

For Young Women Like Nicole, We Can Do Better

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Abstract

Twenty-two-year-old Nicole who had a heroin addiction died of an accidental overdose. Her family tried to get her help as she battled her addiction, but they found that treatment for addiction disorders was hard to access. Nicole's story underscores the need to continue to probe the gaps in the addiction treatment system and to share what we learn in hopes of helping others avoid this kind of tragedy. Fundamental changes are needed in the configuration of services and service providers to make effective treatments sufficiently attractive, accessible, and affordable.

There was a photo of a young woman in a recent article in *The Washington Post* and the headline read “Why We Couldn’t Save Nicole: Finding Treatment for Addiction Was Harder Than We Thought.”¹ It was a moving first-person account by Nicole’s mother, Jacqueline Duda.

The article started on a positive note. “We’re a hardy family, used to weathering all manner of surprises, as we’ve seen four kids through various stages of toddlerhood, childhood, and adolescence. So when our fun-loving 22-year-old, Nicole, shocked us by admitting to a heroin addiction and asked for our help in overcoming it, my husband and I froze only an instant. Then we leapt into action, firmly believing that with the aid of 21st-century medical treatment, we could help her reclaim her life.”¹

But this story, like others, did not have a happy ending. As Nicole’s family scrambled to find help for their drug-addicted daughter, they learned the hard truth: that treatment for addiction disorders is difficult to access. They learned that the treatment community still has much to do to increase services and enhance communication and coordination within the various health care delivery systems.

Jacqueline Duda recalls their challenges. “Over the next few months, Nicole continued the cycle of trying to quit and relapsing. When the pains of withdrawal became severe, she visited our local hospital emergency room. Each time, we hoped that she’d be whisked into detoxification (detox), a three-day hospital stay during which doctors can prescribe medications, such as methadone, to ease withdrawal symptoms and replacement therapy for the addictive substance. The problem is, most hospitals and local treatment programs don’t offer detox, and few hospital emergency rooms (ERs) have addiction experts.”¹

Ultimately, Nicole’s story had a tragic ending. “The next several months of trying to get her affordable treatment were like entering some unknown circle of hell. Then the world as we knew it

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came crashing down when two policemen showed up to tell us that Nicole had been found dead of an accidental overdose.”¹

No one knows for sure whether or not Nicole’s death could have been prevented. Nevertheless, her story underscores the need to continue to probe the gaps in the addiction treatment systems and to share what we learn in hopes of helping others avoid this kind of tragedy.

Nicole’s family learned some painful lessons about addiction treatment systems:

1. Resources are inadequate to meet demand for services, and there are long wait times;
2. There is a false sense in the public that treatment is one phone call away—people believe they can get help, but it’s not there;
3. Most hospitals and local treatment programs don’t offer detox, and few hospital ERs have addiction experts.

What can we do?

In the September–October 2008 issue of *Addiction Professional*,² Willenbring asks a timely question: “Does the treatment field have the courage to change?”

Dr. Willenbring raises several critical points:

1. We tend to focus on the people presenting for care, who have the most severe disorders and forget that addiction disorders exist in a much more varied form in the community at large. If we assume that non-treatment seekers are similar to seekers of care, our attempts to address the treatment gap will fail. We need to focus on prevention and early detection.
2. Fundamental changes are needed in the configuration of services and service providers to make effective treatments sufficiently attractive, accessible, and affordable. For example, only about 5% of current patients are treated with available, research-tested medications, even though they are about as effective as treatments for depression.
3. Addiction is a chronic illness, yet we don’t treat it as one. Because most people in need of specialty treatment have chronic, relapsing dependence as well as co-existing physical and mental disorders. Specialty addiction treatment should seamlessly integrate addiction, primary medical, and psychiatric treatments. In addition, for those unable to achieve or sustain full remission, chronic care models should provide intermittent or continuous treatment and management over years to decades.
4. Most of our clients today are overtly coerced into treatment by the criminal justice system, employers, or family members. Among treatment professionals, this situation divides loyalties and fosters complacency, since programs need not attract clients based upon understanding what customers want and providing good service.
5. Currently, most depression treatment occurs in primary care, about two-thirds of depression episodes are treated, and mental health specialists provide more intensive treatment for those with more severe and complex disorders. The time is right for a similar development in addressing addictions.

Nicole’s mother ended by stating, “Each time I speak at a drug treatment conference or interact with an addict in recovery, I can’t help but see Nicole and think: We can do better.”¹

References

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