Southeast adaCenter

ADALIVE!

EPISODE 67: Opiod Addiction and the ADA

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Kelly Scaggs, Fellowship Hall Drug & Alcohol Recovery Center
Rebecca Williams Southeast ADA Center

Host: Barry Whaley, Southeast ADA Center

Music: [Car starting] Yo. [Car starting, helicopter whirling] [Music] [Car starting] All right, let's roll. Let's go. Wel-come to / Here we come [Music fades out].

MIKE: Hi, I'm Michael Yow

KELLY: I'm Kelly Scaggs. And your listening to ADALive!

BARRY: Good afternoon. On behalf of the Southeast ADA Center, the Burton Blatt Institute at Syracuse University, and the ADA national network, I want to welcome you to episode 67 of ADA Live. Hi everybody, I'm Barry Whaley and I am the director of the SEADA Center. Before we move on, listening audience, let me remind you, you can submit your questions about the ADA and opioid addiction at any time at adalive.org. That's adalive.org.

Every day, more than 130 people in the United States die after overdosing on opioids. When you think about it that is 47,500 people annually dying from opioid overdose. The misuse of and addiction to opioids, including pain relievers, heroin, synthetic opioids like fentanyl, it is a serious national crisis that affects public health, as well as social and

economic welfare. The Centers for Disease Control estimates the total economic burden of prescription opioid misuse alone in the United States is $78.5 billion each year, including in the cost of health care, lost productivity, addiction treatment, and criminal justice involvement.

Over the next two episodes, ADA Live will explore the opioid crisis from a number of different angles, from treatment to the protections offered by the ADA, from the justice system to legal and responsible use of opioids to treat chronic pain. There are several different approaches to management and treatment of opioid addiction, and what may be effective for one person may not work for another. Common treatment options may include medicines, counseling, behavioral therapy, medication assisted therapies, and residential and hospital based programs.

Today we feature Mike Yow, the president and CEO, and Kelly Scaggs, the clinical director from Fellowship Hall Drug and Alcohol Recovery Center based in Greensboro, North Carolina. Mike and Kelly will talk about the treatments used at Fellowship Hall using the Narcotics Anonymous principles and steps.

We'll also be joined by Becky Williams, the technical information specialist here at the Southeast ADA Center to discuss the protections people in treatment have under the ADA. So, Mike and Kelly, I want to thank you for being with us today.

MIKE: It's our pleasure.

KELLY: We are glad to be here.

BARRY: Great. Perhaps a good place to start might be to share what Fellowship Hall is and what kind of treatment model you use there.

MIKE: Well, Fellowship Hall is a private nonprofit. We have been here since December 1971, so we have been around for a long time, so we are proud of that and we hope to have another 47 years or longer. At our core, our philosophy of treatment is an abstinence based 12 step philosophy, so what that's meant traditionally, we our experience has been we think people do best in the long term, if you have a substance

abuse disorder, that in the long term you're not taking substances, and that you align yourself with self-help mutual aid societies, like Alcoholics Anonymous and narcotics anonymous, and so those are our core principles and guiding principles, and we believe that works best for most, but really our treatment process is much, much bigger than just aligning people with AA or NA.

We have a holistic treatment approach, using evidence-based practices, and Kelly will talk about that more across the board. We have a recovery-oriented system of care on our campuses, so we offer a medically supervised detox, all the way to housing and long term additional outpatient treatment. I have been doing this for 30 years, and Kelly is knocking on the number of that door as well. With addiction disease, what we have seen is people's outcome is going to be better if they are not taking addictive substances in the long term we try to support a lot of different pathways of people. We try to cooperate with a lot of different pathways to recovery, and people who come here are looking for specifically, we hope, what it is we are offering.

BARRY: Great. Thank you so much. So when someone comes to Fellowship Hall, can you walk us through what happens when someone first arrives?

KELLY: Sure. Here at Fellowship Hall, we offer full continuum of care. People can enter at different levels of care, depending on the severity of their substance abuse disorder. The majority of people come in a traditional, residential -type setting that people are familiar with for a 28 day treatment.

When they come in, depending on how sick they are, where they are in their substance use, they may require a medical detox. We are a full hospital so they can come in and receive medical detox in our facility. While they are detoxing, they are participating in the programming that we have.

So they are going to therapy groups. They are going to lectures, psychoeducational groups, the whole time focused on how we can build their coping skills, how to live a substance free life, as Mike mentioned earlier, and help them work on any core issues or deep seated issues that may be exacerbating or adding to their addiction issues.

MIKE: So, along those lines, when someone is admitted, there's a long process for getting someone admitted into the hospital. There's an admissions department that is contacted by someone seeking treatment, whether it be a referral source or a family member or a patient themselves, and by tradition, we call our patients guests, because our founders thought it was our privilege to have people here, so we refer to the patients as guests. Sometimes, the guest makes a call. There's a lot of information, demographics and history gathered at admission.

Once a person gets here, they are seen by a nurse for a whole nursing assessment. Within 24 hours, they are given a full health and physical. Our medical director is a board certified psychiatrist and board certified in addiction medicine. We have a family practitioner, an MD on staff who addresses a lot of medical concerns, we have a PA on staff who is psychiatrically trained as well handles a lot of medical issues. We are staffed 24 hours a day, 7 days a week. We have a team of 35 nurses and LPNs. It's a robust assessment process with a lot of wraparound services for medical needs that people are surprised by when they get here.

Like what Kelly said, when people get here they're asked to participate. One of the admission criteria is that you're ambulatory. The reality is we get a lot of people here who are very, very sick from their substance abuse disorders, and it's not unusual for us to be treating someone's medical issues right along with their substance abuse issues, such as out of control diabetes or hypertension and other medical issues that comes along with a substance abuse issue. It's a robust process, and I think a lot of people are surprised happily to receive the level of service that they get when they get here.

BARRY: That's interesting, Mike. So there are these complicating medical issues that you're trying to balance at the same time when addressing the addiction issue.

MIKE: Exactly. Sometimes someone will come in after using large amounts of alcohol or benzodiazepines, and they walk in fairly well but within 24 hours of remission they may have to be in bed and then require a wheelchair for 2 5 days, and if someone has complicated issues during their withdrawal, we have to refer them out to hospital for stabilization. We don't do IV therapy. It's not unusual for someone who has been drinking

a lot to be dehydrated, and they need IV fluids for 12 24 hours, so we send some people to a hospital and they come back for treatment. We see people who are very sick sometimes with substance abuse disorders, and who have not been taking care of their general health very well because of substance abuse issues. So you have to address all of that before having them participate in the treatment process.

MIKE: That's a good segue, and Kelly mentioned the continuum of care at Fellowship Hall. What does a typical day look like once you're able and participating for a guest?

KELLY: One nice thing here at Fellowship Hall is we have a fantastic dietary department, so they begin their day with full breakfast. They are usually up, getting their medication, getting blood pressures checked, they have their breakfast, and then we begin the programming day with what we call eye opener, which is a gathering of the entire guest community. We go over any community issues, any announcements that all of the guests need to hear. It's how they start their day.

We have a morning reading from them from some of the AA or NA texts. That's followed by psychoeducational groups, lectures. We have specialty tracks. For instance, we have a young adults track for those guests age 18 25 that addresses issues specific to that population. We have a specialty track for professionals. So if someone is in a safety sensitive type position, pilot, physician, nurse, if someone works as a lawyer, they may participate in that particular specialty track, if they are working with a professional monitoring organization, people who have chronic relapse histories.

There's a specialty track, those who have been using stimulant type substances, cocaine, methamphetamine, they have a specialty track. Guests are participating all day long in education to help them build the skills they are going to need to support their recovery system.

They also go to small group, which is traditional group therapy, and they attend that six days a week. They also meet with an individual therapist. It's something unique about Fellowship Hall, each guest who comes here is assigned a primary counselor. That's their individual therapist for their entire stay here at Fellowship Hall. They meet with that

person at least twice a week for a full 50 minute session, where they can address their individual issues as well. They work on their aftercare plan. Everyone who comes to Fellowship Hall leaves with an aftercare plan that may be a continuation of services here at Fellowship Hall or in their own home community if they don't live in our area. We have a clinician who does their discharge planning.

There's an entire team approach the work that's done with each of the guests here, involving the medical and clinical team. The guests' days are full, participating in activities, attending outside 12 step meetings in the evening. They have a very full day here at Fellowship Hall, where they have an opportunity to dive into those issues that are going to be important as they move forward in their recovery process.

MIKE: Just to piggyback on what Kelly has laid out, that's a constant effort for us, to offer treatment that's evidence based and gives people what they need as individuals. Also I want to add, one of the things that we are proud of is our continued individualized care. We have continued individual counseling that people are going to benefit from. You get that individual counseling in addition to the group processes.

KELLY: One thing that I think is very a very important part of our program here at Fellowship Hall is our family program. We offer an intensive four day family program. When someone is involved in treatment here at Fellowship Hall, at least one family member, sometimes more, are offered to come to the four day family program where the family is also receiving education on substance use disorder and what recovery means for them.

Substance use doesn't exist in a vacuum, family members are impacted by substance abused disorders. We think it's important to have a pathway to recovery for themselves. We have found our family program has been around almost as long as the hall has been around, and we find that guests who have someone participate in that family program have much better outcomes, because we know with treating the family system, the whole system has much better results for everyone involved.

BARRY: Yeah, I think that's interesting, and that's the remark I was going to make a second ago, is that it sounds like Fellowship Hall has very much a global approach to treatment, and it seems very individualized. It seems like a mix of therapy both individuals from group are there, and I'm really encouraged by what you just said, Kelly, with the family aspect. You're right, addiction is not in a vacuum. It affects your family, other people, friendships and work relationships. So Fellowship Hall, you mentioned there is a primary treatment and an extended treatment. Can you talk a little bit about the difference 2018 the two of those? The primary is the 28 day residential. There is also an extended treatment.

KELLY: So our extended treatment program was designed to allow people who wanted to do more intensive work to do that. Mike was actually part of the creation of that program back in 2011.

The guests who attend our extended treatment program typically do their first 28 days in primary, and then the remaining 62 days take place at the extended treatment lodge which is also on our campus. We are fortunate that all of programs: our intensive outpatient, traditional outpatient, primary treatment extended, structures all happen on our 120 acre campus, which is nice, so they transition from primary treatment into the extended treatment program, where they have the opportunity to work on some of the core issues that continue to be obstacles to people in their recovery process.

Oftentimes, it's individuals who have maybe had some recovery time and are struggling to maintain that. They have chronic relapses, maybe people struggling with childhood trauma issues or other issues that have come up for them in their process of their addiction, which could potentially be or have been obstacles to them in their recovery. It gives them an opportunity to start looking more deeply at the core issues, utilizing different techniques than they may be able to take advantage in a primary program.

For instance, we do a lot of what's referred to as experiential work. So they have the opportunity to do some psychodramas down there. They have the opportunity, they are doing yoga three mornings a week. They are engaging in music therapy. They have some art therapy that they do, as well as intensive group therapy each and every day, and they

also are doing work with an individual therapist done in the extended program as well. So, it is an augmentation to what they are doing in primary. It gives them more time to dig deeper into the issues that are challenging them.

MIKE: And to that end, you know, the extended program here has been a great addition to our staffing and to our programing offerings. Health care professionals who are mandated for 90 day treatments to that end, we are all very aware that the proverbial 28 days in treatment is not nearly enough for people.

I have said, through the years, as we have expanded our treatment processes, we have a lot of people who come to the inpatient setting, and then they continue with us for extensive outpatient, which is another eight weeks of treatment. So even if someone doesn't go into extended, if they are in our catchment area or go to intensive outpatient which is another 8 weeks we also have transitional housing on the grounds. So we have got three short term houses, one for women, two for men, with 18 beds currently, and those folks by design participate in outpatient treatment, so those folks are really getting a 90 day treatment process as well, and of course the success for those folks is better than somebody who just comes to any inpatient facility for 3-4 weeks because the longer you can hold someone, the better.

We also have a long term house for men, and hopefully women in the next month, so we'll have a long-term house for women, which are 5 beds a piece for 3 months to a year and half. We also offer an active care group for people up to two years in the area. Once they complete their full treatment processes, they can continue to come to group once a week. In our traditional outpatient therapies, people can continue to see an individual counselor here as outpatients and to see our physicians for med management for medications to treat anxiety or depression. Through the years, we have tried to build some wrap around services for extending people's treatment processes rather than just having somebody come in for 28 days.

KELLY: One thing that we know, and I think most people are the professionals in this are clear on, maybe not as much consumers, is that it is not a quick fix when you are talking about addictions of any kind. It is a lifelong process. And we often compare it to treating

other lifelong chronic diseases that need management, and so that early recovery group that Mike mentioned that guests can attend for up to two years after they have completed an inpatient treatment process or an outpatient treatment processes is really important because having that support is crucial for people on their recovery journey to have those supports in place. We are proud of the fact that once someone has participated in treatment here, they can stay connected and continue to receive support for as long as they need.

MIKE: And if I can add one more thing, not to belabor the point, but one more thing that we are doing is what Kelly m mentioned, we have an individualized process around discharge planning. So we have a care coordinator, and that's his job. Everyone who leaves treatment here, if they are not within our catchment area, in other words 45 minutes or an hour drive of our campus, everyone who leaves here with at sometimes individual counseling and any medical needs they might have, so our nursing staff is involved in it as well.

Some people leave here with referrals to family doctors or referrals to psychiatrists in the area to continue their process, and our message is very clear to our guests here. When you leave here, it's not over. It's really just a start on dealing with a health issue that you have got to attend to, and so we want to again give everybody an opportunity for as much success as they can have by setting them up with appointments in their own home areas when they leave here, and that's a vital part of what we believe our mission is.

BARRY: That's interesting. Thank you, Mike. Mike and Kelly, I want to stop for a minute and I want to bring in Becky Williams into our conversation, and ask, Rebecca, what protections does the ADA provide for people who are experiencing opioid addiction?

REBECCA: Sure, Barry, I would be glad to answer that. But I do want to thank you and Mike and Kelly for inviting me to be a part of this great and timely webinar. Since we are discussing opioid addiction and treatment, I'm going to frame my answer around treatment services. Substance abuse treatment facilities fall under title III of the ADA, also known as places of public accommodation or places of commerce. Places of commerce are places where we spend money and receive goods or services. The recommendations

of title 3 of the ADA state that public accommodations may not impose eligibility criteria that either screen out or tend to screen out persons with disabilities from fully and equally enjoying whatever goods or services is offered by the business, unless it can show that such requirements are necessary.

The Department of Justice has recently ruled in several cases involving substance abuse treatment facilities that refusal to admit and/or treat someone with opioid use disorder is a discriminatory eligibility criteria under title III of the ADA, and individuals with opioid use disorder must be able to receive the same services from treatment facilities as all others.

BARRY: That's interesting. Thanks, Becky. So, are there circumstances where people might not have protection?

REBECCA: I'm glad you asked that, Barry. There is so much information being circulated regarding drug abuse and ADA protections. First, however, I want listeners to understand who is protected under the ADA. The ADA defines disability as a physical or mental impairment that substantially limits one or more major life activities, which also include the operation of major bodily functions.

Opioid use disorder can substantially limit major life activities, such as caring for one self, learning, concentrating, thinking, communicating, as well as limiting the operation of some major bodily functions, such as neurological and brain functions. In order for an individual's drug addiction to be considered a disability under the ADA, it would have to pose a substantial limitation in one more of these major life activities. Under the ADA’s definition of disability, it does not include an individual who is currently engaging in the use of illegal drugs.

So folks taking prescription opioids, without being under the care of a physician, do not have ADA protections. In fact, anyone using illegal drugs does not have protection under the ADA. In addition, someone who may buy opioids from a friend who has a prescription does not transfer protections. Under the ADA, it is considered to be illegal use of medicine to use somebody’s prescribed drugs. Keep in mind, this exclusion does not apply to individuals who are no longer using illegal drugs, who have successfully

completed drug rehabilitation or are participating in a supervised rehabilitation program or may be erroneously regarded as using illegal drugs.

BARRY: I understand. Thanks. Anything else that you need to tell our listeners about their rights under the ADA when they enroll in the drug or alcohol treatment program?

REBECCA: One important fact for folks to understand is individuals who are participating in medication assistive treatment plan for opioid disorder, or any drug or alcohol treatment plan, do not need to disclose this to their employer or prospective employer until such time that they may need to request an accommodation to either participate in the treatment program or to help them perform the essential functions of their job. On the flip side, if an applicant or employee tests positive for narcotics or controlled substances, an employer can ask whether he or she is using any prescription medications under a doctor's care that may have caused that positive result, and Barry, I believe ADA live will be covering the ADA employment and substance abuse disorder more in depth in a future episode.

BARRY: That's right. The next episode will include people from the Department of Justice. Thanks, Rebecca. One other question, however, before we turn back to Mike and Kelly. What protection does the ADA provide for people experiencing opioid addiction?

REBECCA: Well, again, if somebody with opioid addiction is currently in a treatment plan, they cannot be discriminated against if we are looking at employment, all aspects of employment, so, for interviewing, hiring, actual employment, promotion, training, because at that point the individual is no longer using drugs illegally. They are in a treatment plan. Does that answer it for you?

BARRY: Yes, yes, thank you. So, ADA live listening audience, if you have questions about any ADA topic or the Fellowship Hall Drug and Alcohol Recovery Center and their role, please submit your questions at any time at adalive.org. Let's take a quick break.

VOICE OVER ANNOUNCEMENT: Fellowship Hall located in Greensboro, North Carolina, began as the dream of four recovering alcoholic businessmen who wanted to help others suffering from the disease of alcoholism. Fellowship Hall is private non-for-

profit facility treating adult men and women since 1971. Fellowship Hall's treatment program focuses on the 12 steps of Alcoholics Anonymous. The original program expanded from those trying to fight drug addiction utilizing the Narcotics Anonymous policies and steps. Fellowship Hall offers a range of care to meet individuals where they are in the progression of their addiction disease. You can find out more about Fellowship Hall by visiting www.fellowshiphall.com.

BARRY: Welcome back, everybody. We are speaking with Mike Yow, CEO of Fellowship Hall, and Kelly Scaggs, clinical director, as well as Rebecca Williams from our own staff here at the Southeast ADA Center. Here's a question that I have always been curious about. Are there people who will be at a higher risk of becoming addicted than other people?

MIKE: I think the short answer is yes. So, it's a loaded question in some respects. There's plenty of research and plenty of evidence to support the genetic factor for people. People whose families have long history of alcoholism or drug addiction in them, we typically see people who continue that trend in their own life.

There's a physical genetics issue, but also a lot of those folks are coming from family systems that are dysfunctional, so there's a huge bio psychosocial element to that. It's not so simple to say that it's purely physical genetics. After that is in play, and I think all the good research will support that. As research has continued into substance abuse disorders, it's very clearly that people who have a trauma history are probably more susceptible to drug and alcohol use because of changes in their brain chemistry. I think the emotional and spiritual impact of trauma sets people up for looking for ways to feel better. There's a fair amount of evidence that people who were self medicating psychiatric illness may turn to drugs or alcohol to feel better, and next thing you know, someone who is drinking may develop an addiction to alcohol, and what we have to do is treat their addiction disease as a primary disease function so you can stabilize their stabilize depression and/or other psychiatric needs as needed.

So, again, I would say the short answer is yes. There are some people who run a high risk and become addicted, and there's a lot of factors I think that will contribute to that.

KELLY: I would agree with what Mike has said as well, and the reality is anyone taking a prescription opioid runs the risk of becoming physically dependent on that. Whether they are addicted to it or not, they are going to have some withdrawal symptoms once they stop using it. Those who use it for an extended period of time, maybe it was prescribed by their doctor initially, but then they began taking it more frequently, not necessarily as prescribed, they get to the point that they are overusing, or they are abusing it. What we find is that oftentimes people have convinced themselves they need to continue taking it at those large quantities for their physical pain, when, in reality, oftentimes it's emotional pain that they are numbing versus physical pain, but they are no longer able to separate those for themselves. Treatment spends a lot of time looking at that. How can we help people to recognize what part of it is physical pain, and what's really emotional pain that they have found relief from by using these opioids?

MIKE: I do want to add, too, just again to kind of knock down some of the myths if you will, we see plenty of people every day who come into treatment with stable family histories, no trauma history, who develop an addiction process, there is some literature out there that has suggested that all addictions are trauma related, and I would push back against that notion. That's not been my experience. I don't think that's true. I have treated enough people through the years to know that that's not valid. And what Kelly said as well, what we have seen for folks who were on prescription meds, had them stop for whatever reason, and they turn to street drugs to fill in that gap, and the next thing you know they are in a mess. There's a lot of factors involved, and that's one of the things we do well at. We like to help people look at how they got here, and more importantly looking at how to get out of the place that they are in.

BARRY: There seems to be a lot of impact, a lot of factors that we can't simplify by pointing at one thing or another saying that's cause of addiction. Mike and Kelly, how effective are most opioid addiction treatments? Even with your best efforts, there must be some return to use or relapse. Can you talk about that a little bit?

MIKE: Again, it's an involved conversation. Let me talk a little bit about what we are doing and some statistics I'm aware of. For opiate use disorder, we do use medication assisted

treatment or MAT. One of the criticisms that I have had about the industry, if you will, what's been lost in conversations in some respects, MAT should not include drug replacement therapy, so to speak. They are two different things. If you have someone on a maintenance dose of Buprenorphine or methadone, that's a replacement therapy, and if that's what they need, I would tell you they should move forward with that. The bigger umbrella is MAT, and drug replacement therapy lives under that umbrella. It's not talked about as much as it should be, a criticism of me and others in the field. We offer a robust MAT process, using Buprenorphine or Subutex, to taper people from opiate use.

Opiate withdrawal is terrible. If you talk to anybody who has been addicted to opiates, they will tell you their biggest fear is being sick. So there's the objective withdrawal. One of the difficulties in treating people with opiate use disorder is the subjective withdrawal, people who have chronic complaints, they don't feel good, their body hurts, they are afraid of being sicker, that subjective withdrawal I would suggest is the cause of a lot of people returning to use of opiates, because it is difficult. One of the things that we have gotten good at, frankly just by paying attention, and by utilizing the medication Buprenorphine more effectively, by analyzing objective and subjective withdrawal while in the course of an inpatient treatment process.

Outpatient treatment for opiate detox disorder is very difficult. You can't really manage people's withdrawal processes because they won't stay in treatment long enough to do that, particularly in an outpatient basis. Last year, as we looked at our internal numbers, we were losing 40% of our opiate use disorder people because they were leaving treatment. In the past year, our medical department has done a fantastic job in conjunction with our clinical department to manage people's subjective withdrawal symptoms more effectively with the use of Subutex, and we reduced our loss of people from 40% to 20%, which means as we are treating those opiate use withdrawal systems We are keeping people engaged and keeping for them longer in benefit of the treatment.

The other thing that we are doing is once we get people stabilized in an inpatient environment, which is a classic way of doing that, and I think probably one of the more beneficial ways for people with opiate abuse disorders is engaging people with the use of

naltrexone, showing that it is equally effective to the use of Suboxone in the long term. The difficulty is getting people through the detox period to start use on the medication. We do not drug replacement therapy here for a lot of reasons, one of them being we treat so many out of area patients, and it is hard to find out of area providers in their home areas to do that.

Also, there has almost been a niche of people who have come to us. People have come to us on various levels of drug replacement and simply not been able to comply, because it's just so hard to take that Suboxone pill every day. Also, if you follow the news, there's a lot of bad actors and a lot of bad players in the addiction industry, which is a very sad statement. There's a lot of for profit entities, pill mills.

We have all seen the people getting arrested, rightfully so, in my opinion, but if you're on Suboxone, and you're drinking, smoking pot, and taking crystal meth or cocaine, it's very difficult for us to say that's somehow that's stabilizing. We admitted a young man here yesterday who has been on Suboxone at a provider. He has taken his pills every now and then. He's diverting some of his medications and selling them, and he's continuing to use opiates, and he's here saying, look, I can't do this, I have got to be off this stuff totally if I'm going to stay alive, frankly. Not by our own promotion, but who we are and what our treatment philosophy is, there are people who are seeking not to be on drug replacement, but to get on an MAT process as a taper, we are finding some real benefits for that population NIDILRR suggested 50% of people with opiate abuse disorders are returned to use.

The numbers are not great. I don't know many people who have numbers greater than that. The one thing I would say, is you see the word success, so if you come to treatment here. Let's say you do 90 days of treatment between inpatient and outpatient. You leave here, you're on Vivitrol, and you return to use, if you come back for a second course of treatment, I would argue all day long your initial course of treatment was successful because you had enough success to know that you can come back and don't have to wait and continue on until some God awful event. The research says there are seven attempts to quit.

KELLY: They say most people have seven quit attempts before they finally enter a long term recovery process. And that's regardless of the substance somebody's using. A quit attempt does not have to mean seven quit attempts but seven experiences to try to stop using before they are successful. We want to be there to support people through that process. You had asked about the relapse or recidivism that comes with treating opiate addiction.

This is a chronic disease for a lot of people. Like any chronic disease, like diabetes, heart disease, those are some that are often compared to addiction in terms of their relapse rates. This is right in line with those. If you think about a diabetic who knows they need to avoid eating cookies or cake, they may sometimes have a bite of cake somewhere. That's not to say that that is healthy for them, but when you're treating substance use, it's not a failure, as Mike indicated, if someone has a return to use.

The goal, of course, is complete abstinence, but we are realistic that this disease can have a component of relapse to it. It doesn't mean failure for somebody. What we hope when people experience that, we want to be able to be there and support people in looking at where were the missteps for them in the recovery process. What could have been done differently? What other support needs to be in place? Is it something like a summation, such as Vivitrol? Do they need to be attending more self-help groups? We want to be there to help people see where the potholes on their road to recovery will be.

MIKE: We have traveled fairly extensively around the country to various conferences, and my job, specifically, here at the hall now, is to make sure that we are offering what we think is the best treatment for people as individuals. We have been in conferences where people have yelled at participants that if you're not doing drug replacement you should be sued for malpractice and everyone should be on drug replacement therapy. In the same room, we have had people say if you're doing drug replacement therapy, and in the same room, somebody has a position that if you're doing drug replacement therapy, you're killing folks and shouldn't be doing that.

We are trying to find what's best for people, and if someone says I want to be off of drug replacement, it's too hard and it's very difficult for people to do that we need to support

them with medication-assisted treatment to bridge them with their opiate abuse disorder. It's a tough position we're in to do what's best for people without taking either end of the argument. This is a hot topic in the industry, you know. I don't find taking an extreme position on either end of that useful.

BARRY: That's fascinating. Thank you so much. I learned so much from that last exchange. One thing that resonated with me is, you know, I would imagine that, you know, if you successfully complete a treatment and then you have a relapse, imagine that feeling of failure must be so strong, and for you to be able to say, no, this is a positive, this is success, I think that's fantastic and can aid in recovery.

MIKE: You know, for us it's valid. I have talked to a huge number of people who have come in here with a return to use of I let you down or I failed. And we are very quick to tell somebody, look, the failure for me is if I see you in the newspaper, in the obituaries. If you're back in treatment, that means you have a chance to find out what's the recipe to get this done. But as Kelly said very clearly, it's not a failure. It's something is missing.

BARRY: Interesting.

MIKE: Again, if you're a diabetic and you go to the doctor and your diet is off, he doesn't kick you off out of the door. He chastises you, gives you lecture and gets you and your family involved. That's the approach we have really taken here, we give people ongoing support in the treatment of their substance abuse disorder. If we are not the place for them, we want to find the place for them to be.

If we have a person with onset at 15 and they come in at 21, that's a person who can maybe benefit from drug replacement therapy for a while until their brain catches up. WE have partners in the area we can refer people to for that. It depends on what people's needs are, so the services that we can't provide, we connect people to folks who provide those, because, again, at the end of the day, that's what we are wanting to do. We are wanting to be a solution for people, rather than standing on this is what we believe and that is the end of conversation. That's insane. We are not going to do that.

BARRY: Mike and Kelly, we are about out of time. Is there anything else that you would like to share with the audience?

KELLY: I think it's important, and we have talked around a little bit, the idea that when someone is struggling with opioid abuse, there's a lot of shame that can be associated with that, really any substance abuse, but particularly opioids and guilt about the impact it may have had on family, friends, coworkers, recognizing that individuals who struggle with substance use disorder are experiencing a tremendous amount of shame. Whether people are aware of it or not is an important piece in the recovery process, because really what they need is that support. They don't need someone else telling them they are terrible or look what you're doing. We really want to be there to offer that support and to help them to recognize that there is a different way and there is a better life that they can lead for themselves, free of chemicals. And that's really our ultimate goal, to provide that forum. Our mission at Fellowship Hall is to provide effective cost savings treatment for individuals suffering from substance abuse use. Based on what I'm hearing from everybody today, that's what we want to see is people get the help that they need and support to have successful outcomes.

MIKE: Here in North Carolina, late last year the STOP Act was passed in the legislature, to address the over prescription of opiates. There's a registry in the state that doctors should be checking to make sure that patients don't have four, five doctors using six and seven pharmacies.

There have been unintended consequences for people who need pain management, and that's a separate issue. Hopefully as the pendulum swings back, that will be addressed so people's needs can be met. But there's no doubt that the over prescription of opiates has been a problem throughout history the use of analogs, fentanyl a lot of deaths at this point are attributed fentanyl and analogs. At the end of the day, I want to echo what Kelly said. Our big message is that treatment works. Recovery is available. And a lot of providers who are good actors who are doing the right things for the right reasons, and treatment works. We want to encourage people to make calls to us. If we can't help, we have a list of people that we refer out to. SAMHSA has a website. You can call hospitals in your

area. Call 12 step help lines. Sometimes you can get help from those folks, but not to give up and not to fall into a place when you're not sure what to do- Start to ask around and find out who is available to help. There is a solution, and that's the bigger message.

BARRY: That's an excellent summation. Listeners, guests for this episode of ADA Live have been Mike Yow, the president and CEO of Fellowship Hall, along with him Kelly Scaggs, the clinical director at Fellowship Hall Drug and Alcohol Recovery Centers. As always, we want to thank you for joining us for this episode. As a reminder, this and all other ADA Live episodes are available on adalive.org, all episodes are archived in streamed audio and accessible transcripts. You can also download episodes as podcasts. It's as easy as going to the podcast icon on your mobile device and searching for ADA Live. As a reminder, if you have questions about the Americans with Disabilities Act, you can submit your question anytime online at adalive.org or contact your regional center at 1 800 949 4232, and remember, those calls are always free and they are confidential. ADA Live is a program of the Southeast ADA Center. Our producer is Celestia Ohrazda with Beth Harrison, Mary Morder, Emily Rueber, Marsha Schwanke, and me, Barry Whaley. Our music is from 4 Wheel City, the Movement for Improvement. See you next episode.

[Music]

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