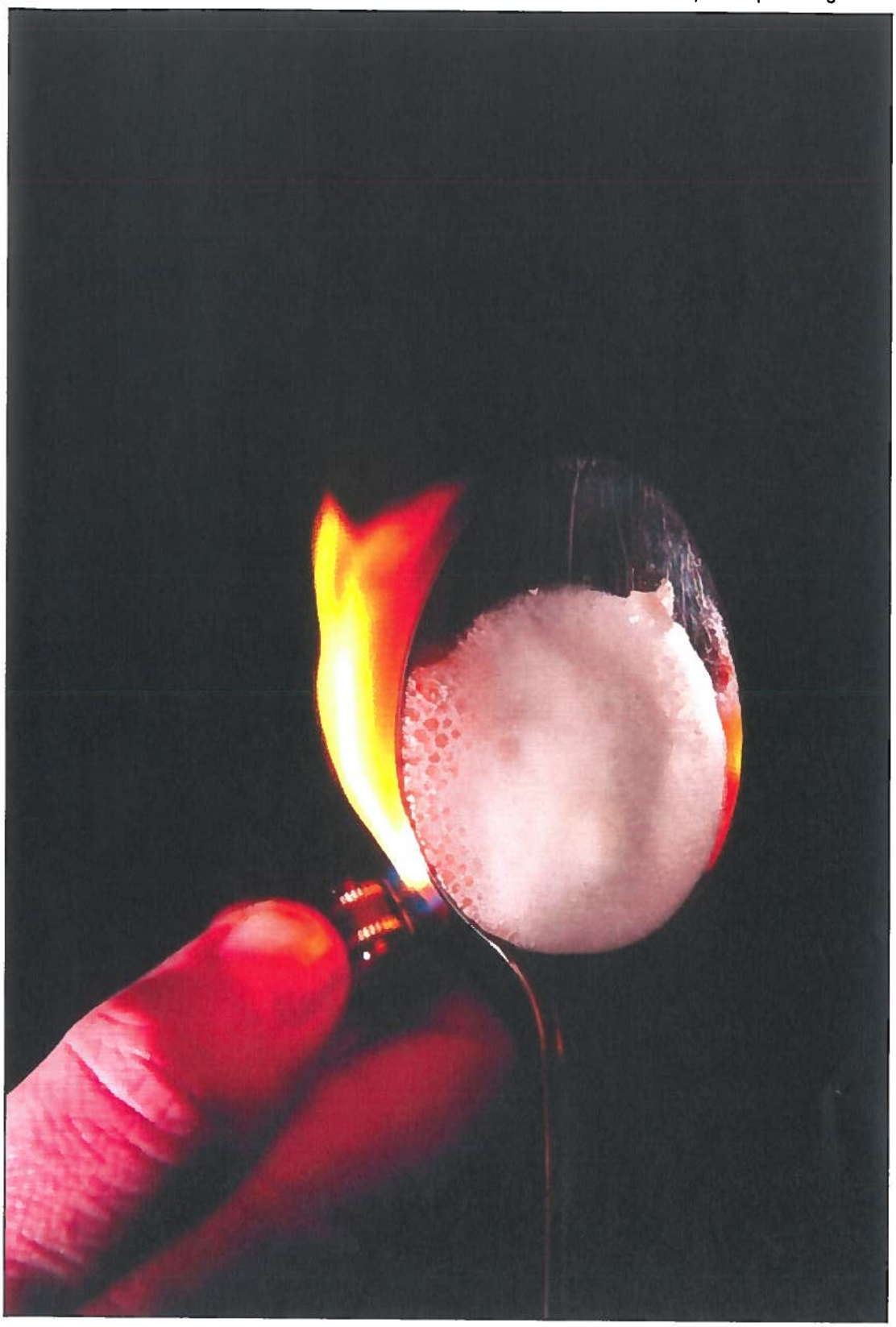
Overdosed and Overrun: Alaska's heroin epidemic

OCTOBER 11, 2012 - 12:38 POSTED IN: NEWS BY: SCOTT CHRISTIANSEN



A rising tide of heroin addiction has been killing people in Anchorage and around Alaska. Police have been making more arrests and more drug seizures. Ambulance crews are being called more often to homes where an addict lies unconscious on the floor after overdosing on the drug. And the state has few places for an addict to turn for help.

Ron Greene, clinical director at the Center for Drug Problems, believed his clinic was

clearing a hurdle in spring of 2009, and could help stem a problem that had building for years. The clinic had been running on flat funding, but state lawmakers committed about $210,000 to increase drug rehabilitation services around Alaska. The Center for Drug Problems would get its share and would be able to increase the number of patients in its budget from 75 to 100.

"We thought that would fix the problem, that we wouldn't have a waiting list," said Greene, the Center's clinical director.

That didn't happen. The number of patients grew as fast as the clinic could accommodate them. The clinic was serving about 78 people on its previous budget. Today it serves 108 on a budget meant for 100 (The clinic never turns away pregnant women, which is why the patient-count is always slightly higher than projected in its budget).

Most of the new patients want help to kick heroin, some were turned on to the drug after abusing prescription painkillers, which had become harder to come by on the street.

"Heroin is cheap and it's in abundance. The drug of choice for the people who come to this clinic for the last few years has been heroin. It has been epidemic in Alaska, especially in Anchorage," Greene said.

Drug counselors aren't the only people who have watched heroin become Alaska's hard drug of choice. Paramedics are being called to rescue more people who have overdosed. Police have been arresting more heroin addicts, who are often dealing drugs, or engaged in prostitution, robbery or burglaries to afford their habit.

Last month an addict named Jason Barnum was accused of attempted murder after he allegedly ambushed two policemen inside a motel room near Merrill Field. There was a stand-off, complete with news media cameras and an evacuation of the motel. The cops who arrived first were looking for Barnum, who police later described as a serial burglar, a heroin addict and a suspect in a string of thefts. Police say Barnum shot first, firing from the motel room's bathroom, and in the close quarters patrol officer Dan Thyen was grazed in the back by a bullet. Barnum took a bullet to his right arm, and would later be charged with attempted murder.

The charging documents in Barnum's case say he admitted to burglarizing homes to support his addiction. Things could have gone down much worse, and in many news reports about the ambush, the shooting and the standoff, the drug that seems to have been central to Barnum's crimes was barely mentioned. Heroin might be at the center of more crimes than the police or the public will ever know about. The quick, straight-forward

confession Barnum allegedly made to cops is likely the exception, rather than the rule. Cops say direct links between heroin abuse and crime (with the exception of possession or dealing) are not always easily established.

"Sometimes, they will say it, but when you are arresting people they don't necessarily want to talk," said Sergeant Kathy Lacey, supervisor of the Anchorage Police Department vice squad. "It's not something we can prove with statistics, but whenever people don't have a full-time job and they're also addicted, they may be paying for that through property crime."

Heroin's popularity crosses a lot of social boundaries, and thuggish characters such as Barnum are not the only people using it.

"Lately, we have been pulling people out of cars," said Michael Crotty, a paramedic and the chief medical officer at Anchorage Fire Department. "They are looking for a private place to use heroin, and if they have a car, that gives them privacy."

Paramedics generally only meet addicts in the event of an overdose. Some overdose victims have hollow cheeks and needle scars on their arms. But some, Crotty said, "look like they just came from a community college campus—like they just tried it because somebody told them it was cool."

When a paramedic meets a heroin addict, Crotty said, it's usually because of an overdose that someone witnessed. "They will typically be blue and on the floor" and the ambulance crew has to make quick decisions to save their life. Crotty has a bird's-eye view of the city's ambulance crews. As a supervisor and chief medical officer, he can roam from station to station, sometimes riding along with crews to fill in for an absent paramedic or to ride with a new paramedic being mentored.

Crotty says if the purity of heroin changes on the street paramedics will notice a rise in overdoses. "It's hard to quantify how much is out there, but when something changes within that community—It could be a change in purity or if there's a lot of money on the street, like after the permanent fund dividend—we will notice that," he said. "I have saved an awful lot of overdose patients, some of them more than once."

Last month Crotty was on a shift during which two heroin users overdosed and were hospitalized the same day. "Both of them would have been fatal, one of them may have a poor outcome," he said. By "poor outcome" Crotty means permanent brain damage.

Heroin is a depressant, or downer. During an overdose the patient's heartbeat and breathing slow down and eventually can stop completely. The breathing will stop first. The

heart muscle will continue pumping blood until the heart itself has no oxygen. But before that happens the brain is slowly deprived and dying, in a fashion similar to drowning. A person cannot sleep-off a heroin overdose. To make matters worse, a junkie slipping into a coma looks a lot like a junkie experiencing their normal high. The witness who calls 911, whether a friend, relative or other drug user, will often make the decision too late.

There are also street myths to contend with, among them that a person can be shot up with another drug, or with salt water, tap water or even milk as a form of first aid for an overdose. None of those things work. Calling 911 promptly is the single most important thing anyone can do.

Crotty once arrived at a home where some people had used a needle to administer milk to an overdose patient. "I don't know where [the myth] comes from, but it's out there," he said. "They had the milk out and needle drawn up. They were crying and apologizing and saying they did everything they could do. The outcome for that patient was not good."

The more a paramedic knows about the patient the better, of course, but often the people who called for help split as soon as an ambulance arrives. They don't want to deal with police, but when they disappear it can leave paramedics with scant information about the patient. There's no one to explain what mix of drugs the victim used, or anything about the victim's drug abuse history or how much heroin might be in their blood.

Paramedics use a drug called Naloxone to counter the effects of an overdose of heroin. Naloxone can be injected with a needle but paramedics often use a mask and mist device to administer the drug nasally. The drug is called an opioid antagonist—it almost instantly counters the effects of opiates. "They can go from unconscious and not breathing to wide awake and wanting to fight you in a matter of minutes. They can go from at-death's-door, to walking to the ambulance," Crotty said.

The seemingly miraculous recovery is only temporary, however. It wears off in 30 or 40 minutes and the patient must be taken to a hospital. They must be carefully monitored for several hours afterward. In some users, the Naloxone triggers withdrawal symptoms, so the patient will vomit and risk choking. Other patients slip back toward respiratory failure and could die.

Detective Sergeant Lacey has been in charge of the Anchorage Police vice squad for seven years, and worked a street crime unit before that. As a department policy, patrol officers contact Lacey whenever they see an overdose of hard rugs such as heroin. But police don't have automatic access to medical files—medical privacy laws prevent that—so Lacey is often left with only sketchy details about what mix of drugs the person used.

"We do know that overdosing has really sky-rocketed in the last year or two," Lacey said. "That could be from [the heroin] being stepped on, and you don't really know what chemicals they used."

The Anchorage Police and the state medical examiner are working on new protocols for collecting information about drug overdoses. The use of street drugs called "spice" and "bath salts," which purport to be synthetic marijuana and synthetic cocaine, is on the rise. Lacey says those chemicals are leading to overdoses, too.

Lacey said 71 people died from overdose in Anchorage between 2008 and 2009, the last period for which she had statistics. In that same two-year period, there were 33 traffic fatalities.

Lacey said police intend to work more closely with the medical examiner to gather information about what drugs people are using. "We are trying to get a handle on this information, so that we can know what we can do to combat this," Lacey said. "A lot of

what we have is anecdotal. The only thing we can know for certain is, if they die, what was in their body."

Heroin has supplanted prescription painkillers such as oxycodone, because heroin sells for about $40 for one-tenth of a gram dose. Compare that to an 80-milligram oxycodone pill that costs $160 in Anchorage—double the 1990s price for the same drug. "Oxies are expensive and the expense and the difficulty in getting them has been pushing people to heroin," Lacey said. "We are also seeing a lot of prostitutes on heroin now, who used to be on crack—they bypassed the oxy route."

Part of Ron Green's voicemail greeting at Center for Drug problems is dedicated to informing callers about a meeting just for addicts who are on the clinic's waiting list. Like the rule about never turning away a pregnant woman, the meeting for wait-listed clients is a requirement of the programs that fund the clinic. It's not very well attended. The waiting list includes about 17 people, Greene said, but only two or three will make it to his Wednesday meeting. "We just added a guy to the program. We just got him in here and he had been on our waiting list since December 12, 2010—That's how long it took to get him into this program, almost two years," Greene said. (The Center for Drug Problems is run by a non-profit called Narcotic Drug Treatment Center, Inc. and uses federal and state money.)

As clinical director at Anchorage's only methadone clinic, Greene manages counselors and oversees the counseling of individual addicts. His work is purposefully separated from the medical doctor who can write a prescription for methadone. The counseling staff and the medical staff are divided by a Great Wall-type policy that has become standard at clinics that dispense methadone. "We don't even go in the same room where they dispense it," Greene said.

Decisions to use methadone are between the doctor and the patient, and Greene's counseling staff won't interfere. They don't advise addicts when to get off methadone, but they will be there to help when an addict decides to take that step. "If they do it too fast, they will fail," Greene said.

Greene's small office has a bookshelf stocked with titles that illustrate two distinct, but interrelated themes: addiction recovery and criminal rehabilitation. His office is adjacent a meeting room where a white board has the words "Relapse prevention lesson 1" on it. It could be a boardroom, except that it lacks the long table the culture of decision-makers requires. Chairs are stacked in one corner, waiting to be arranged in a talking circle or in rows. One poster on the wall is all text, titled "Criminal Thinking Errors" and lists examples—anger, pride, sexuality, perfectionism and "fear of fear" among them.

Kicking heroin—or the prescription drugs that mimic opiates such as heroin—leads to severe withdrawal. It begins with anxiety and progresses to include fevers, sweating, nausea, vomiting and pain in the stomach, back and legs. Some symptoms don't peak until a day after the last dose of heroin, and for some addicts it can take days for the pain and nausea to subside.

"They won't die [from withdrawal]," Greene said. "But they get sick enough that they wish they were dead. It's why addicts continue to use heroin, because they don't want to go through withdrawal. They get dope-sick and that dope-sick is what heroin users fear the most."

Greene can describe a clear distinction between clients who are dependent on methadone and a drug abuser who is addicted. Phrases such as "doctor shopping" are part of his trade. ("If you are doctor shopping, you are an addict," he said.) The clinic's controls on methadone are called "diversion control" and the clinic must prove the methadone it dispenses is not being abused by clients or diverting onto the street. Patients are monitored—there are home visits, random tests for drugs and alcohol, and empty bottles to be accounted for—and the clinic is inspected by an independent accreditation agency.

Methadone itself is addictive and most of people with prescriptions must take it orally at the clinic. Some are allowed to take the medicine home, but only after months of counseling and meeting goals set by the program—staying clean, achieving a stable home life and length of time in the program are among them.

The patient also must prove that there is a benefit of decreasing attendance at the clinic that outweighs the risks. Currently, 27 of the 108 clients at Center for Drug Problems have take-home privileges, according to Greene. "They have earned that right," Geene said. "They have proven they are not involved in any illegal activity."

Methadone works by stopping the cravings for other opioids and in small doses gives a milder high than heroin. The effect last longer, in what clinicians call a "half-life" that prevents withdrawal. It can be taken once a day to replace a habit that may have required a dose of heroin every four or five hours.

The treatment is controversial. (That's partly why Greene draws a distinction between methadone dependence and addiction.) One thing clinics such as Center for Drug Problems have shown, is that a recovering addict can lead a productive life when the fear of withdrawal is removed from their lives. The counseling is a vital part of that, but so is removing the addict's biggest fear. They no longer panic about where and how to score the

illegal drug before withdrawal sets in. And a doctor controls their dose, so they no longer run the risk of overdose, or buying contaminated supply.

"Some of them will be dependent on this medication for the rest of their lives," Greene said, "and if you ask them if they should stop, they will say 'Why should I do that?'—They were robbing, stealing and dealing. Now that they have this medication they are able to work at a job and pay taxes. They are able to keep their family together."

The Center for Drugs Problems has, since the late-1970s, held out a standing offer of hope for heroin addicts. Their clients come with referrals, often from family members and doctors, or attorneys and even cops. But with tight funding by the state and federal governments, and a clientele that's far from recognized as a political constituency, it's not clear if the clinic will ever catch up.

Greene, in his office surrounded by files and paperwork, had been explaining the jargon-laden technicalities of his job to a reporter, when he paused. His tone softened and looked straight across his desk. This year, he said, one addict died while on his waiting list. Greene shook his head gently. "You don't need to be dying at the age of 23," he said.