

Opioids – One More Epidemic for Catholic Health Care

FRED ROTTNEK, MD, MAHCM

Long before there was Catholic health care, members of the church cared for each other, sometimes as individuals and sometimes as members of religious orders. Caring for others' health was part of community and parish life — special facilities and buildings were rare, and care was provided in homes, in churches and even on the streets. In fact, the modern version of a hospital didn't exist until the 18th century. Prior to this, most activities in buildings set aside for the care of the sick offered chiefly palliative care. The focus of work was comfort, not investigation. And the care was provided by religious orders.¹

Modern Catholic health care can build on centuries of experience the church has had with epidemics. Scores of our patron saints are revered for their leadership in responding to public crises involving illness — jumping into the fray, mobilizing a work force and gathering resources to care for the sick, build shelters and hospitals, shape community response and public policy towards greater health and train pipelines of providers to provide a sustained response.

Regardless of the epidemic, the responses of our historical church's health care providers shared characteristics: They ensured that people got acute treatment, either curatively or through comfort measures only. They helped their community members sustain a recovery and regain wellness. They found ways to prevent contagion with education, behavior change and science. And, when they were at their best, they sought ways to prevent another epidemic from occurring.

Although these workers of the past responded in ways that were sometimes uneven and occasionally delayed, they engaged. As a ministry, they had a philosophy of human flourishing that extends beyond recovery.

Today, when we speak of Catholic health care, we tend to refer to systems, hospitals, facilities

and ministries. We use special vocabulary. We use words that often require definitions. We are working in complicated systems with complex equipment and almost endless resources.

But those of us working in Catholic health care would benefit by embracing the stories and charisms of the founders who went before us. Because right now, we need to move faster in our response to the opioid epidemic. And the barriers holding us back are not new.

As in previous epidemics, we are intimidated not only by the epidemic, but also by what we do not yet know about its size, scope or natural course. We confuse disease, behavior, choice and moral failing. We question the efficacy of service delivery models we understand, promote and disseminate. We worry about our stewardship of limited resources. And, sadly, we get stuck in hand-wringing and fear of acknowledging the urgency

Modern Catholic health care can build on centuries of experience the church has had with epidemics.



of the situation, as if we are hoping that the threat will go away on its own.

But these kinds of fears and unknowns did not stop saints who have gone before us — like Camillus de Lellis, Damien of Molokai, Mark Ji Tianxiang and Teresa of Calcutta — from bravely stepping into their communities to bring healing, comfort and care to their patients. Their legacies are our calls to action in 2018.

THE OPIOID EPIDEMIC

Public health experts agree that the opioid epidemic will not go away on its own.

In December 2016, the federal government passed the 21st Century Cures Act, which reorganized and reprioritized delivery of behavioral health and addiction services in the United States. Part of the act is the Opioid State-Targeted Response, a two-year program that funds each state to create and implement its past proposals to fight the opioid epidemic.

The Missouri STR team has stepped up by creating a four-point plan. Although the initial targets of the program are community mental health centers and federally qualified health centers, we have expanded our efforts to include our partners in Catholic health care. We must work in concert to fight the epidemic, and here is our framework for the delivery of services.

Missouri's Opioid STR 4-Point Plan:

■ **Prevention** includes opioid and addiction education in schools and communities, education for providers on best practices for chronic pain management and providing overdose education and naloxone (Narcan) distribution and education.

■ **Treatment** includes recruiting, training

and supporting providers to increase access and capacity for treating opioid use disorders, providing medications for individuals with opioid use disorders and connecting hospital-based services to community services for continuity of care.

■ **Recovery** includes identifying and expanding recovery housing, building a workforce of certified peer specialists and promoting individual and community wellness through recovery community centers in high-need areas.

■ **Sustainability and community impact** includes changing Department of Mental Health billing and service policies in order to reduce barriers to providing opioid use disorder medications; providing education, training and recovery services to create needed infrastructure reform in order to sustain treatment and recovery services after the



Eric Nyffeler

STR grant concludes; and evaluating implementation of STR efforts to best inform legislative and policy reform.

Although the STR program's primary goal is to expand access and capacity to treatment and recovery services, the Missouri STR team has a broader goal: culture change. Our STR team is advocating for Missouri to update and adapt our health delivery models to enhance the treatment, recovery, and prevention and sustainability goals.

Catholic health care can support and adapt the Missouri template or similar approaches taken by other states, but Catholic health care also could do much more. The mission of our ministry gives us the means to lead the fight in the opioid epidemic. Catholic health care is uniquely situated to take a lead in what we must do as a nation.

BEACONS IN MINISTRY TO THE SICK AND MARGINALIZED

Although hundreds of saints have been associated with health care, illness and even plagues, the following have unique charisms that can inspire our work at hand.

St. Camillus de Lellis, MI, 1550-1614, demonstrated response to community need and institutionalization of resources to promote community health. His observations of poor care received by the sick motivated him to establish the Clerks Regular, Ministers of the Infirm (MI). First on the battlefield, and later in the battle against the bubonic plague and subsequent famine in Rome, his congregation raised the standard of care for the injured and poor. When Pope Gregory XIV elevated the congregation to a religious order in 1591, the order added a fourth unique religious vow, “to serve the sick, even with danger to one’s own life.” Camillus is the patron saint of the sick, hospitals, nurses and physicians.¹

St. Damien of Molokai, SSCC, 1840-1889, exemplified care to the ostracized, community engagement and collaboration to build needed infrastructure. St. Damien, born Jozef De Veuster in Belgium, was a member of the Congregation of the Sacred Hearts of Jesus and Mary. He became a missionary to Hawaii, where he was ordained a priest, taking the name Damien. After several years in Hawaii, he volunteered to serve the people who occupied Kalawao, a remote and almost inaccessible village on the island of Molokai. Kalawao was a quarantine settlement where Hawaiians who contracted leprosy, now known as Hansen’s disease, were

required by law to live. At that time the disease was neither treatable nor curable.

Father Damien became a community organizer and helped Kalawao’s residents create a system of law, build infrastructure and found schools and orphanages. His own death from leprosy among those ostracized from their society has contributed to his status as a martyr of charity. He was canonized in 2009 and is patron saint of those with communicable diseases — including leprosy and AIDS.²

St. Teresa of Calcutta, 1910-1997, demonstrated care to marginalized populations and development of a pipeline of providers to continue and expand her vision. Mother Teresa is respected for founding the Missionaries of Charity. In her words, the Missionaries would care for “the hungry, the naked, the homeless, the crippled, the blind, the lepers, all those people who feel unwanted, unloved, uncared for throughout society, people that have become a burden to the society and are shunned by everyone.” By 1997 the Calcutta congregation had grown to more than 4,000 sisters who managed orphanages, AIDS hospices and charity centers worldwide, caring for refugees, the blind, disabled, aged, alcoholics, the poor and homeless, and victims of floods, epidemics and famine. Mother Teresa was canonized in 2016.³

St. Mark Ji Tianxiang, 1834?-1900, spent his life caring for the poor and devoting himself to the same church that denied him sacraments for 30 years. St. Mark was a wealthy physician who cared for the poor

without charge. After taking opium for a stomach ailment, he developed an addiction that continued for the rest of his life. Since his confessor did not understand addiction, he felt Mark’s confessions were not genuine. As result, Mark was denied sacraments. He nevertheless continued his life of service to the poor and his frequent confessions of weakness against opium until he and his family were martyred in 1900 during the Boxer Rebellion. St. Mark Ji Tianxiang, canonized in 2000, has become the patron saint of those with addictions, those who cannot receive sacraments and those with the courage to continue to do good without the sacramental support of the church.^{4,5}

NOTES

1. *Catholic Encyclopedia*, “St. Camillus de Lellis,” www.newadvent.org/cathen/03217b.htm.
2. Kalaupapa National Historic Park, Hawaii, “Father Damien,” National Park Service website. www.nps.gov/kala/learn/historyculture/damien.htm.
3. Biography.com, “Mother Teresa,” website. www.biography.com/people/mother-teresa-9504160.
4. Jim Manney, “This Addict Is a Saint,” *Ignatian Spirituality* website. www.ignatianspirituality.com/10830/this-addict-is-a-saint.
5. Meg Hunter-Kilmer, “He Was an Opium Addict Who Couldn’t Receive the Sacraments, but He’s a Martyr and a Saint,” *Aleteia* website, July 6, 2017. <https://aleteia.org/2017/07/06/he-was-an-opium-addict-who-couldnt-receive-the-sacraments-but-hes-a-martyr-and-a-saint/>.



OPERATIONALIZING OUR MISSION

In 2018, Catholic health care is well positioned to fight the opioid epidemic. Because this isn't our first time at the rodeo, Catholic health care can act quickly based on best practices and established resources. We have the science we need to effectively fight the opioid epidemic. We have clinical guidelines, we have alternate therapies and we have models of care delivery. We have relationships with legislators, administrators and law enforcement. We work with international agencies that collect data about threats and health challenges across the globe.

But we don't have sustained and collaborative efforts. We don't have an effective distribution of financial and administrative resources to provide opioid addiction treatment, prevention, drug diversion and decreased demand. We desperately need moral courage, fortitude, collaboration and perseverance to face the roots of this crisis and succeed. Our history is rich in examples.

OUR CALLS TO ACTION

Imagine an expert panel convened in a government building in Washington, D.C. to fight the opioid epidemic, or in a walnut-paneled conference room at a respected research university. Now imagine that the expert panel is composed of Sts. Camillus, Damien, Teresa and Mark. Although they might acknowledge the scope of the opioid problem, the magnitude of the work and the difficulties of framing collaboration, I doubt any of them would be hand-wringing. These saints were doers. They rolled up their own sleeves, but they also recruited others for help, set up institutions for training and built the infrastructure they needed to face the challenge in front of them. And though they likely saw their work as driven more by obedience than courage, they measured success in terms of action — not accolades.

As an expert panel, the saints might be startled by the wealth of resources we have in the church today. They might wonder at our hesitancy to collaborate, to advocate, to take chances and to wade into controversial waters to save lives, restore families and prevent future addictions. But any distraction would be set aside quickly so that they could create their response, their call to action. It would look like this:

1. Do something. Enough with the summits! Save lives. Prevent overdoses. Expand access and capacity for treatment. Support and expand community programs that provide overdose education and Narcan rescue. Work with your state's Opioid STR team to find people and communities who need services and training. Show kindness. Normalize conversations around addiction. First and foremost, remember: Dead people don't recover.

2. Honor science and the expertise of others. Use what works. Embrace the science. Seek evidence. Don't duplicate efforts. Change and improve your systems to deliver care in ways that produce the best outcomes — don't be afraid to change what you think or what you know about addiction. That means don't let antiquated notions of moral failing and unproductive concepts of evil stand in the way of intervention. Share your results. Always strive to do more and do better.

3. Leverage our church's resources, networks and power responsibly and effectively. Catholic health care is a ministry of the church, as are Catholic education, Catholic higher education and Catholic social services. The ministries of the church often do not communicate well with each other — that can and must change, in order to battle this epidemic. Our parishes are embedded in communities and in history as neighborhood and regional hubs. We have schools, colleges and universities that are centers of education, scholarship and service. Lead and support prevention, treatment and recovery programs at our parishes, schools and universities. Our health care systems provide the full spectrum of health care. And our caregivers are local and national experts — because they are doing the work. Everyone has a role to play in this epidemic.

4. Step off our campuses and go to those we serve. Share missions and resources with community agencies who know our communities and our people in ways we don't. Get back to the community. To paraphrase St. Vincent de Paul's charge to the Daughters of Charity, "Let the streets be your campus." Build critical mass by

working with people of shared intentions. Don't worry about who gets credit.

5. Meaningfully promote what we do well as a ministry and what we have done poorly, so that others can learn through our history. Demonstrate how we put human dignity at the center of care. Embody our history of pipeline training for health care professionals by making every Catholic health care institution a teaching facility. Speak out loud to educate others why and how we value human life. Don't be afraid to relearn vocabulary.

6. Speak to policymakers to address addictions. Educate our leaders. Be prepared with a request for them. Reframe health care more broadly so that they can understand how social determinants can drive people to view risky substance use as a good choice. Demand better. And give suggestions.

CONCLUSION

For most people who misuse opioids, addiction is not a primary issue. The primary issue may be a poor outcome from an acute episode of pain or chronic pain management. It may be self-medication for serious mental illness or trauma — public or private, episodic or continuous.

Since addiction is often not the primary issue, long-term recovery is more than treatment and sobriety — it is human flourishing. Catholic

health care, at its best, is all about human flourishing. Our health care ministries provide treatment and tertiary prevention. We provide emergent, urgent and long-term care.

We must collaborate with our ministries and partners in education, research and service to gain the means to change culture, find cures and promote effective ideas and models. We must broadcast prevention and health equity through all these venues and then preach them from our pulpits. And we must not try to do these things alone.

This quote attributed to Mother Teresa sums it up: "I used to pray that God would feed the hungry, or do this or that, but now I pray that he will guide me to do whatever I'm supposed to do, what I can do. I used to pray for answers, but now I'm praying for strength. I used to believe that prayer changes things, but now I know that prayer changes us, and we change things."

FRED ROTTNEK is professor and director of community medicine, Department of Family and Community Medicine, Saint Louis University School of Medicine, and medical director of the physician assistant program in the university's Doisy College of Health Sciences, St. Louis.

NOTE

1. Andrew Cunningham and Ole Peter Grell, *Health Care and Poor Relief in Protestant Europe 1500-1700* (London: Routledge, 1997).

QUESTIONS FOR DISCUSSION

Fred Rottnek, MD, believes that Catholic health care has an important role in leading the fight against the opioid crisis. Recalling saints and martyrs of the church who risked everything to minister to so many people who were sick, dying and outcast because of their afflictions, Rottnek challenges today's ministry to do the same. He presents six very specific calls to action.

- Do you think today's opioid epidemic and the bubonic plague of the 16th century make for a good comparison? Can you discuss that in terms of margin and mission, as well as the resources and red tape of large health care systems?
- What are the programs and practices your ministry engages in to operationalize the best treatment and support of people suffering from the opioid crisis? What partnerships with public health departments, law enforcement, local schools and universities are in place or should be in place?
- Rottnek delivers his six action points as terse imperatives. Do you think he underestimates process and planning? Do you think too much time and resources go to meetings and summits? If you had one suggestion to make to the leaders of your ministry about how it should respond to the opioid epidemic, what would it be?

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, March - April 2018
Copyright © 2018 by The Catholic Health Association of the United States
