

What I Would Do to Help a Loved One with an Addiction in the New River Valley

August 6, 2016 by [Anne Giles](#) [5 Comments](#)

I live in Blacksburg, Virginia. Blacksburg is located within Montgomery County, and within a larger area generally termed the New River Valley (NRV) in Southwest Virginia. Blacksburg, Virginia, according to the U.S. Census Bureau, has over 46% of its population living in poverty. More than 16,000 people in my locale have problems with alcohol and other drugs. In terms of receiving or allocating funding for health care, Virginia is ranked poorly with other states. This means we have scarce health care resources and high demand for them.

Scarcity requires scrambling.

Disclosure and disclaimer: I am a counselor at a community services agency. The opinions expressed here are mine alone and do not necessarily reflect the positions of my employer. This content is for informational purposes only and is not a substitute for medical or professional advice. Consult a qualified health care professional for personalized medical and professional advice.

In this post, I elaborate upon What You Can Do to Help Fight Addiction with specific details on what to do for a loved one with addiction in our area.

This list is based on my experience in getting help for myself and others. Some readers may find themselves outraged by the workarounds needed to get addictions care. I have no time for outrage or debate. I may not want to be a do-it-yourself addictions treatment care coordinator, or may feel unqualified or ill-prepared to do so, but addiction is a critical illness and right-here, right-now, I need to get my loved one care.

“Love, evidence & respect.”

– Maia Szalavitz’s answer via Twitter to the question, “What fights addiction?”

If I discovered my loved one had an addiction and I wanted to get him or her addictions treatment in my locale, this is what I would do to address immediate needs.

0) SAFETY FIRST. Unfortunately, much addictions treatment in our area begins with a medical or legal emergency resulting from untreated addiction progressing to an acute

stage. If my loved one, or I, or anyone present is in danger or is behaving dangerously, that must be addressed first. I may need to remove myself and vulnerable people immediately – even if I long to stay and help my loved one or fear his or her anger, even retribution – then call 911.

Important: The rest of this list is based on getting help for a loved in an urgent situation, not an emergency situation. The loved one is able to converse, perhaps unwillingly, but perhaps willingly enough to co-create next steps.

1) *Lead with my heart to support my loved one.*

Hug my loved one. Say, “I am so very sorry you have developed this health condition. It’s too bad but you are not bad. I love you and I am here for you.”

Realize I need to become my loved one’s care manager and advocate. My loved one is ill. Few can take effective action when they don’t feel good.

2) *Lead with my head and prepare to take strategic action.*

Recognize my loved one needs full physical and psychiatric evaluations to determine the dimensions of his or her particular case. Addiction is often accompanied by mental illness, physical illness, emotional and physical pain, and trauma. Issues of temperament and personality may need assessment. All of these factors need to be considered and evaluated by medical professionals. Blood work needs to be done to test for the presence of function and dysfunction, both to diagnose illness and to assess suitability for medications. Ideally, these assessments would be done by one specialist or a team of specialists, but I may need to cobble this together from multiple sources. From all this data, the first version of an individualized treatment plan can be devised.

Realize I need to get my loved one “in the system” ASAP. Wait lists exist for all services.

Realize that understanding addiction is a health condition needing health care – rather than believing it is a moral problem needing punishment – is new. I will need to listen carefully to what care providers advise. In 99% of my contact with local health

care providers, I have experienced them as caring, determined, and resourceful. But if I hear disrespectful, shaming statements, or presentation of beliefs rather than science about addiction, I can't walk away because I'll just be put on another wait list. I'll need to work with this care provider and his or her views in order to receive the piece of data this provider can offer. I must do what I can to protect my vulnerable loved one, but I may, at times, feel challenged to manage my own emotions.

Prepare to document. I'll need to get copies of all previous medical reports for as many years back as I can find them, keep them organized in reverse chronological order in a binder, and take that binder to all appointments. I'll need a list of all current and past medications. Our multiple health care providers have electronic health record software programs that don't "talk" to each other so care providers may not be able to "see" data from other providers. Data from previous years may still be in paper file folders rather than available electronically. I'll only have a few minutes with each care provider so I need to have a one-page summary at the front of the binder, then the medications list, so the care provider can be oriented to my loved one's case quickly. I'll need to update the summary after each appointment.

Consider the ER. If my loved one is in a state of emergency, I will call 911. If my loved one is not in a state of emergency, I need to know that it is through the emergency room that many people with addiction make first contact with our local health care system. ERs help stabilize patients briefly, but are limited in the length of care they can provide, sometimes under 24 hours. Local hospitals do not provide addiction treatment, medication-assisted treatment, or prescriptions for detox or pain meds. If my loved one is released without immediate follow-up care, relapse is probable.

Depending upon the system in which the ER operates, referrals will be made to additional treatment through these emergency evaluation services. Referrals from those services are to local treatment providers. Many referrals are for treatment at in-patient facilities, few of which have beds available immediately, most of which require health insurance or a needs-based assessment prior to admission. If my loved one is considered a threat to himself or herself or others, a stay at a mental hospital is required. An ER visit may result in a range of outcomes, including release of my loved one into my care, to a stay at a mental hospital, possibly in another part of Virginia. When I/we leave, I will be sure to get a printout of lab reports and treatment notes, or

return the next day for copies of them to add to my documentation binder. Again, in an emergency, I would call 911.

Consider urgent care. I have taken several people *with* health insurance coverage with illnesses or injuries that have resulted from addiction – *not for addiction itself* – to Velocity Care urgent care centers and have been impressed with how quickly the person is seen and how much attention each person is given by the care provider. Velocity Care also hands me a printout for my binder without asking. If my loved one is in a state of physical or mental emergency, however, they will refer us to the ER and it is a wasted trip.

Ask my loved one, “What help do you think you need first?” Although I’m nearly insane with worry and I see my loved one is in dire condition – but I have determined I do not need to call 911 for an ambulance and my loved one is not a child for whom it is my responsibility to make decisions – if my loved one’s answer to the question, is “I don’t want or need help,” then that is where the conversation must begin in hopes of mutually-deriving a plan of action.

In my experience, my view of what is the most important next step has never been what my loved ones have thought was important. I wanted to hurry them into shoes so I could get them into my car and race them to the ER faster than an ambulance could get there. They wanted a glass of orange juice. I need to continue to remind myself that this is *a person*, however ill or impaired, with needs, wants, preferences, priorities, and values. In my experience, co-creating next steps has been the most difficult, frustrating, and anguish-engendering part of helping someone with addiction. When is the person too ill to make a decision? Should I step in or not? Am I respecting this person’s autonomy and right to decide next steps on a life’s path? This is a realm of terrifying uncertainty, sometimes requiring life-and-death judgment calls, all made in the context of respect for human dignity.

3) Make appointments.

Start trying to get an appointment with a psychiatrist *now*. Most psychiatrists require a referral from a primary care physician (PCP) so an appointment with a PCP needs to be made ASAP. The PCP will make the appointment and can get back to me. Hearing back from the PCP, plus the wait to see the psychiatrist, and can take 6 months or

more. Whether or not my loved one has insurance, whether or not I have a clue how we're going to pay for it, whether or not my loved one may be able to make the appointment, I'm going to make an appointment *now* knowing I'll have 6 months to figure out the money.

If I or we can self-pay, I would make an appointment for my loved one to see a physician at TASL, the one and only medical practice specializing in addictions medicine in our locale. Clients pay directly for services and the provider does not bill insurance. Payment in person by cash is required to make the first appointment and cash or credit cards are accepted after that. TASL explains its services clearly and specifically via phone recording. Select option 3 for new patient information, 540-443-0114.

If I can't find a way to self-pay, and my loved one has health insurance, acknowledging the need to wait half a year for a psychiatric care appointment, I would immediately make an appointment with a primary care physician (PCP), ideally with my loved one's current PCP or, if he or she doesn't have one, with mine. An appointment with a Nurse Practitioner (NP) can be more readily available for immediate care if the PCP is booked. I would be sure to still keep the appointment with the PCP. The NP's assessment will become part of the data that the PCP considers.

If my loved one doesn't have health insurance, I would assist my loved one in calling ACCESS at New River Valley Community Services, 540-961-8400, between 8:30 AM and 5:00 PM, and asking for a GAP insurance assessment appointment. (Appointments must be made by the individual requesting an appointment. Assessments are not done on Mondays). If my loved one is assessed as having severe mental illness (SMI) he or she may qualify for coverage through the Virginia Governor's Access Plan (GAP). If I can bring documentation of my loved one having been diagnosed with SMI to the GAP assessment appointment, that can expedite the process. (Although the National Institute on Drug Abuse (NIDA) itself defines addiction as a brain disease, addiction/substance use disorder is not considered an SMI.)

If we can't self-pay, my loved one doesn't have health insurance, and doesn't qualify for GAP insurance, I would call the Community Health Care Center

of the New River Valley, make an appointment to see a physician, prepare the application forms, and start calling churches and asking for help with co-pays.

(Community members, please help me expand this section. How would a person get cash in the NRV to pay for non-covered medical expenses for addictions treatment?)

For each appointment, I would make a list of the top questions, in priority order, for which answers are sought. To get the most out of my limited time with a care provider, I need to focus primarily on information, secondarily on getting reassurance for my loved one. I will talk with my loved one beforehand, take notes, and co-create a brief list. If I can accompany my loved one, I can bring the list, listen carefully, and ask for assistance with any questions not addressed. If I can't go, I can provide the list for my loved one to take. After each appointment, I will cross off answered questions and note additional ones for the next appointment.

Contribute to my loved one's documentation. I would hand write or type a timeline of what I know about my loved one's life with all of these components in order as they happened. I would include years and ages if I can: 1) first use of cigarettes, alcohol, marijuana, other substances; 2) substance use history – what did they use, when did they use it, how much did they use, and how long did they use it, prescribed or otherwise, any incidents that seemed like just teenager stuff or just overdoing it at the time? 3) onset of physical illnesses or occurrence of physical injuries; 4) traumas – deaths in the family, losses, neglect, abuse, witnessing or experiencing emotional, physical, or sexual violence; 5) incidents I remember in which the person seemed to have a very strong reaction or surprisingly little reaction to an event, 6) anything else I think might be helpful for care providers to know.

4) Get my loved one to appointments.

Cover transportation. My loved one may not have a license or a vehicle. Ideally, I would transport and accompany my loved to all appointments to listen and to help as needed. If I can't take the person myself, I need to help them find a ride, or find them a ride myself, perhaps from a friend or neighbor. If I have a credit card and a late model smartphone that can handle the Uber app, I could arrange for and pay for transportation through my local Uber service.

Cover dependent care. My loved ones may be parents of small children, and/or may provide care for a partner, ill or elderly friends or family members, or have pets. I need to find a way to arrange for coverage to ease my loved ones' stress and concern about beings in their care.

Cover medication costs. Physical and mental stability is the top priority for my loved one and meds will likely be needed to achieve that. If my loved one can't pay or doesn't have insurance, I need to think about finding a way to cover this necessary expense.

5) Follow-up on recommendations received during health care appointments.

If out-patient treatment is recommended, New River Valley Community Services (NRVCS) is the public provider of behavioral health services and the primary provider of addictions treatment services in our locale. To be screened for services, I would assist my loved one in personally calling ACCESS at New River Valley Community Services, 540-961-8400, between 8:30 AM and 5:00 PM, and asking for a Rapid Access intake appointment.

If in-patient residential treatment, i.e. "rehab," and/or "detox" is recommended for my loved one, I would read carefully Maia Szalavitz's article on the rehab industry, then call providers in this area and listen carefully to what they have to say about their services. Residential treatment can be helpful to some. For others, life is distressingly disrupted. An extended absence can compromise jobs, finances, relationships with children and partners, and subject one to addictions-related stigma. Many with addictions have trauma-related issues and find that in-patient treatment can exacerbate trauma symptoms. Rehab can be enormously expensive and is increasingly under scrutiny for ineffective treatment outcomes and high relapse rates upon release. This is a decision that needs to be made thoughtfully.

If my loved one did attend residential treatment, during visits, I would do my best to co-create with my loved one a life-in-recovery schedule for us to follow that would begin at the moment of discharge. Because I can't do my life and theirs, too, I, would create a Doodle schedule, then ask for help from my friends. At my loved one's discharge, I would be there to transport my loved one into our best efforts to create a new life in recovery.

If individual counseling is recommended, I know of two counselors in our area who specialize in substance use disorders and both are not taking new clients. I would ask physicians and friends for referrals, screen that list for counselors who specialize in cognitive behavior therapy, the top evidence-based counseling method for addressing substance use disorders, and take the first available appointment with the first available counselor. (Few specialize in Dialectical Behavior Therapy (DBT) which is showing increasing promise as an evidence-based counseling protocol for addictions treatment.)

Understand that addiction, in early recovery, is a 24-7 condition that requires 24-7 care. Although I may assist my loved one, once stabilized, a person with addiction serves as his or her own primary care provider. I would point my loved one to these self-help suggestions:

- Addictions treatment options list derived from studying addictions treatment research (.pdf opens in new tab)
- Addictions recovery self-evaluation checklist derived from evidence-based addictions treatments
- Local recovery support groups
- Local recovery resources

Practice self-care. Although it's last on the list and hard to practice in urgent moments, self-care is to what I have to continually return my attention. I need to be high-functioning to help anyone with anything. And this may well be one of the hardest fights of my life. I need food and rest. I may need counseling for myself and definitely need time with supportive friends. The self-care checklist for addictions recovery that I will suggest to my loved one can assist me with my self-care, too.

I need love, too.

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If my loved one has an opioid addiction, I would:

Buy opioid overdose antidote Naloxone kits – available now without a prescription from the pharmacy at CVS on University City Boulevard in Blacksburg – for my loved

one, myself, and others with whom my loved one has frequent contact in case of my loved one's return to use. (See helpful discussion of Naloxone in [NYT letters to the editor, 8/7/16.](#))

Study carefully and learn [What Science Says to Do If Your Loved One Has an Opioid Addiction.](#)

Get my loved one assessed for medication-assisted treatment (MAT), the [top evidence-based treatment for opioid use disorder.](#) Unfortunately, my loved one has an immediate need for an MAT assessment and wait lists for assessments and treatment from local public providers and providers who take insurance are 6 months or more. (Here's an explanation of [why we have wait lists for opioid addiction treatment.](#)) To bypass wait lists, I have to self-pay. The closest self-pay source of buprenorphine/Suboxone/Subutex to me in Blacksburg is TASL, 540-443-0114. Methadone is only available at highly regulated clinics in Salem and Roanoke.

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I am so grateful to the many who have shared their lives and struggles with me so that I could write this post in hopes that we can help many more.

This post is a work in progress. If you have suggestions, please leave them in the comments or email me at anne@handshake20.com. Last updated 9/16/16

UPDATE: On my personal blog, I am writing a series of posts entitled [DIY Addictions Recovery](#) for people with addictions who are seeking help for themselves.

If you or someone else is experiencing a substance use and/or mental health emergency, call 911 and/or ACCESS, 540-961-8400.

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