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**Access to Substance Abuse Treatment in
Western Kentucky**

By:

Robin M. Palmer

**Project submitted in partial fulfillment of the
Requirements for the
Bachelor of Integrated Studies Degree**

**Continuing Education and Academic Outreach
Murray State University**

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Acknowledgement

Personally I would like to thank my higher power, whom I refer to as God for giving me another chance at living a sober life & fulfilling his purpose for my life. If it weren't for God, I would not be alive due to the disease of addiction. I would like to thank my mother, sister, and brother in-law for sacrificing their time and lives to help care for my two boys, Brandon and Jackson. Another thank you goes to Phyllis Teeters, my project advisor, who has always believed in me and continued to encourage and mentor me throughout all the times I wanted to give up on my dreams of graduating. I'm extremely grateful for my coworkers at DCBS. Without my coworkers, I would have given up a long time ago. I'm blessed to know and work with an incredible team of women who put their families second in order to help families throughout the state of Kentucky who are less fortunate on a daily basis. I'm ceaselessly appreciative and beyond blessed to be encircled with such remarkable people in my life who constantly provide me with unconditional love and support.

Abstract

Substance abuse in Western Kentucky has reached near epidemic proportions. One of the major concerns for this epidemic is limited access to treatment. Although access to treatment in Western Kentucky may be limited, the region offers many different treatment options. This manual will help each individual to take an honest look at their drinking and drug use, assist them into entering a treatment facility, and provide long term treatment alternatives to help obtain sobriety. Recovery is a way of life and results vary for each person and are dependent upon their efforts to change their entire way of life. This guide will give those affected a hope for freedom and many healthy alternatives to substance abuse.

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Definition of Addiction

According to The National Survey on Drug Use and Health (NSDUH), which is an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), the annual total anticipated public cost of substance abuse in the United States alone is \$510.8 billion. The National Survey on Drug Use and Health interviews an estimated 67,500 people each year. This survey is a primary source of information regarding the use of illicit drugs, alcohol, and tobacco in the civilian, non-institutionalized population (does not include people in hospitals, jails, shelters, nursing homes, or treatment centers) of the United States ages 12 years old or older. As a direct result of this survey, it has been estimated that by 2020, behavioral health disorders will surpass all physical diseases as a major cause of disability worldwide (SAMHSA, 2017).

According to The National Council on Alcoholism & Drug Dependence, numerous people lack understanding about why or how other people become addicted to drugs or alcohol. Many people make the mistake of falsely assuming that drug and alcohol abusers lack ethical principles or determination and that they could stop using by simply choosing to change their behavior. Addiction has been defined as a complex disease and research has proven that quitting takes more than good objectives or strong self-control (Understanding Addiction, 2017).

History of Substance Abuse & Treatment

Since drugs have been used, there were always those who abused them. The History of Drug Abuse suggests that drugs of abuse have been abused for hundreds of years and the effects of those drugs abused have been felt for just as long. Naturally, this led to absolute addiction and the multitude of side effects that come with the disease. As the physical and mental health implications of addiction became more clear, rehabilitation efforts began to appear. As a result, the history of rehabilitation in the United States dates back hundreds of years (History of Drug Abuse, 2012).

According to Drug Abuse and Drug Addiction, humans have used drugs of one sort or another for thousands of years. Wine was used on occasion by the early Egyptians, narcotic use dates back to 4000 B.C.; and marijuana used for medicinal purposes has been dated back to 2737 B.C. in China. Late in the 19th Century A.D. was when the active substances in drugs were initially extracted. Some of those newly discovered substances (morphine, laudanum and cocaine) were entirely unregulated and prescribed generously by doctors for a broad variety of ailments. These substances were available in patent medicines and sold by traveling tinkers, through the mail and in drugstores. Morphine was used openhandedly during the American Civil War. War wounded veterans returned home with their kits of morphine and hypodermic needles. Opium dens started to flourish at that time (Drug Addiction & Drug Abuse, 2012).

During the early 1900s, there were an estimated 250,000 addicts in the United States alone. Benjamin Rush was one of the first known to believe that alcoholism was not a matter of personal willpower but relatively due to the alcohol itself. Rush also challenged the established idea at the time that alcoholism was a moral failing. Benjamin Rush began to improve and fully develop the concept that addiction was not a moral failing, but rather a disease. Once the physical and mental health suggestions of addiction became more understood, rehabilitation efforts began to emerge (History of Drug Abuse, 2012).

In the past, addiction was often treated as a criminal transgression, with rigorous faith-based prayer, or in mental institutions and this signified a change to screening an illness that could be managed. It wasn't until 1864 that the New York State Inebriate Asylum was founded. The New York Inebriate Asylum was the first hospital intended for solely for the purpose of treating alcoholism as a mental health illness (History of Drug Abuse, 2012). The New York State Inebriate Asylum was the first in the country and opened in Binghamton, NY. A growing network of inebriate asylums will treat alcoholism and addiction to a growing list of other drugs: opium, morphine, cocaine, chloral, ether, and chloroform (White, 1998). As the public began to view alcoholism and related drug abuse more seriously, more community groups and sober houses began appearing (History of Drug Abuse, 2012).

Gradually, the problems of addiction were recognized. Society in turn started viewing alcoholism and addiction as a serious issue. As the perception of society changed regarding drug addiction and alcoholism, an increasing number of inebriate asylums opened up to treat an

increasing large variety of drugs which included the following: morphine, cocaine, ether, opium, and chloroform. In 1849, The Swedish physician Magnus Huss described a disease that resulted from chronic alcohol consumption and christened it *Alcoholismus chronicus*. This distinguishes the introduction of the term alcoholism. In 1867 the Martha Washington Home in Chicago, IL opened and signified the first institution in the United States that focused in the treatment of inebriate women (White, 1998).

It wasn't until 1875 that legal actions against drug abuse in the United States were established after opium dens were banned in San Francisco (Drug Addiction and Drug Abuse, 2012). In 1879, Dr. Leslie Keeley announced that "Drunkenness is a disease and I can cure it." He opened more than 120 Keeley Institutes across the United States, which represented the beginning of private, franchised, for-profit addiction treatment institutes/sanatoria in the United States (White, 1998). In 1906, The Pure Food and Drug act of 1906 was passed, which was the first drug law and required precise labeling of patent medicines containing opium and certain other drugs. In 1914, the Harrison Narcotic Act was passed. The Harrison Narcotic Act forbade the sale of large doses of opiates or cocaine with the exception of licensed doctors and pharmacies. Not long after the Harrison Narcotic Act was passed, heroin was banned completely. Succeeding decisions made by the Supreme Court made it illegal for doctors to prescribe any narcotic to addicts. Doctors who continued to prescribe maintenance doses of narcotics as part of a treatment plan for addicts suffering from addiction were incarcerated. Approximately 25,000 physicians were indicted for violating the Harrison Narcotic Act between 1919 and 1935. Shortly after, all efforts for the treatment of addicts were abandoned. In 1919,

the strength of restraint eventually led to the prohibition of alcohol, by the passing of the Eighteenth Amendment to the Constitution (Drug Addiction and Drug Abuse, 2012).

It was during the 1920s that most inebriate homes, inebriate asylums and private addiction cure institutes collapsed between 1910 and 1925. *The Journal of Inebriety* ceased publication in 1914 and its parent association collapsed in the early 1920s (White, 1998). In the 1920s, use of cocaine and narcotics diminished. In 1933, Prohibition was repealed. During the 1930s, most states began requiring antidrug education in school. Due to fear that the knowledge obtained by antidrug education would result in experimentation with drugs, the requirement for antidrug education was discarded in most places (Drug Addiction and Drug Abuse, 2012).

Not long after Prohibition was repealed, the United States Federal Bureau of Narcotics (now known as the Drug Enforcement Administration or DEA) began a campaign to expose marijuana as an intoxicating and addicting substance that would lead users into narcotics addiction (Drug Addiction and Drug Abuse, 2012). After the Twenty-first Amendment, which reversed Prohibition, a main step for the rehabilitation movement came in 1935, when Dr. Bob Smith and Bill Wilson (more universally known as Dr. Bob and Bill W.) founded Alcoholics Anonymous (AA). Dr. Bob and Bill W. used a spiritually based approach to rehabilitation and AA presented a hospitable atmosphere where recovering alcoholics could find comfort and support. Eventually, Narcotics Anonymous (NA), Cocaine Anonymous (CA) and Marijuana Anonymous (MA) formed from the same AA method. This led to the publication of the book *Alcoholics Anonymous* in 1937 (History of Drug Abuse, 2012).

In 1935, the first federal narcotics farm called U.S. Public Health Prison Hospital was opened in Lexington, Kentucky and the second facility opened in Fort Worth, Texas in 1938. These openings marked the beginning of federal involvement in addiction research and addiction treatment. Throughout the 1900s, the perception held by the public regarding the dangers of specific substances changed (White, 1998).

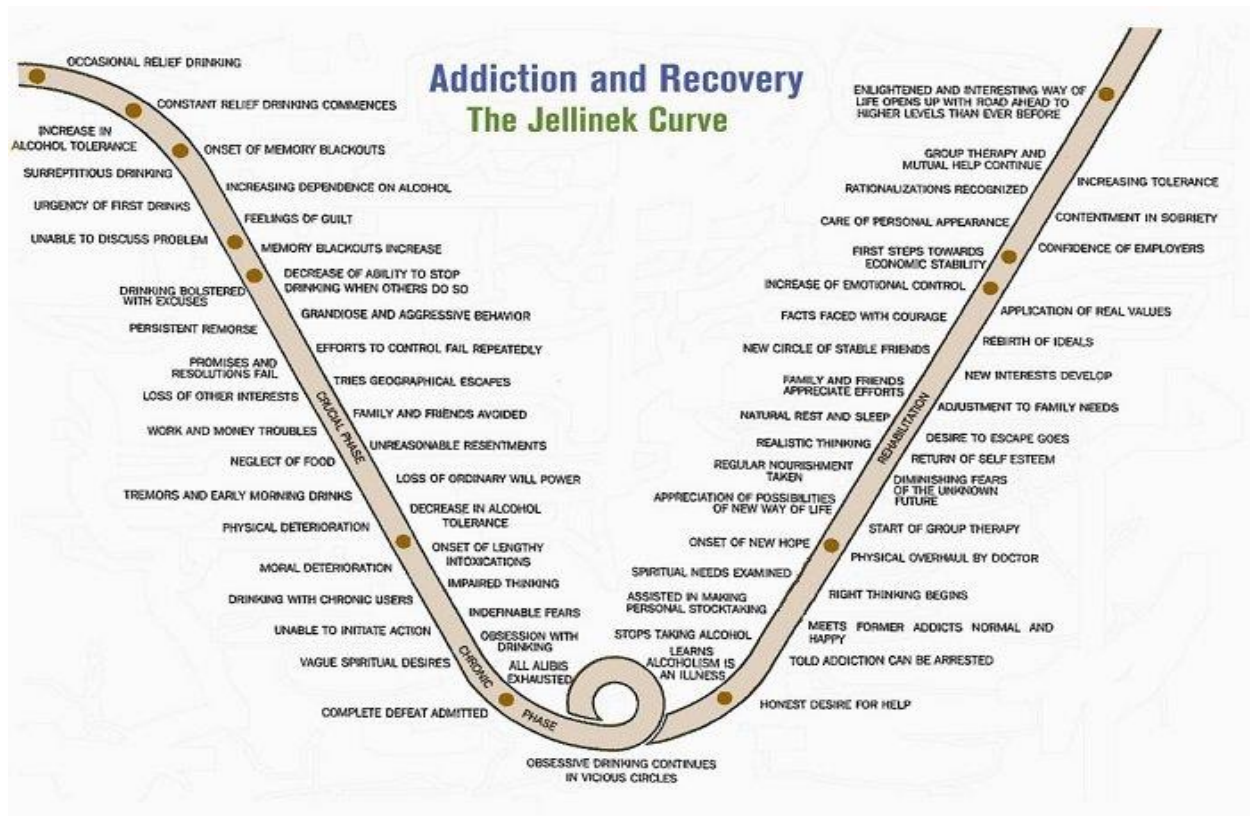
In 1942, Dwight Anderson of the Research Council on Problems of Alcohol calls for persistent promotion of public education to change American's view of alcoholism and the alcoholic. In 1944, the first state alcoholism commissions were founded. These state alcoholism commissions supported the labors at local community education and treatment. In 1948, Alcoholics Victorious was founded within the Chicago Christian Industrial League and spread as a Christian, recovery support group within many of the nation's municipal missions (White, 1998).

Between 1948 and 1950, the "Minnesota Model" of chemical dependency treatment emerged in the synergy between three institutions: Pioneer House, Hazelden, and Willmar State Hospital. During this time, Antabuse (also known as disulfiram) was introduced as an addition in the treatment of alcoholism in the United States. Antabuse was not the only drug being used in the treatment of alcoholism at that time. Barbiturates, amphetamines (Benzedrine), and LSD were all used in the treatment of alcoholism during this period. In the 1950s, marijuana use increased again, along with that of amphetamines and tranquilizers. In 1950, The Twelve Traditions were formally adopted to manage the group life of Alcoholics Anonymous. The

National Institute of Mental Health also established a special division on alcoholism. The American Medical Association (AMA) decided to generate a special committee to develop a program for “medicine’s aggressive participation in the work of solving problems of alcoholism” in 1950 as well. During the early 1950s, AA membership surpassed 90,000 as America became interested in the subject of alcoholism. In 1951, Louis W. and Anne B. started a cleaning house for the growing number of family support groups that had grown in tandem with AA throughout the 1940s. The opening of the Clearing House marked the formal organization of these groups into Al-Anon Family Groups. It wasn’t until 1952 that the American Medical Association first defined alcoholism. In 1954, Ruth Fox, MD established the New York City Medical Society on Alcoholism. Today it is known as the American Society of Addiction Medicine (ASAM). The Minnesota State Civil Service Commission became the first such body in the entire United States to approve a state job classification position for “Counselor on Alcoholism.” The halfway house movement culminated the founding of the Association of Halfway House Alcoholism Programs of North American in 1958 (White, 1998).

It wasn’t until 1960 that E.M. Jellinek published *The Disease Concept of Alcoholism*. In his book, Jellinek identifies five different types of alcoholism and defines them in terms of their abnormal psychological processes. The first type of alcoholism that Jellinek defined is called Alpha Alcoholism. Alpha Alcoholism is the first stage of the disease, which manifests the solely psychological continual dependence on the effects of alcohol to relieve bodily or emotional pain. Jellinek goes on to explain that the Alpha Alcoholism type is the “problem drinker.” Jellinek argued that this type of alcoholic has not yet lost control and the people who fall into this

category may have suffered some social and personal problems, but nonetheless these Alpha Alcoholics can stop drinking if they really want to. Jellinek explains that this type of alcoholic has not yet lost control and as a result do not have a disease. The second type of alcoholism that Jellinek defined is called Beta alcoholism. Jellinek defined the Beta alcoholics as heavy drinkers who drink nearly every day. Jellinek suggests that since this type does not have a physical addiction or withdrawal symptoms, people who are in this group do not have a disease. The third type of alcoholic Jellinek describes is what he called Gamma alcoholism. Gamma alcoholism involves acquired tissue tolerance, physical dependence, and loss of control. According to Jellinek's classification, those who meet criteria to fall into this category and in fact do have a disease, due to the fact that this type of alcoholic is very much out of control and has lost all control. The fourth type of alcoholic that Jellinek defines is called Delta alcoholism. Jellinek explains that this type of alcoholic doesn't have the ability to abstain and is also classified as having a disease. The fifth and final type of alcoholic Jellinek describes is what he called Epsilon alcoholism. Jellinek says Epsilon alcoholism is the most advanced stage of the disease and often apparent as dipsomania. Jellinek suggests that those who fall into the Epsilon alcoholism category do, in fact have a disease, as they have lost all control. The classification of the five types of alcoholics defined by Jellinek, eventually resulted in the "Jellinek Curve," which was named out of respect for his work (History of Drug Abuse, 2012).



Due to the social disturbances of the 1960s, this time period was also filled with a remarkable raise in drug use and an enhanced social acceptance of drug use. In 1961, The American Public Health Association adopted an official statement on alcoholism, identifying it as a treatable illness for the first time in history in 1963. (White, 1998) Throughout this decade, medical interventions were also being explored. In 1964, Dr. Vincent Dole (an endocrinologist) and Dr. Marie Nyswander (a psychiatrist) teamed up together and introduced methadone blockade therapy in the treatment of narcotic addiction

(Drug Addiction and Drug Abuse, 2012). Between 1963 and 1966, provision for local alcoholism and addiction counseling were included in federal legislation funding the development of local comprehensive community mental health centers, anti-poverty programs, and criminal justice diversion programs. Such federal funding later increased throughout the 1960s. While alcoholism programs spread throughout the 1960s, much heated debates arose that were centered around the question of who is qualified to treat the alcoholic. Tensions proliferated between “paraprofessional” recovering alcoholics and psychiatrists, psychologists and social workers within newly developing alcoholism treatment programs (White, 1998).

Between 1964 and 1975 the insurance industry began to reimburse the treatment of alcoholism on the same level as the treatment of other illnesses. In 1967, special alcoholism counseling/treatment initiatives began within all major branches of the United States Armed Forces. In 1968, the Federal Advisory Committee on Traffic Safety acknowledged the substantial role alcohol plays in car accidents. Federal agencies in the 1970s, through the Safety Action Program, promoted new impaired driving laws and the rise of remedial education and assessment/referral/treatment services for those arrested for alcohol-impaired driving. Around the early 1970s, some states and localities had legally recognized marijuana and lowered drinking ages. By 1970, over 55 federal drug laws and innumerable state laws specified an array of penalizing procedures, including life imprisonment and even the death penalty. To illuminate the circumstances, the Comprehensive Drug Abuse Prevention and Control Act of 1970 repealed, replaced, or restructured all previous federal laws concerned with narcotics and all other dangerous drugs. While possession was made illegal, the severest penalties were reserved for

illicit distribution and manufacture of drugs. The Comprehensive Drug Abuse Prevention and Control Act of 1970 dealt with prevention and treatment of drug abuse as well as control of drug traffic (Drug Addiction and Drug Abuse, 2012). In 1970, Congress passed the “Comprehensive Alcohol Prevention Treatment and Rehabilitation Act,” known as the Hughes Act, as it was sponsored by Harold E. Hughes, who was a member of the Senate. The legislation established the National Institute on Alcohol Abuse and Alcoholism (NIAA). Several testified in support of the Comprehensive Alcohol Prevention Treatment and Rehabilitation Act. Amongst those testifying in support of the legislation were Bill Wilson, Co-founder of Alcoholics Anonymous and Mary Mann of NCA (White, 1998).

In 1978, First Lady Betty Ford spoke to the nation about entering recovery from addiction to alcohol and other drugs. In 1980, Mothers against Drunk Driving, which is an influential working class advocacy group, was formed. During the 1980s, there was a decline in the use and abuse of most drugs, but the use of cocaine and crack skyrocketed. The military became involved in border patrols for the first time, and troops invaded Panama and brought its de facto leader, Manuel Noriega, to trial for drug trafficking. By 1982, former First Lady Betty Ford had lent her name to a treatment center for alcoholism and other drug addictions. The federal Block Grant Program transfers responsibility for the delivery of treatment and prevention services to the states. Cocaine Anonymous (CA) was also founded in 1982. The first certification exam for addiction medicine specialty was offered in California in 1983 and the National Association for Children of Alcoholics (NACA) was also founded the same year. In 1984, The National Minimum Drinking Age Act required all states to make purchase or public

possession of alcoholic beverages illegal for anyone under the age of 21 or lose federal funding for highways. This act reflected a growing apprehension about the lowered age of alcohol consumption. Around 1985, the first appearance of crack cocaine emphasized massive public awareness on the illicit drug dilemma. Concerns about cocaine-exposed babies lead to the extension of treatment resources for women and dedicated programs to treat women involved in the child protection system. The American Academy of Psychiatrists in Alcoholism and Addictions was also established in 1985 (Drug Addiction and Drug Abuse, 2012).

During the late 1980s, the founding of Secular Organization for Sobriety and Rational Recovery marked the rising pluralism within the American culture of recovery. Between 1985 and 1990, Addiction treatment became progressively more disturbed about “special populations” and launched specific treatment paths for adolescents, women, gays and lesbians, the elderly, and those who had been “dually diagnosed.” As the difficulties of treating new patterns of cocaine addiction grew, relapse paths also became a regular treatment contrivance (White, 1998).

Between 1982 and 1992, the number of women-only treatment units tripled as NIAAA and NIDA focused their attention on the special needs of addicted women. Today, thousands of drug abuse rehabilitation programs offer addicts a wide variety of treatment approaches, ranging all the way from conventional, evidence-based care to more experimental or holistic services. Care should be modified according to the personality of the patient, oftentimes one’s treatment regime will consist of a range of therapies the have been chose specifically for the individual (History of Drug Abuse, 2012).

In 1986 the Anti-Drug Abuse Act authorized four billion dollars to fight drugs, mostly through law enforcement officers. President Ronald Reagan also issued an executive order that mandated the federal Drug-Free Workplace program. This marked a shift in the spotlight from the association of drug-impaired workers to treatment/recovery resources to the referral of drug using employees to such resources (White, 1998). The Anti-Drug Abuse Acts of 1986 & 1988 also increased funding for treatment and rehabilitation. The Anti-Drug Abuse Act of 1988 created the Office of National Drug Control policy. The director of the Office of National Drug Control has often been referred to as the drug “czar,” and is responsible for coordinating national drug control policy in the United States (Drug Addiction and Drug Abuse, 2012).

It wasn't until 1987 that President Ronald Reagan formally announced the “War on Drugs.” The “War on Drugs” shifted the attention of the United States from treatment toward punishment and incarceration became more acute. During the same year, The American Medical Association decided all drug dependency diseases were a legitimate part of medical practice (White, 1998).

In 1989, Stanton Peel published *Diseasing of America: Addiction Treatment Out of Control*. This marked the full appearance of a movement whose primary mission was opposition to Twelve Step programs and Twelve Step oriented addiction treatment. The first specific “drug court” was also started the same year by Miami Judge Stanley Goldstein. This sparked a national movement to link addicted, non-violent offenders to treatment as an alternative to incarceration (White, 1998).

It wasn't until 1989-1994 that following an attrition of alcoholism treatment reimbursement benefits by insurance carriers, a forceful system of managed care all but eliminated the 28-day inpatient healing program in hospitals and private, free-standing centers. The downsizing and closure of hospital-based treatment units sparked a movement toward the integration of many psychiatric and addiction treatment units as well as a transformed community tendency of incorporating addiction treatment services under the umbrella of mental health or "behavioral health" services. Most inpatient treatment programs began leaning their emphasis toward outpatient and rigorous outpatient services. The loss of residential services added fuel to an increasing recovery home movement (White, 1998).

Throughout the year of 1990, the explosive escalation of the internet led to a creation of on-line recovery support groups and services. This created a virtual community without geographical limitations. The Society of Americans for Recovery (SOAR) was also founded by Senator Harold Hughes. The NCA also changed its name to National Council on Alcoholism and Drug Dependence, which marked a momentous landmark in the incorporation of alcoholism and drug abuse fields (White, 1998).

In 1992, The Center for Substance Abuse Treatment was formed to expand the availability and quality of addiction treatment. That same year, the Americans with Disabilities Act extended job security (not including safety-sensitive positions) to alcoholics and recovering drug addicts in the private sector. President Bill Clinton included a treatment benefit for

alcoholism and other drug addictions in his notional health care reform proposal in 1993(White, 1998).

By 1995, the Food and Drug Administration was considering its regulation. When Fetal Alcohol Syndrome became recognized, warning labels started to appear on alcohol products. The addictive character of prescription drugs such as diazepam (Valium) became acknowledged, and caffeine came under examination as well (Drug Addiction and Drug Abuse, 2012). That same year, the United States Supreme Court upheld the right of public schools to test student athletes for drug use. The United States Food and Drug Administration also approached prescription use of naltrexone in the treatment for alcoholism in 1995. Naltrexone marked the emergence of a new creation of pharmacological adjuncts in the treatment of alcoholism and other addictions (White, 1998).

In 1998, The Center for Substance Abuse Treatment began funding regional and local Recovery Community Support Projects whose primary purposes were recovery promotion. It wasn't until the year 2000 that the new and renewed grassroots recovery support organizations are christened the "New Recovery Movement." A landmark article in the *Journal of the American Medical Association* by Drs. McLellan, Lewish, O'Brien, and Kleber called for the re-conceptualization and treatment of addiction as a chronic medical illness (White, 1998).

Throughout the past, the public's perspective of the dangers of specific substances became altered. The surgeon general's warning label on tobacco packaging slowly made people aware of the addictive nature of nicotine (Drug Addiction and Drug Abuse, 2012).

Today, there are thousands of drug abuse rehabilitation programs that offer addicts a variety of treatment approaches that range from traditional, evidenced-based care to more experimental or holistic based treatment practices. In many instances, treatment options are tailored to meet the individual client and are regularly composed of an assortment of special therapies designed particularly for the specific client (History of Drug Abuse, 2012).

Causes of Substance Abuse

Not one factor that has been discovered is a predictor or indicator of whether someone will develop an addiction to drugs or alcohol. Addiction psychiatrist, Dr. Edward Khazian suggests that “Suffering is at the heart of addictions. Nowhere is this more apparent than with individuals who have developed posttraumatic stress disorder (PTSD) and restore to addictive drugs to medicate the stress and pain associated with PTSD. It should not surprise the reader that individuals with PTSD are three to four times more likely than individuals without PTSD to have substance use disorders (Khazian, 2004).”

Risk Factors for Addiction

The National Council on Alcoholism and Drug Dependence suggests that risk for substance abuse is influenced by an amalgamation of factors that include a person’s genetic composition, social surroundings, and age or stage of maturity. The additional risk factors a

person has, the bigger the chance that taking drugs or consuming alcohol can lead to addiction (Understanding Addiction, 2015).

According to Talbott Recovery, there are five most common risk factors involved in addiction. The five most common risk factors are as follows: Stressful environments, drinking at an early age, mental health problems like depression, taking alcohol with medicine, and family history. An example of a stressful environment is an individual's career. Talbott Recovery gives specific career examples that involve stressful environments, such as doctors and nurses. If a person's work atmosphere is nerve-racking, the probability of the person drinking or using drugs will increase, as their day to day lives can become immensely demanding. Talbott Recovery suggest taking time to relax and unwind with positive substitutes such as taking naps, exercising, or reading a book to help lower the risk-factor (5 Most Common Causes of Alcoholism, 2017). According to the Mayo Clinic, "Those who begin drinking at an early age are more likely to have an alcohol problem or physical dependence on alcohol as they get older. Not only is this because drinking may become a comfortable habit, but also because the body's tolerance levels may increase (Alcohol Use Disorder, 2015)."

Your lifestyle, environment and personality can all be contributing factors to whether you will develop an addiction or not. Your personality can be the trigger for an addiction: there are other factors in this equation but reports have been carried out which show that some people appear to be vulnerable to addiction. These include: Immature personality, anti-social personality, passive-aggressive personality, anxious or stressed personality, and self-penalizing

personality. These are personality types, but what about personality traits? Traits are individual patterns of behavior, emotion and thoughts which form part of a personality. There are people who display certain traits which are symptomatic of addiction. These include: an unwillingness to accept responsibility for their actions or face up to their addiction; compulsive or impulsive behavior; a tendency to blame others rather than taking ownership and the use of substances such as alcohol or drugs to cope with stress. Research has shown that drug and alcohol addiction is more prevalent in men, especially single men, than women. However, the gender gap appears to be closing. Studies have shown that women are more likely to become addicted to painkillers and tranquilizers whereas men tend to misuse cannabis, alcohol and other drugs (Social effects of Drug Addiction, n.d.).

Trauma Factors in Substance Use Disorders

Widespread studies have been performed when it comes to considering the factors linked between adolescents and substance abuse. “Results of this research indicated that stressful life events (such as illness and divorce) and conflicted relationships with peers and parents are consistent predictors for substance abuse among teens (Rogers, 2013).” Rogers advises that “many adult addictions are established in their teen years (Rogers, 2013).”

One particular study conducted was composed of 402 men and women age 18 and older from 11 residential drug abuse treatment programs that provided publicly funded treatment to adults within Los Angeles County, who were all within 30 days of admission into treatment.

Amongst those 402 participants in the study, 52.8% were men. 35% of the participants were African American, 44% Caucasian, 13% Latino, and 8% were of other ethnicities. The average age of the participants in this study was 36.4 years. 82% of the participants in the study had a record of homelessness and 59% had been under legal administration at least once in the past. Roughly two thirds of those who participated in the study had a diagnosis of mood disorder such as major depression, dysthymia, bipolar disorder, mood disorder not otherwise specified and the remainder were diagnosed with a psychotic disorder such as schizophrenia, schizoaffective disorder, and psychosis not otherwise specified. More than half of the participants in the study were diagnosed with PTSD (Post Traumatic Stress Disorder).

The studies performed weren't able to confirm a major association with cannabis dependence. The studies performed also revealed that individuals who were exposed to childhood traumatic events have had an increased risk of 24% of having a history of sexually transmitted diseases. Being exposed to childhood traumatic events has also been proven to cause an 18% increased risk for digestive/stomach problems and a 29% increased risk for muscle/bone problems. "Studies find the importance of early prevention and intervention to prevent long lasting negative effects (Wu, Schairer, Dellor, & Grella, 2009)."

Zlotnick suggests that "Adverse Childhood Events (ACE) may influence later behaviors, which include adulthood substance abuse and social affiliation (Zlotnick, Tam, & Robertson, 2004)." Zlotnick has defined adverse childhood events as "living in foster care, group home, sexual abuse, physical abuse, running away from home for seven nights or more,

being arrested, and early regular alcohol or drug abuse. Nine types of adverse childhood experiences have been identified as follows: 1. Emotional Abuse and Neglect, 2. Physical neglect, 3. Physical abuse, 4. Sexual abuse, 5. Family Violence, 6. Parental separation and divorce 7. Incarcerated family member, 8. Out-of-home placement and 9. Death of someone close (Wu, Schairer, Dellor, & Grella, 2009). A study of 397 homeless persons in Alameda County California shows that almost 75 percent of this sample experienced at least one ACE. Hence showing the correlation between ACE's, adulthood substance abuse, and social affiliation (Zlotnick, et al., 2004).”

Trauma Factors in Mental Health Disorders

Adverse Childhood Events (ACE's) have been proven to be directly associated with multiple negative health consequences. Douglas suggests that, “A strong association also exists between ACE's and psychiatric illness, particularly depression and post-traumatic stress disorder (PTSD). Childhood sexual abuse, specifically, is a strong predictor of psychopathology in adulthood, especially major depression, PTSD, and alcohol dependence. For example, in a study of 17, 337 adults who experienced five or more ACE's were seven to ten times more likely to report illicit drug use and addiction and a 60 percent increased risk of attempting suicide (Douglas, et al., 2009).” Therefore, the connection between adverse childhood events and mental health disorders have been shown.

Mental Health Disorders

The 2014 National Survey on Drug Use and Health (NSDUH) used by the Substance Abuse and Mental Health Services Act (SAMHSA) suggests that approximately 43.6 million or 18.1 percent of Americans ages 18 and up have qualified for some form of mental illness. The assistant secretary at the Health and Recovery Services Administration of the Washington state Department of Social and Health Services, Doug Porter suggests that “Most state Medicaid programs involve 5 percent of the patients being responsible for 50 percent of the cost (Porter, 2008).”

Washington State has different numbers. Up to 20 percent of the most expensive medical assistance that the population needs is for alcohol-substance abuse treatment, yet only 6 percent of those affected receive it. One-third of the age 5-50 population has mental health issues, and 13 percent of them have substance abuse and alcohol issues. Treatment of depression, schizophrenia and pain represents 60 percent of pharmacy expenditures in the age 5 to 50 populations. Emergency rooms are crowded with patients who have undiagnosed or undertreated substance abuse and mental health problems. Primary-care providers write prescriptions for anti-depressants and anti-psychotics for children without the ability to first check with psychiatrists or psycho-pharmacologists. Because of the inadequate availability, these specialists are generally difficult to reach in many locations (Porter, 2008).

When Washington State’s Governor Christine Gregoire started the process of repairing the issue, she appointed a secretary for the Department of Social & Health Services (DSHS) who understood the problems implicated. One of the major important actions was made by

Secretary Robin Arnold-Williams. Secretary Robin Arnold-Williams decided it necessary to first reorganize the administration in Department of Social & Health Services, which in turn obligated those officials to put the patient's accumulation of problems in the center of their care. Porter suggests, Washington State began with a cost-benefit study that showed reduced medical expenses for clients who had been treated for chemical dependency, several trends became apparent in the data. The statistics exposed that "Those clients who received a high frequency of care in emergency rooms most frequently had an 89 percent chance of a diagnosis of mental illness or chemical dependency. The top narcotic users were obtaining prescriptions from many providers while in the coordination of care system. Getting clients into treatment saves the state money in medical and mental health claims (Porter, 2008)."

Mental disorders consist of changes in thoughts, temper, and /or actions. Anxiety disorders are the most common type of mental disorders, followed by depressive disorders. Different mental disorders are further probable to begin and occur at different stages in life and are consequently further prevalent in certain age groups. Not all mental health issues are first experienced during childhood or adolescence continues into adulthood, and not all mental health issues are encountered before adulthood. Mental disorders can occur at once, recur intermittently, or be more chronic in nature (SAMHSA, 2016).

Stages of Substance Abuse

Research and studies have shown that there is a difference between substance abuse and full-blown addiction. Just because a person uses a particular substance or drug does not mean

they are addicted. However, if a person continues to abuse a substance it is highly likely that they will become addicted. Each addict is in fact a substance abuser, but not all substance abusers are addicts. The stages of substance abuse are experienced differently by each individual and each experience may vary from person to person (Stages of Substance Abuse, 2008).

Each substance abuser tends to follow a comparable course, which involves five different stages. The five stages of substance abuse are as follows: 1. Experimentation, 2. Becoming a regular user, 3. Substance Abuse, 4. Dependence, and 5. Addiction. The experimentation stage is when an individual begins to experiment with a particular drug. During the stage of becoming a regular user, an individual has enjoyed their experimentation with a certain drug and begins to use the substance on a regular basis. There are some individuals or don't ever go past this stage of substance abuse. The third stage of actual substance abuse is when a person has begun to use a particular drug so much that they have started to experience damaging consequences. It can be explained that the stage of substance abuse is the equivalent to a habit of abuse. Each individual responds to the negative consequences of abuse in different ways. Some are able to abstain from the drug or cut back on their use and others continue abusing the substance and ignoring the harmful consequences that follow the abuse. An example of substance abuse is one experience of binge drinking. The dependence stage is next and is encountered when a person feels they need the substance just to make it through the day. During the dependence stage, not only have the consequences of their use have amplified, but their unwillingness to give up the drug have also increased. The final stage of substance abuse is complete addiction. Addiction occurs when a person is not only physically reliant on a drug, but also psychologically dependent. In this final

stage, a person has increased tolerance to the drug and will experience withdrawal symptoms if and when they choose to stop using the substance (Stages of Substance Abuse, 2008).

Physical, Mental, & Social Effects of Addiction

Addiction affects not only just the addict, but it affects the friends and families of the addict as well. Depending on what substance is being abused, the physical signs of addiction may vary. However, most of the following physical signs of addiction are universal to most substances. Generally speaking, the physical signs of addiction are:

- Weight Loss
- Poor Skin health/pale skin
- Spots especially around the nose or mouth
- Red rimmed eyes
- Dull or lank hair
- Brittle or broken nails
- Sweating
- Tremors
- Palpitations
- A decline in overall health
- Bloodshot or glazed eyes
- Dilated or constricted pupils
- Abrupt weight loss or weight gain

- Bruises, infections, or other physical signs at the drug's entrance site on the body

Just as there are physical signs of addiction, there are also mental or psychological signs of an addiction. Most people who are addicted can hide the following signs in the beginning, but as their addiction progresses, they will be less concerned about hiding the signs and they will be driven for their need for their drug of choice. Their need for their drug of choice will begin to dominate all other concerns. The addict will become less concerned about their appearance and how they are seen by others. The drug itself can alter the brain's ability to focus from coherent thoughts, depending on the substance. The following signs are psychological signs of an addiction.

- Nervousness and anxiety
- Poor Concentration
- Irritability
- Mood Swings
- Lying
- Stealing/Borrowing money or possessions
- Withdrawal from society
- Paranoia

- Lack of interest in other people
- Increased aggression or irritability
- Changes in attitude or personality
- Lethargy
- Depression
- Sudden changes in a social network
- Dramatic changes in habits and/or priorities
- Financial Problems
- Involvement in criminal activity

Addicts will go from severe highs to acute lows in a short stage of time and space and will become edgy or nervous if they are unable to suit those cravings (Signs of An Addiction).

The social effects of an addiction can be more harmful than the physical and psychological effects combined. Some of the social effects that are negatively impacted during addiction are: marriages/relationships, law and order, personality, education, home/family life, health and wellbeing, employment, and financial issues. Someone in the midst of an addiction can become selfish, self-centered, and unmindful to others concerns. Day to day life and other things such as paying the electric bill on time are no longer important to the addict. Many times,

this can lead to a breakdown in a relationship or marriage. The other partner involved in the marriage or relationship is left to cope on their own, which is often more difficult if there are children involved. The addict may be suffering financial difficulties that the spouse or partner in the relationship isn't aware of. Financial difficulties mixed with irrational behavior, illicit behavior, and even paranoia (in some severe cases) can be a formula for catastrophe for a marriage or relationship (Social Effects of Addiction, n.d.).

Addiction is in fact a family disease. Even though sometimes it may appear like the addict's family has pushed them out, many times families use "tough love" in order to give the addict time to reveal upon their addiction and themselves. Many families utilize tough love with their addicted loved one in an attempt to get them to seek healing from their addiction. Some further signs of addiction will transpire at school. Poor concentration and motivation may be exhibited by the addict and grades may start to drop. Employment will also suffer as a result of an addiction. Addicts tend to be late for work, uncaring about their appearance and hygiene, and will exhibit outlandish behaviors. Health and well-being is one of the most apparent effects of addiction. Some of the short-term health risks implicated with addiction are unplanned pregnancies, birth defects in newborns, and an increase in sexually transmitted diseases. Addiction has long term health effects and can cause suicide, overdose, or physical damage. Personality is also affected by addiction. Addiction will cause bizarre behaviors such as stealing and lying. Other strange behaviors may include strange suspicions, lack of trust in others, and low self-esteem. Financial issues are also an effect of addiction, as the addict may resort to criminal behavior or borrowing and stealing money from friends and family in order to support

their habit. Turning to crime as a way to support one's addiction often results in problems with the law. Many people who suffer from addiction will engage in disruptive behavior in public, which causes fights and arrests (Social Effects of Addiction).

. The harmful physical, mental, and social effects of addiction are far greater than the short acting and artificial rewarding feelings that drinking or using can generate. It's no revelation that substance abuse comes with such a high price tag when you factor in all the health, legal, criminal, family, relationship, employment, education, and personal problems that frequently come in its wake (Social Effects of Addiction).

Treatment Options

According to the National Institute on Drug Abuse, addiction treatment consists of many different options and mechanisms. Some of the options for effective treatment include detoxification, short-term treatment, long-term treatment, inpatient treatment & outpatient treatment. The figure below shows the many mechanisms involved in addiction treatment (Treatment Approaches for Drug Addiction, 2016).

Components of Comprehensive Drug Addiction Treatment



The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.

The life of an addict is typically hectic. Entering a treatment center removes the client from their immediate environment and triggers and allows them to begin to recover from addiction. Choosing to obtain treatment in an inpatient facility is often necessary and beneficial for the addict. The National Institute on Drug Abuse suggests that the best treatment programs provide clients with a combination of therapies and services tailored to meet the needs of each individual client. According to The National Institute on Drug Abuse, effective addiction treatment involves five steps which are detoxification, behavioral counseling, medication, evaluation and treatment for comorbid mental health problems, and long-term aftercare to maintain sobriety and help prevent relapse (Treatment Approaches for Drug Addiction, 2016). According to the Substance Abuse and Mental Health Services Administration's (SAMSHA's)

National Survey on Drug Use and Health, 23.5 million people (or 9.3%) who were 12 years and older needed treatment for an illicit drug or alcohol abuse problem in 2009. Only 2.6 million (or 11.2%) of those who actually needed treatment received treatment in a treatment center (SAMSHA, 2015).

Detoxification is the period of time the body takes to rid itself of toxins such as drugs and alcohol. The detoxification phase of treatment occurs under the care of a physician. During this time, a client is closely monitored and may receive medication to help repress the withdrawal symptoms of drugs and alcohol. According to Addictions and Recovery, Withdrawal occurs because your brain works like a spring when it comes to addiction. When you stop taking drugs or alcohol, your brain rebounds and produces a surge of adrenaline that causes withdrawal symptoms. Withdrawal symptoms are different depending on the substance and person. Some of the emotional withdrawal symptoms include headaches, insomnia, anxiety, restlessness, irritability, poor concentration, social isolation, and depression. Physical withdrawals symptoms include tremors, difficulty breathing, sweating, palpitations, muscle tension, racing heart, tightness in the chest, nausea, diarrhea, and vomiting. It is possible to experience both physical and emotional withdrawals. The drugs that produce significant physical withdrawal symptoms include opiates, alcohol, and tranquilizers. The drugs that produce emotional withdrawal symptoms are marijuana, cocaine, and ecstasy. Withdrawal symptoms are dangerous and can be life threatening. Abruptly quitting drinking alcohol or taking tranquilizers can lead to heart attacks, strokes, or seizures in high risk patients. Detoxification under the supervision of a medical professional helps to reduce withdrawal symptoms and also minimizes the risk of

hazardous complications. Detoxification from alcohol and tranquilizers create the most treacherous physical withdrawals. These physical withdrawals can cause Delirium Tremens (also known as DTs), heart attacks, grand mal seizures, hallucinations, and strokes. Detoxification from opiates such as heroin or oxycontin has been proven to be extremely painful, but not dangerous unless these drugs are mixed with other drugs. Withdrawal from heroin or oxycontin on its own does not cause seizures, delirium tremens (dts), strokes, or heart attacks (Withdrawal, 2016).

The withdrawal time period has two stages, which are the acute stage and the post-acute stage (PAWS). The acute stage of withdrawal commonly lasts for a few weeks. The post-acute stage of withdrawal is the second stage of withdrawal and can last anywhere from twenty months to two years. In this stage, physical symptoms lessen and emotional and psychological symptoms increase. The post-acute withdrawal stage is the process of your brain chemistry returning to normal. Since your brain is beginning to recover, the levels of your brain's chemicals change as they are approaching the new symmetry, which causes the post-acute withdrawals. Post-acute withdrawal symptoms include the following: troubled sleep, mood swings, variable concentration, low eagerness, weariness, touchiness, anxiety, uneven concentration, and variable energy. Some people refer to this two year time period as an emotional rollercoaster. In the beginning of this phase, the symptoms can change minute to minute and hour to hour, but the longer one recovers the longer the symptoms disappear and only reappear week to week or month to month. The good stretches will get longer and longer and the bad periods will get shorter and shorter. These episodes are not triggered by anything, and it is

important to remember to hang in there, as these phases will subside just as quickly as they started. All episodes of post-acute withdrawal are time restricted. It is important to know that this phase most commonly lasts for two years. If someone suffering from an addiction enters this phase unprepared, it is common to be caught by surprise and studies have shown that relapse occurs more often when someone is disappointed. It is suggested to remember five different strategies to cope and persist through post-acute withdrawals. Being patient, going with the flow, practicing self-care, being able to relax, and recognizing that post-acute withdrawal can be a trigger for relapse (Withdrawal, 2016).

Different medications may be used to manage withdrawal symptoms, prevent relapse, and effectively treat comorbid disorders. Some of those medications include the following: Methadone (Dolophine), buprenorphine (Suboxone, Subutex, Probuphine), Naltrexone (Vivitrol), Chantix, Zyban, Acamprosate (Campral), and Disulfiram (Antabuse). Methadone, buprenorphine, and naltrexone are used to treat opioid addiction. Zyban and Chantix are used to treat tobacco addiction. Naltrexone, Acamprosate, and Disulfiram are used to treat alcohol addiction (Treatment Approaches for Drug Addiction, 2016). According to SAMSHA, Detoxification is not in itself “treatment”, but it is the first step involved in addiction treatment. People who do not continue treatment after the detoxification period usually resume using drugs and alcohol. Studies of treatment centers have proven that medications were used in almost 80% of detoxifications (SAMSHA, 2014).

After the detoxification phase of treatment is completed and physical dependence is cured, social and psychological factors are often prominent stimuli and puts addicts at a greater risk for relapse without a good treatment program. Short-term treatment became a popular option as many health insurance companies implemented limitations on addiction treatment (usually 30 days). The Detoxification and adjustment phases of long-term treatment can last up to two weeks. Most research suggests that 14 days isn't enough time to supply enduring change. Studies have shown that it takes up to three months to implant considerable new ways of thinking, doing, and speaking into our subconscious. Even though this type of treatment may not give professionals enough time to help an individual end their addiction permanently, this approach has been proven to be effective. According to the National Institute on Drug Abuse, short-term treatment (also known as inpatient or residential treatment) can be extremely successful. This type of treatment is advantageous for those suffering from more severe problems, such as comorbid disorders. Short-term treatment, most commonly focuses on detoxification as well as thorough counseling. This type of treatment prepares the client for treatment in a community based environment. Short-term treatment is intensive at first and offers 24-hour care in a safe environment, which includes medical awareness. This type of facility may use various therapeutic approaches and typically targets helping the client live a lifestyle that is free from drugs, alcohol, and crime after they leave. Short-term treatment usually lasts anywhere from one to three months. Some facilities offer recovery housing (sometimes known as a halfway house), which provide short-term housing for clients after they have completed short-term treatment. This type of housing can help the client shift to an independent life and better

prepare them to be a functioning member of their community. In addition to a safe housing environment, recovery housing can help the client learn to deal with finances, search for employment, and connect to local support services for after-care (Treatment Approaches for Drug Addiction, 2016).

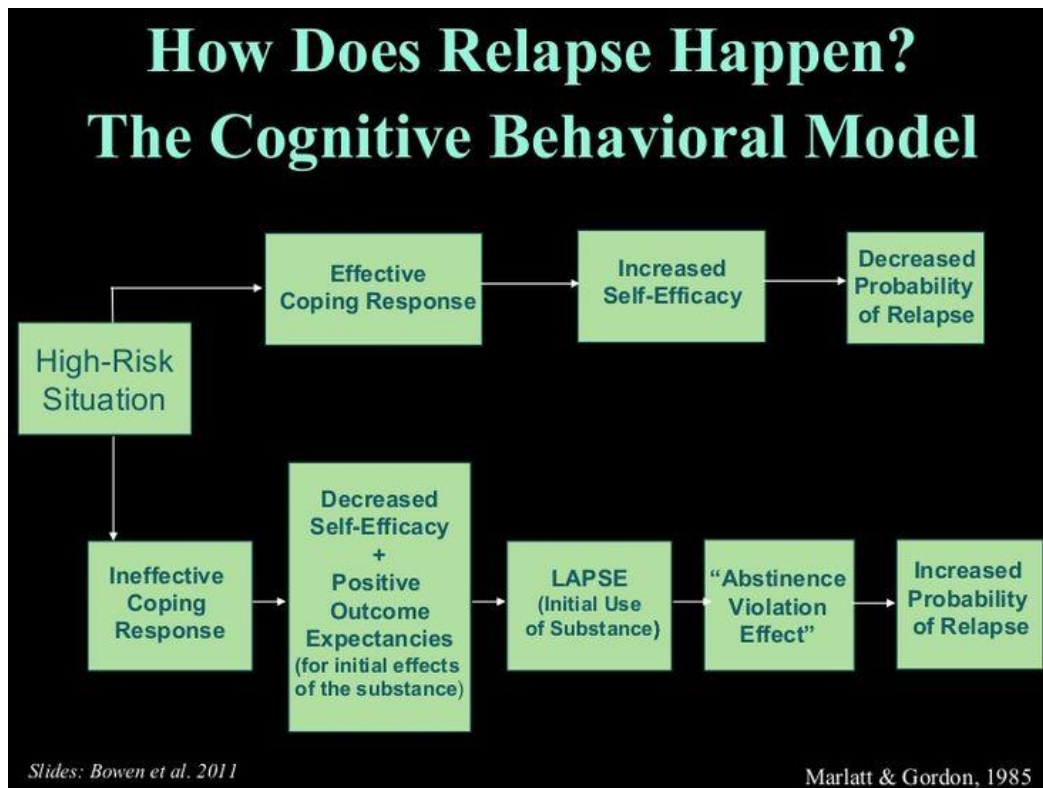
Research has shown that longer treatment programs (ninety days or more) are considerably more successful in helping a client to maintain long-term sobriety. According to the National Institute on Drug Abuse, long-term treatment in a residential treatment facility usually lasts for 6 to 12 months. After detoxification is complete, long-term treatment centers offer an adjustment period to help the client acclimatize to living in a full-time facility. The Detoxification and adjustment phases of long-term treatment can last up to two weeks. In this type of treatment, the patient lives in the treatment facility with staff and others in recovery that operate as key instruments of change and influence the client's outlook, understanding, and behaviors associated with drug use. Long-term treatment allows an individual struggling with addiction to have more time to address the primary issues that sparked their addiction. This type of treatment puts an emphasis on identifying and eradicating disparaging habit patterns of behavior. Long-term treatment allows a client to make recovery their primary focus by

eliminating all external distractions and situations (The Choice for Long-Term Drug Recovery Options).

According to the National Institute on Drug Abuse, Outpatient behavioral treatment is also a beneficial treatment option. Outpatient behavioral therapy is offered in numerous diverse settings with assorted approaches. Outpatient Behavioral therapy can help clients to enhance constructive life skills, alter their attitudes and behaviors related to using or drinking, and persevere with other types of treatment such as medication (Treatment Approaches for Drug Addiction, 2016).

Some behavior methods used in outpatient behavioral treatment include cognitive-behavioral therapy, motivational incentives, meditation, and physical exercise. Cognitive Behavioral Therapy (CBT) helps addicts to distinguish, evade, and handle the situations in which they are most likely to drink or use drugs. Cognitive Behavioral Therapy also teaches techniques which instantaneously minimize stress, depression, anxiety, guilt, and fear. Motivational incentives (also referred to as contingency management) are another outpatient behavior treatment that incorporates constructive reinforcement to encourage the client to stay abstinent from drugs and alcohol. Meditation helps the client to increase their ability to focus and aids in monitoring negative thought processes. Meditation creates healthy changes in the brain and balances mood. Physical exercise is used to help boost the brain chemicals such as dopamine, which makes people feel rewarded and calm. Meditation and physical exercise are strategies that have been proven to provide a slow release of dopamine, which is a key component for stable

mood and emotional well-being (Treatment Approaches for Drug Addiction, 2016). The following Cognitive Behavioral Model shows how coping mechanisms are vital components in recovery to avoid relapse.



The Benefits of Treatment

Many of those suffering from addiction are unable to recover and maintain a sober lifestyle alone. Initially, many addicts find the help and support they need to maintain a sober lifestyle in a treatment facility. There are many benefits obtained by utilizing the aptitude of a treatment center.

The benefits of treatment are numerous and outweigh the impediments of addiction. A few advantages of making the decision to go to treatment are: structure, removal of harmful influences, peer support, and learning. Treatment facilities offer structure to the client and allow them very little free time to be left to their own devices or to be able to think about obtaining or using drugs or alcohol. Most treatment centers will ask a client to leave if they are caught with drugs or alcohol. In a treatment center, patients will have a daily routine which is very different than the life of chaos they were acclimated to when they were using drugs and alcohol. The less an addict has time to think about planning on buying and using drugs or alcohol, the less likely they are to relapse in the future (10 Inpatient Rehab benefits).

The removal of harmful influences and distractions is another reward offered by obtaining treatment in a facility. Most inpatient treatment facilities restrict phone calls and visitors to a few hours a week per client. Removing people who may encourage or trigger a client to use or drink is essential to recovery. Limiting phone calls and visitors can also provide a client with the ability to focus on them self, while the stressors of their life prior to treatment are temporarily removed. Removing outside influences and distractions also offers a client and their family a significant amount of privacy and peace of mind. No one should ever find out about anyone being in treatment unless the addict wants them to. If a client chooses to enter into a residential treatment facility, the addict's family will not have to witness the detoxification phase or the beginning of the emotional rollercoaster that the client will have to go through (10 Inpatient Rehab Benefits).

Peer support is another benefit of choosing to enter a treatment facility. Not only are there experts and trained medical staff on site 24 hours a day, but clients will be able to formulate friendships with many other addicts who are all there to get help for their addiction and are all working toward the identical general goal of lifelong sobriety. During this time, clients may feel isolated or alone and these feelings have the ability to obliterate an addict's recovery. Peer support has been proven to help this stage of recovery and allows clients the opportunity to share their feelings, strength, and hope with other addicts. The peer support that a treatment facility provides to addicts also provides them with the opportunity to give and take suggestions from other patients who are experiencing the same feelings, thoughts, and experiences (10 Inpatient Rehab Benefits).

Learning is also a reward that treatment has to offer. Most treatment facilities offer clients classes or information that provide them with knowledge about living sober, the disease of addiction, relapse, relapse avoidance, handling finances, 12 step support groups, meditation, prayer, and sponsorship. Choosing to enter a treatment center provides clients with the tools they need to maintain long-term sobriety by learning how to live a happy life and overcome addiction (10 Inpatient Rehab Benefits).

Local Treatment Resources

Although substance abuse in Western Kentucky continues to be a growing problem, resources throughout Western Kentucky are limited and those suffering from drug or alcohol addiction may have to travel throughout the state to be admitted into a facility and receive help.

Below is a list of detoxification, medication assisted, inpatient, sober living (halfway houses), & outpatient treatment facilities & services that are offered in Western Kentucky.

Local Detoxification Treatment Facilities

William H. Fuller Memorial Substance Abuse Treatment Center

1525 Cuba Road

Mayfield, KY 42066

(270) 247-2588

Recovery Works

4747 Old Dublin Road

Mayfield, KY 42066

(270) 623-8500

Local Medication Assisted Treatment Facilities

SelfRefind

220 Berger Road

Paducah, KY 42003

(866)755-4258

West Kentucky Medical

609 Hammond Drive

Paducah, KY 42001

(270) 443-0096

Paducah Professional Associates

125 South 17th Street

Paducah, KY 42001

(270) 443-0096

Recovery Works

4747 Old Dublin Road

Mayfield, KY 42066

(270) 623-8500

Local Inpatient Treatment Facilities

Ladies Living Free Inc.

2000 Bloom Avenue

Paducah, KY 42003

(270) 448-0961

Trilogy Center for Women

100 Trilogy Avenue

Hopkinsville, KY 42240

Director: Holy Perez-Knight (270) 885-2905

The Hope Center Recovery Program for Women

1524 Versailles Road

Lexington, KY

(859) 252-2002

Women's Addiction Recovery Manor (W.A.R.M.)

56 North McKinley Street

Henderson, KY 42420

Director: Sharice Benson (270) 826-0036

The Healing Place Women & Children's Community

1503 South 15th Street

Louisville, KY 40210

(502)-568-6680

Liberty Place for Women

218 Lake Street

Richmond, KY 40475

Director: Jeri Allison

(859) 625-0104

Cumberland Hope Community Center for Women

6050 Highway 38

Evarts, KY 40828

(606) 837-0100 or (606) 837-0200

Director: Mary Mosley

Brighton Recovery Center for Women

375 Weaver Road

Florence, KY 41042

(859) 282-9390

Director: Anita Prater

Paducah Lifeline Ministries

2806 Morgan Lane

Paducah, KY 42001

(270) 443-4743

Center Point Recovery Center for Men

530 County Park Road

Paducah, KY 42001

Director: Darin Thomas (270) 444-3640

Owensboro Regional Recovery Center for Men

4301 Veach Road

Owensboro, KY 42303

(270) 689-0905

Director: Sarah Adkins

The Healing Place of Campbellsville

105 Hiestad Road

Campbellsville, KY 42718

(270) 789-0176

Director: Karyn Hascal

Hickory Hill Recovery Center

100 Recovery Way

Emmalena, KY 41740

(606) 785-0141

George Privett Recovery Center for Men

250 West London Avenue

Lexington, KY 40508

(859) 225-4673

Men's Addiction Recovery Campus

1791 Old Louisville Road

Bowling Green, KY 42101

(270) 715-0810

Transitions Grateful Life Center for Men

305 Pleasure Isle Drive

Erlanger, KY 41018

(859) 359-4500

Director: Wes Costin

The Healing Place for Men

1020 West Market Street

Louisville, KY 40202

(502) 585-4848

Morehead Inspiration Center for Men

1111 West US 60

Morehead, KY 40351

(606) 783-0404

Director: Tony White

Genesis Recovery Kentucky Center

400 CW Stephen Blvd.

Grayson, KY 41143

(606) 898-2111

Local Sober Living (Halfway Houses) Facilities

The Burns M. Brady Center

1000 West Market Street

Louisville, KY 40202

(502) 259-0080

Director: Maurice Ludwick

Transitions, Inc. W.R.A.P. House

1629 Madison Avenue

Covington, KY 41011

(606) 491-2090

Director: Liza Brown

Transitions, Inc.

601 York Street

Newport, KY 41071

(859) 291-3665

Director: Jim Grorene

Local Outpatient Treatment Facilities

Four Rivers Behavioral Health

425 Broadway Street

Paducah, KY 42001

(270) 442-7121

Pennyroyal Center

735 North Drive

Hopkinsville, KY 42240

(270) 886-2205

Wellness Place, LLC

68 Cedar Street

Kuttawa, KY 42055

(270) 601-4235

Email: info@wellnessplaceky.com

Four Rivers Behavioral Health

1051 North 16th Street B

Murray, KY 42071

(270) 753-6622

Pennyroyal Center

1350 US Highway 62

Princeton, KY 42445

(270) 365-2007

Mountain Comprehensive Care

1055 National Mine Road

Madisonville, KY 42431

(270) 825-0414

Aftercare Options

After leaving treatment, it is crucial that an addict continue to maintain sobriety and work on avoiding relapse by attending a self-help (mutual support) group of their choice to avoid relapse. Self-help groups are an important part of recovery, because they have been proven to be effective and they are available all around the world. These aftercare groups provide a judgment free zone, a safe location to go, recovery techniques, & access to other addicts in recovery. Mutual support groups also provide an addict with constant reminders of the rewards of sobriety as well as consequences of drinking or using. Many times the voice of addiction tells an addict that they can control their drinking or using after being sober for 6 to 12 months. When this happens as it often does throughout sobriety, it is vital to know the tools to use to prevent relapse (12 Step Groups, 2017).

According to the Center for Substance Abuse Treatment, attendance and active involvement in any kind of self-help group increases the chances of abstinence from drugs and alcohol (Center for Substance Abuse Treatment, 2008). A few of the mutual support groups that

are offered for addicts and alcoholics are: Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Celebrate Recovery (CR), and SMART Recovery.

Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are 12 step groups that focus on abstinence and 12 steps to recovering. AA is one of the oldest programs available and focuses on working closely with a sponsor, who guides the newcomer through the 12 steps by providing support and sharing their experience, strength and hope. The AA representation has also been modified by people with reliance on drugs, such as Narcotics Anonymous. Narcotics Anonymous focuses on any type of drug use. Like other 12 step groups, AA & NA meetings can be open or closed. Anyone is welcome to attend an open meeting, but attendance at closed meetings is limited to those who have a desire to stop drinking or using. AA and NA groups believe that recovery from drugs and alcohol involves lifelong participation (Center for Substance Abuse Treatment). There are presently 174 AA meetings in Western Kentucky each week. More information about AA and local meetings can be found below:

Western Kentucky Intergroup

6804 US Hwy 641 North

Gilbertsville, KY 42044

(800)606-6047 or (270)362-7141

<http://wkintergroup.org>

More information about NA and local meetings can be found below:

Helpline

(877)708-6614

<http://www.na-pana.org/meetings.htm>

Email: questions@na-pana.org

Conclusion

Most addicts & alcoholics have tried for years to escape their reality, underlying issues, spiritual sickness, mental health disorders, traumatic events of the past, physical pain & emotional pain by using mind altering substances such as drugs and alcohol. Many have found an immediate release and escape from these problems in the beginning of their drinking and using, but over time these substance abusers have found themselves in active addiction and totally powerless over drugs and alcohol. This guide will teach the reader about the causes, effects and solutions of substance abuse. By providing education on substance abuse and active addiction, prospective clients will be able to acknowledge the signs and symptoms of the disease of addiction & will have access to local treatment resources and post-treatment options for themselves & their loved ones in order to begin living a joyous and happy life free from the chains of addiction. Addiction is a powerful disease that ultimately leads to death and incarceration. Recovery from drugs and alcohol is attainable if those affected are ready to try a new way of life one day at a time.

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