For our season finale, we’ll be talking about the class of drugs that has affected most of our lives in some way shape or form over the past decade: Opiates. Over the past ten years the opiate crisis has claimed millions of lives and has had devastating ripple effects on countless others, from family members to doctors and patients, but the people most responsible for the overprescription and lobbying on behalf of the drug companies still largely haven’t faced accountability for their part in facilitating the crisis. I’ve also got a return special guest, Dr. Bruce Baker, a board certified addictionist, to speak on what he’s seen in his career and the recent changes he’s seen in opiate trends.

Humans have long used poppy seeds for pain relief, but the refinement of opium from the plant to the extremely potent formulations available today has led to numerous health crises across the world, including the current national opioid epidemic still ongoing today. Opium dependence was even weaponized by the British empire against the Qing dynasty in the 1800’s to legalize and control opium trade in China. Merchants would give out free opium at the port to laborers to begin their dependence in an attempt to secure a trade foothold in the region after China had banned opium’s trade and usage. Two wars were fought before China ceded the port city of Hong Kong to the British empire. This was the first recorded epidemic of opiate addiction that stretched across the world and continues to have lasting consequences on international relations. When it wasn’t in the form of opium, morphine was used for everything and anything by doctors along with cocaine in Western medicine at the time, so most of the “professionals” we consider the forefathers of our respective fields were likely hopped up on one or both of those drugs from their doctors. Edgar Allen Poe was a well-known morphine user, something that historians believe factor into his death, and Sigmund Freud was known for constantly espousing the properties of cocaine on making him feel like the most important person in the world. Then heroin came along, something Dr. Baker spoke about during our interview.

The individuals that created heroin from morphine was in the late 1890’s, and there were seven people in the laboratory and all seven died from opiate addiction. The name heroin came from the word hero, which the seven laboratory scientists decided was the best name as when you use heroin. It makes you feel like a hero and that's how it received its name. And heroin and morphine were used extensively in over-the-counter syrups and elixirs for children when they have a cough and it is said that more children died from the elixirs containing opium and morphine than they did from the disease itself. So this has been a problem ever since it was first developed.

Yes you heard him right, morphine and heroin in children’s cough syrup. Technically it did stop kids from coughing, by stopping their breathing entirely. If they’re already dealing with a stressed respiratory system, the respiratory depression from opiates certainly wouldn’t help. But that’s far from the darkest chapter in the origins of Western medicine and the scientific revolution, and far from the last time we’ve given actual children highly addictive drugs to treat relatively minor health problems.

Today, we’ve been living in a crisis created by overprescription from lobbying on behalf of the drug companies who were producing opiate based medications. While that may sound dramatic, 80% of opiate users started with a prescription for opiate painkillers over the past decade. The longer someone is prescribed opiates, the more likely they are to develop a dependence on them. For chronic pain patients for whom opiates were often the first and only response by their doctors, this left them at a disadvantage when companies, such as Purdue Pharma and Johnson & Johnson, began their lobbying efforts to convince doctors to prescribe their versions of OxyContin and other opiate painkillers to their patients. While most companies involved at this point have faced suits and settlements of millions of dollars, for most people it’s a long way to go until they feel the Sackler family and others have truly faced accountability for their contributions to this crisis.

Dr. Baker will speak more on this later, but it needs to be said that most of the people using these drugs aren’t doing them for fun. Especially opiates, while the brief feeling of comfort gives you may entice people to start using, it quickly becomes all consuming and will actually leave you with extreme chronic pain, organ issues, and potential death from withdrawals the longer you use it. Going without can make users extremely sick, from shakes and fever to diarrhea, vomiting, and potentially a coma, quickly creating a very severe physical dependence on opiates to function. Take too much? You’ll die. Take too little or try going cold turkey? You can die that way too. While there are treatments available now, access to and readiness to quit are two major factors standing in the way of getting help. That’s why you’ll hear about initiatives for safe injection sites and needle exchange programs not to encourage use, but to keep people alive who do until they feel ready themselves to get assistance with their use. As I’ve said before, there’s an idea that providing help to drug users will encourage use, but people are using drugs regardless of if these resources are available or not. And they’re dying from opiates at record rates still, so keeping people alive seems like it should be the immediate priority until we actually have widespread access to drug treatment programs.

So far, it’s estimated at least 500,000 deaths in the United States can be attributed to the opiate epidemic, with the death toll still counting and countless more who are living with ongoing addiction. There is some hope though, and I’ll let Dr. Baker talk about what he does best, opiate treatments:

There's multiple treatments now for opiate addiction making actually heroin the easiest to treat addiction that is out there. And one of the new acts for the Congress did was the data act of a 2001 which allowed doctors for the first time in history to write medicine to write opiates for addiction that was limited to the use of a drug called buprenorphine. It comes in different preparations and different dosages and this alleviates the cravings for opiates entirely. And this was brand new and it doesn't have to be at a methadone clinic which has its own set of rules right now in America. There's over 800,000 people on Suboxone, which is the trade name for buprenorphine and there's Only 250,000 in the methadone clinics in America and both of those are called Agonist therapy. And the last therapy that's available is called Vivitrol and what Vivitrol is is a Narcan that's injectable. And that lasts 30 days in your system, and it will not allow you to get high very easily.

So if you suspect anybody has an opiate overdose, there's absolutely no harm whatsoever in giving them a shot of Narcan and you don't have to use alcohol wipes. You don't have to take their pants down or their shirt, you just inject them because this is life-threatening and seconds truly matter.

Hear that? You can just administer NARCAN with no worries instantly to anyone you may suspect be overdosing.

He also mentioned a drug called Vivitrol, something singer and actor Demi Lovato has recently opened up about being on as part of her addiction treatment for opiates. Now, there’s countless celebrities and public figures who have dealt with addiction, particularly to heroin, but Lovato’s recent documentary included discussions around what the “right” treatment path looks like for her and how not everyone can follow the same path to sobriety. Numerous articles have come out discussing her choice to be “California Sober,” (continuing to moderately use cannabis and alcohol according to her definition) and painting it as some kind of dark slippery slope, but no one has mentioned what her treatment plan that she opened up about actually entails. No data currently available shows cannabis as a gateway drug to other substances, and her being on Vivitrol means that even if she tried to use opiates, they couldn’t take effect. Vivitrol is a long acting naloxone shot that prevents the opiates from binding to the receptors, so she wouldn’t be able to get high if she tried as long as she’s on those shots. It won’t work for her other substance struggles with crack cocaine, but there’s been a wave of criticism from those who seem to be unaware of what the information she chose to share with the world actually means. This is also someone who can afford the best treatment, the best care, and access to all basic needs that many other drug users may not have, sharing her personal experience, and is by no means representative of what most people go through when it comes to dealing with addiction. As she herself has stated multiple times, her decision to use cannabis and alcohol still is not something that will work for everyone going through addiction recovery, but her new documentary details the user’s perspective as addiction as a disease to be treated, rather than a moral choice as it’s been seen for so long across the world. Back to the doctor though.

So, what does he actually do in his day-to day role at the Suboxone clinic?

Well, the first thing I do is take a shower. It's always a good thing to do but in all seriousness, I have a medication assisted treatment clinic in Newaygo.

And I service approximately 30 people for their medication for their opiate addiction. The drug that I usually utilize is suboxone, which is a combination of buprenorphine and naloxone. The buprenorphine is relatively safe as it has what's known as a ceiling effect for both pain relief and respiratory depression. So if you're just utilizing Suboxone alone, it’s not impossible to overdose, but you'd really have to work at it. Unfortunately when it's combined with other drugs such as benzodiazepines or alcohol all bets are off. Then it becomes a drug that is quite dangerous which is why we monitor people so closely. So people come in looking for assistance with their opiate addiction, we set them up with counseling and we balance their brain as fast as we can with suboxone.

If that is not available to them methadone is the drug of choice then unfortunately methadone can only be dispensed for addiction out of federally run and or federally approved clinics the to enter those clinics is a commitment to arrive there at the beginning six out of seven days for the first 90 days and that's hard for a lot of people but it's completely necessary because these opiates isolate people and they're not used to being around other people. The basic skills of life are reviewed and worked on through counseling while we, well, I balance their brain with different types of drugs. Hopefully just a single drug, either with methadone when I was running to methadone clinics or Suboxone in which I work out of Newaygo. I also have a small clinic in White Cloud where I work with people what who have what's known as dual diagnosis. And that is that they have both mental health issues as well as substance abuse issues. We have I have found that approximately 60 to 70 percent of the people who were diagnosed originally with mental health issues did not have any mental health issues, but had substance misuse or substance use issues. And that's quite optimistic for a number of people as you can make a full recovery rather rapidly when you look at a lifespan for opiates, than you can otherwise.

But there’s some major issues when it comes to getting access to these kind of treatments. For starters, finances. With no universal healthcare system of any kind in the United States still, all recovery costs are out of pocket and it is expensive. Even the lower priced options are thousands of dollars, and that’s not counting the other major hurdles of getting access to treatment: location and transportation. Methadone is much more difficult to access than Suboxone, and access to both heavily depends on where you live and what transportation you have access to. Dr. Baker sees the effects of these systemic barriers every day in his work.

In a state of Michigan right now that there's a [Methadone] clinic in Muskegon. There's three clinics in Grand Rapids. There's a clinic in Mount Pleasant. And I believe that's all. And a number of clinics in Detroit. Other than that, there is no methadone available North of Mount Pleasant in the state of Michigan and in the Upper Peninsula, there is none. That's a huge issue, a huge issue and you have to live close enough in order to utilize the services. And many people come early. We opened at 5:30. So people can be at work by 6 o'clock and I'd say over 50% of the patients at the methadone clinic work or are employed. As far as Suboxone, I would say 70 to 80 percent of my patients who begin Suboxone within three months have employment.

While this is all wonderful to hear, there’s a bigger concern he’s seeing: most heroin isn’t heroin anymore, it’s fentanyl of varying purities and strengths that has replaced most heroin in the United States.

And are we seeing obviously we're not seeing as much heroin anymore. So fentanyl is coming from, no one seems to know specifically but it seems to be coming from China and processed in Mexico. That seems to be where most of his coming from now.. Prior, a number of years ago there was a manufacturer in Grand Rapids and they discovered that many of the employees were carrying out cases of Fentanyl patches because they were not being watched which is unbelievable, but that's true.

But if there’s one thing he really wants other doctors and medical professionals to know, it’s how to treat their patients.

I have had a recent number of patients who have gone to the emergency room who have been grossly mistreated. And this is a problem with anyone who states that they've had an addiction issue or they're utilizing Suboxone or methadone, the healthcare profession continues to be quite biased and individuals are injured on a daily basis from providers of medical care who simply don't like addicts.

And unfortunately, in the medical field the group of people that are ignored the most are the group of people who could use our assistance the most, and that’s pregnant addicted women. For some reason healthcare professionals walk away from this as quickly as possible. Unfortunately, this is detrimental to two people and not one.

Wait, pregnant women can receive opiate treatment safely?

It's absolutely necessary. If you are pregnant and you have multiple small withdrawals, which is when people use again because you know, everyone wants their drug to last as long as they can but as far as fetal injury multiple small withdrawals will injure the fetus and that's where the issue comes in. When it comes to methadone and pregnant women, and on day one independent of what she has in her system I can begin methadone. When it comes to Suboxone, or buprenorphine the generic part of it, they have to be in withdrawal, which means that I would have to make them become dehydrated, have diarrhea, and vomit in order to begin my drug Suboxone. So methadone remains the drug of choice for pregnant women as long as they live close enough to reach a methadone clinic, hopefully within 45 miles.

It’s also completely safe to give NARCAN to pregnant women, as the most important thing is stabilizing the fetus so that no further harm is done. Also to be noted, regardless of who it is, once NARCAN has been administered you need to still get emergency medical attention. Yes that does mean actually calling 911, seconds matter and an ambulance can get to you much quicker than convincing an Uber driver to speed to the hospital. Even if the person wakes up, they still need emergency medical attention in case of respiratory distress.

If you notice someone turning blue, skin going cold, and breath slowing, that may be signs of an overdose and even if you don’t have NARCAN on your person calling 911 may save someone’s life. If it turns out to be a different medical emergency and you gave somebody NARCAN, it also won’t hurt them. NARCAN won’t have any affect on someone who has no opiates in their system, so there’s genuinely no harm in using it in the case of a suspected overdose. Even if you don’t think someone took opiates, like say your friend took a pill but now is not responding, it may be a case of fentanyl tainted supply and seconds count when it comes to using NARCAN. Their website, narcan.com, has resources for you to find and learn how to use the nasal spray version of NARCAN. Depending on where you live there may even be regular training sessions through community organizations or activists where they give you a dose to have on hand after learning how to properly administer it.

If you’re struggling with your usage of any of these substances, Grand Valley has options to help. Our Alcohol and Other Drugs Services and Counseling Center has numerous options for support, many of which are included in the tuition you’re already paying.

Thank you to Dr. Baker for sharing his knowledge with us. Thank you for listening to this podcast series. This is the season finale, we will be back in the fall with new topics, new hosts, and hopefully newly in person. One last time, I have been Alex Baker asking you to be safe, smart, and responsible.