The Cycle of Substance Use and Stigma




35th Annual Jose I. Ricard, MD
Family Medicine and
Sports Medicine Conference

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Office of Drug Control Policy
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WEST VIRGINIA Department of Health & Human Resources
Office of Drug Control Policy

Learning Objectives

Participants will be able to:

- Understand what drugs are being used in the state and contributing to overdose
- Understand the negative effects of stigma on substance use disorder (SUD) outcomes
- Understand best practices in addiction prevention, early intervention, and treatment
- Understand and access existing state resources and processes to address addiction
- Identify and utilize effective evidence-based programs

West Virginia Data and Drug Trends

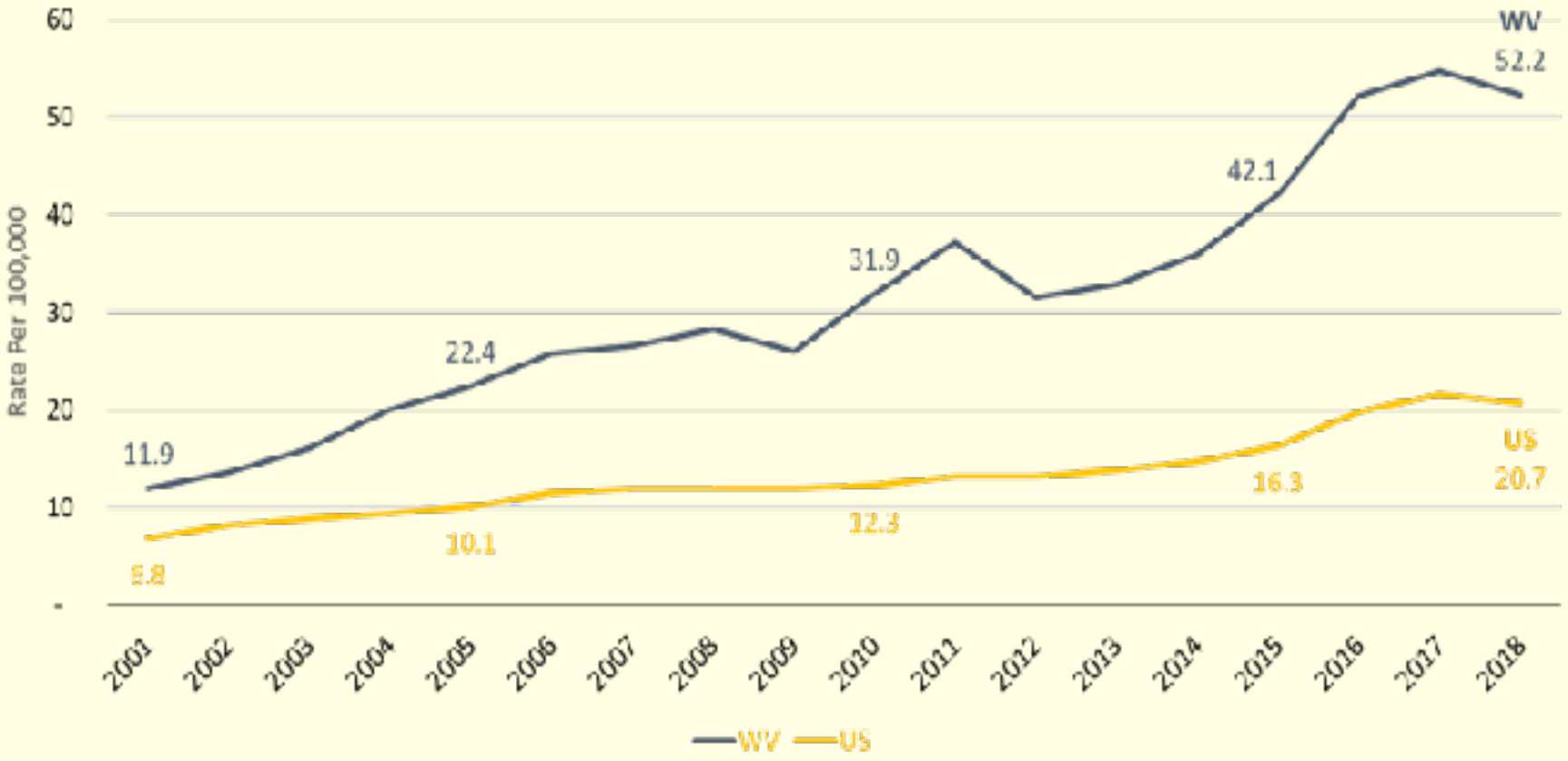
The Drug Epidemic

The drug epidemic in West Virginia is:

- A health crisis
- A social services crisis
- An economic crisis
- An evolving crisis

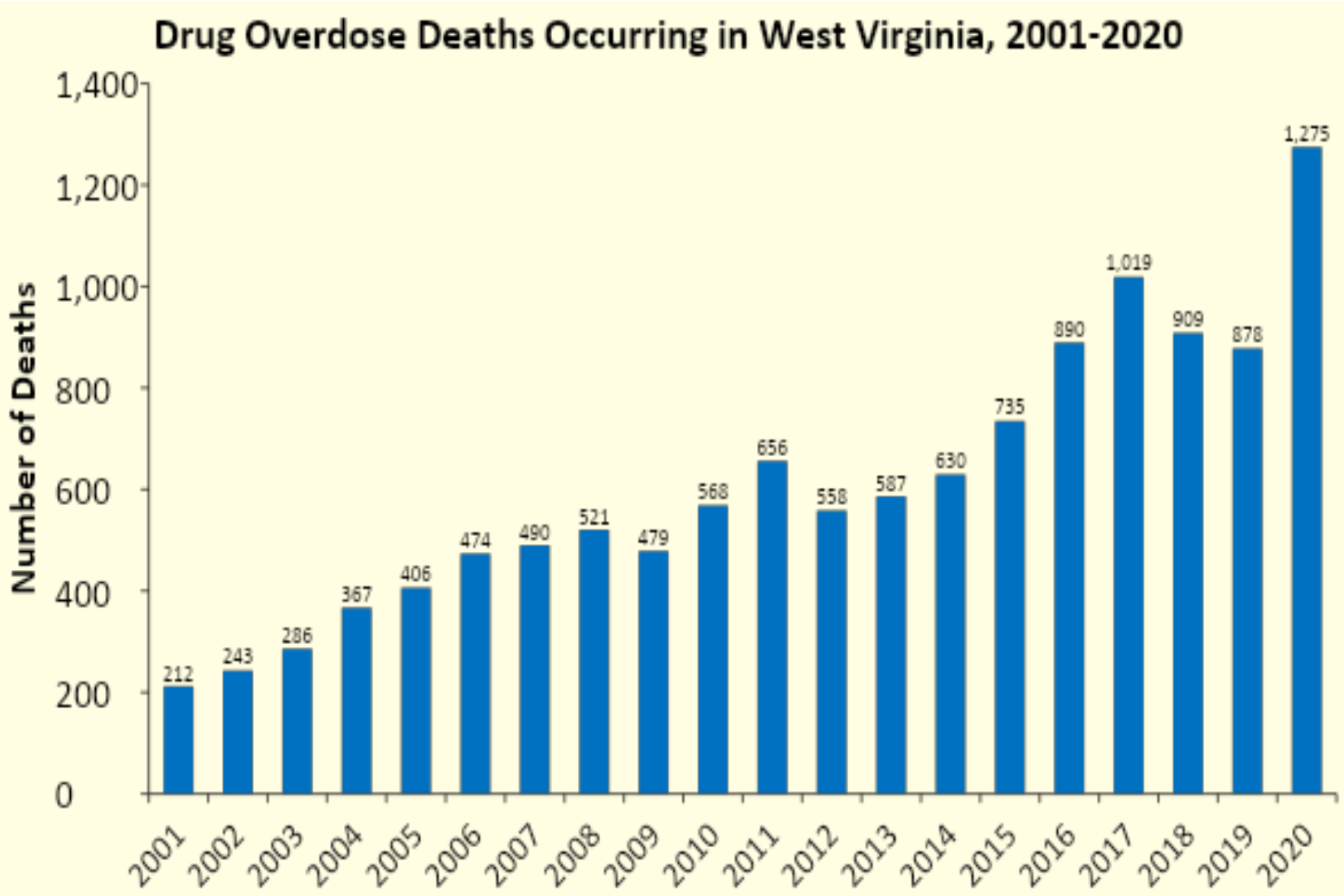
U.S. and WV Resident Drug Overdose Mortality, 2000-2018*

Age-Adjusted Rate per 100,000 Population



Note: Data from 2018 are preliminary and subject to change. WV Health Statistics Center data may vary from Centers for Disease Control and Prevention data due to the closure of the national data reporting window as well as other procedural differences.
Source: WV Data - WV Health Statistics Center, Vital Statistics System, February 2020.
US Data - Centers for Disease Control and Prevention, National Center for Health Statistics.

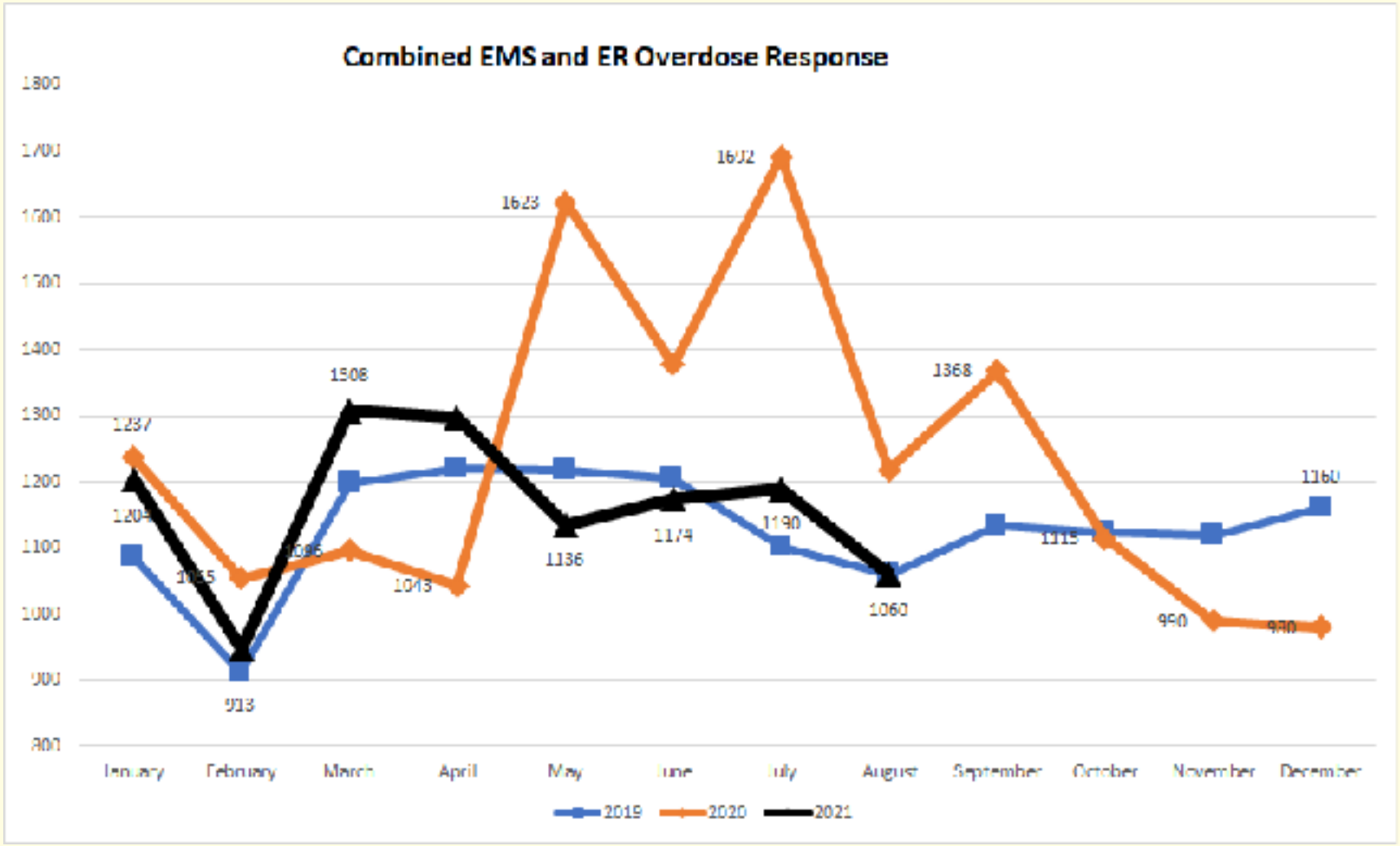
WV Drug Overdose Deaths



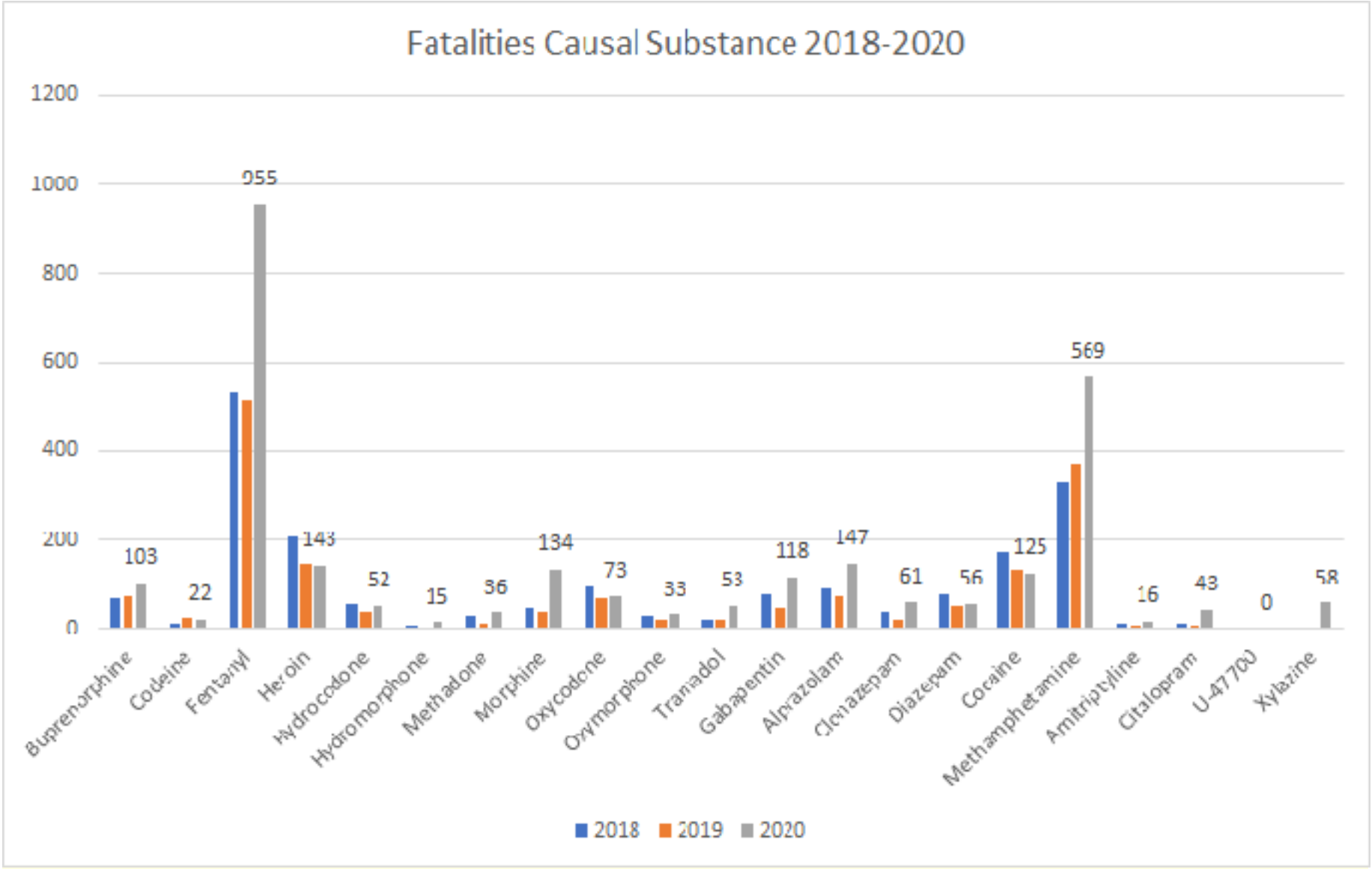
Data Source: WV Health Statistics Center, Vital Statistics System

These statistics include all manners of drug overdose deaths including accidents, suicides, homicides, and undetermined intent with an underlying cause of death ICD-10 code of X40-X44 (accidents), X60-X64 (suicides), X85 (homicides), or Y10-Y14 (undetermined intent). Data from 2018 and 2019 are preliminary and subject to change.

Overdose Response Rates



WV Drug Trends



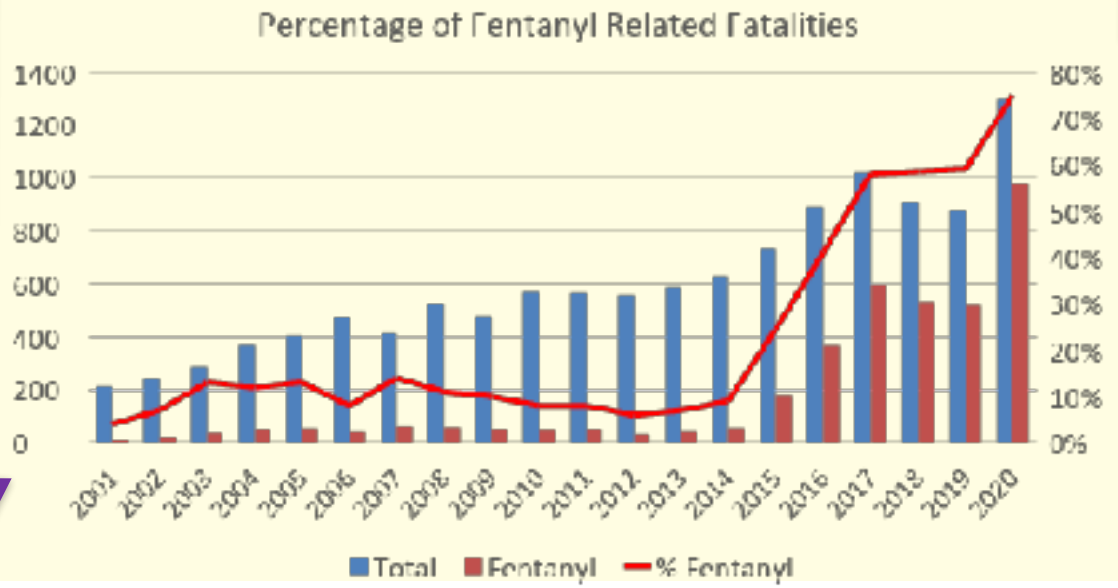
Effects of COVID-19

Flattening the COVID Curve:

- Existing mental illness exacerbated
- Created new barriers for those with mental illness and SUD
- Increased unemployment
- Increased substance use
- Burnout among frontline workers

Overdose Curve Rises:

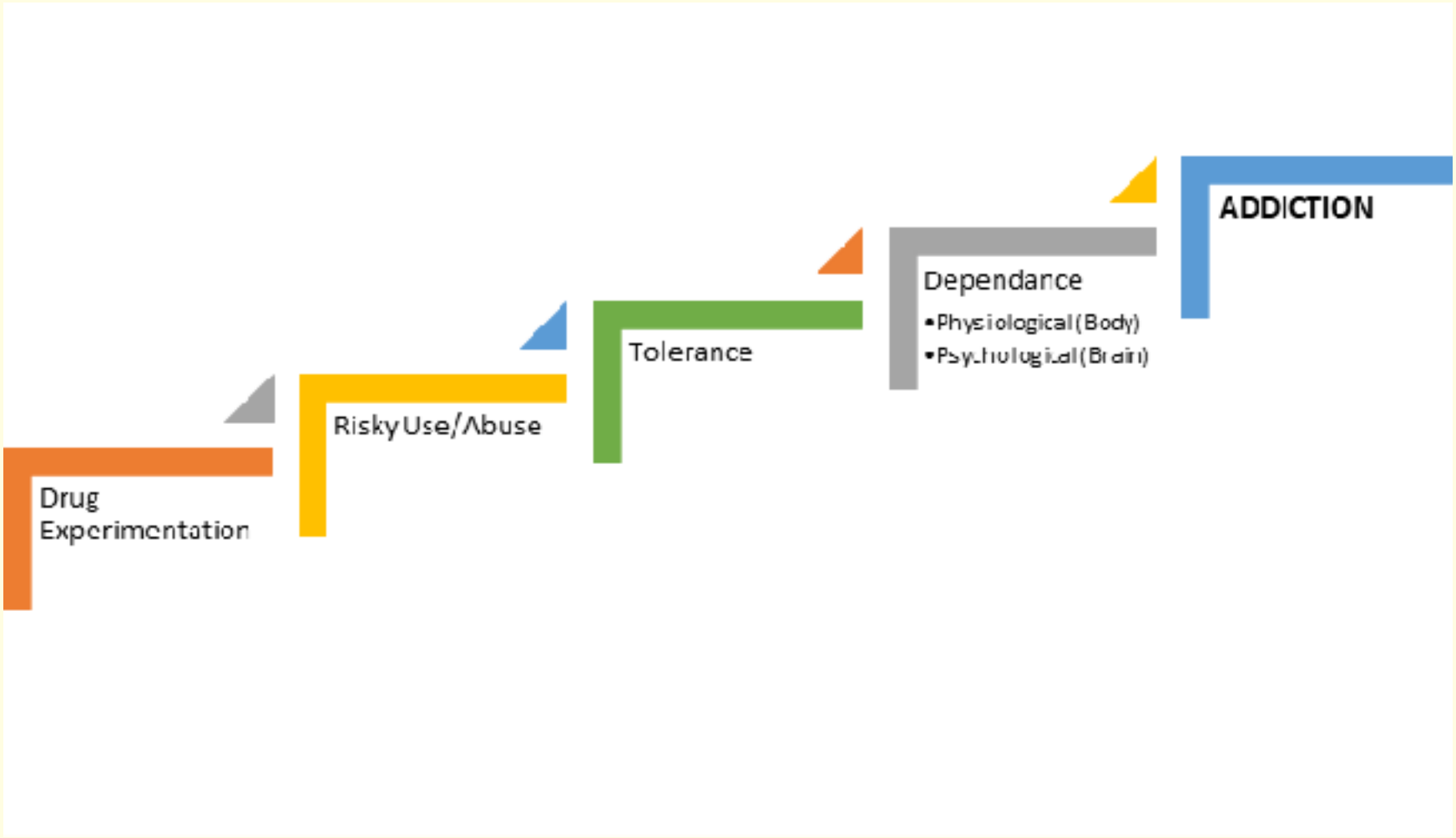
- Percentage of fentanyl-related fatalities rose from 59% in 2019 to 75% in 2020
  - 45% increase in fatal overdoses from 2019 to 2020 based on preliminary data
  - Fentanyl shows a nearly 87% increase in causation from 2019 to 2020
  - Methamphetamine has a 53% increase



SUD and Stigma

Understanding Addiction

Understanding Addiction



Understanding Addiction

There are three major brain changes with chronic drug use:

1. Decreased ability to activate reward pathways in brain
2. Long lasting memories that enable relapse long after the last use
3. Impaired cortex control (the good brain!) over the primitive brain (survival brain)

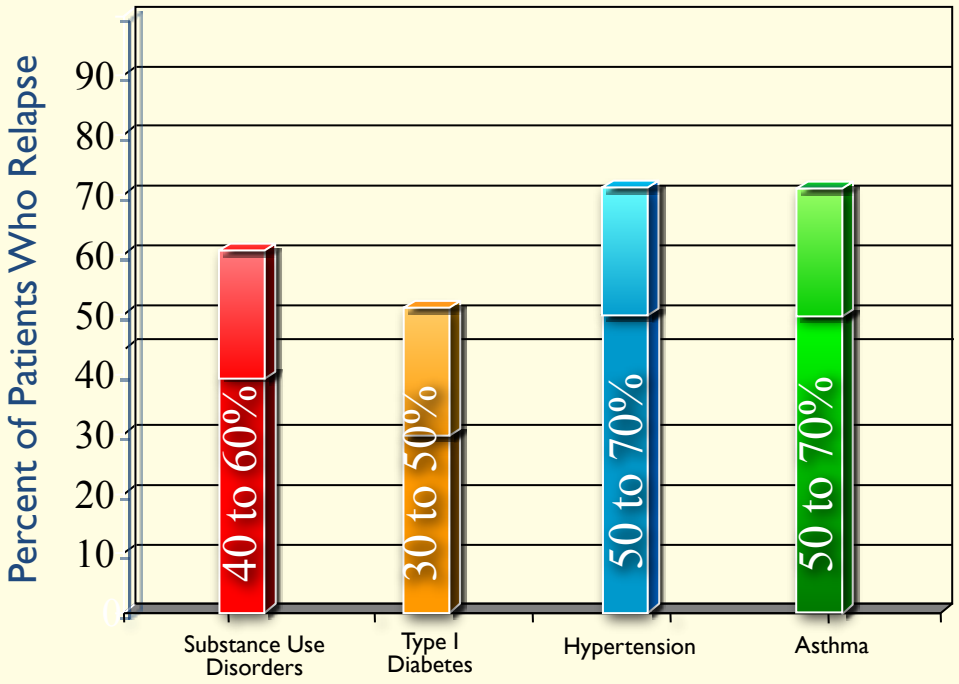
Drugs take over the brain's survival machinery.

Non-addicted or drug user
Drug = "fun"
Drug = hard to stop
Drug = next day hangover
Drug = drug

Person with addiction
Drug = survival

Treatment of Chronic Diseases

- SUD is a chronic disease and should be treated as such.
- Relapse is not a sign of failure. It is simply a sign that additional treatment is necessary.



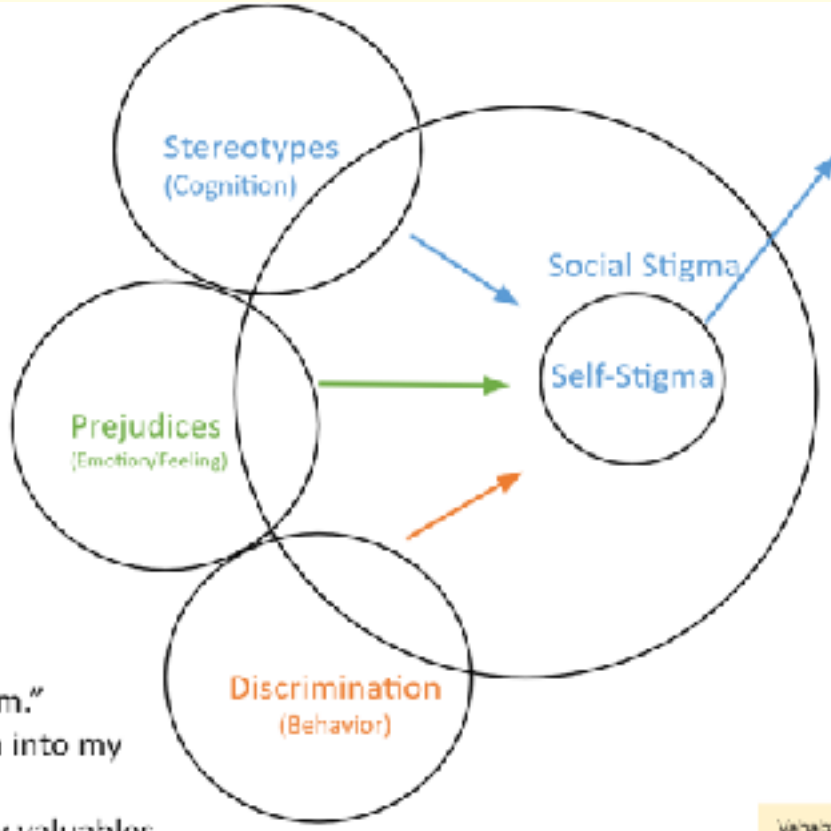
McLellan, A.T., Lewis, D. C., O'Brien, C.P., Kleber, H.D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association*, 284(13):1689-1695. doi:10.1001/jama.284.13.1689.

What is Stigma?

- "People with substance use disorders are bad people."

- "I can't trust them."

- "I won't hire them."
- "I won't let them into my dorm room."
- "I won't leave my valuables around them."



Internalization of Social Stigma

- Feeling rejected by society
- Avoiding interactions with society and others
- Denial of their condition
- Mental health problems
- Isolation

Mahajan, A. [khanacademymedicine] (2015, January 22). *Stigma – Social and self | Individuals and Society | MCAT | Khan Academy* [Video file]. Retrieved from https://www.youtube.com/watch?v=_jt2vo7L820

Outcomes

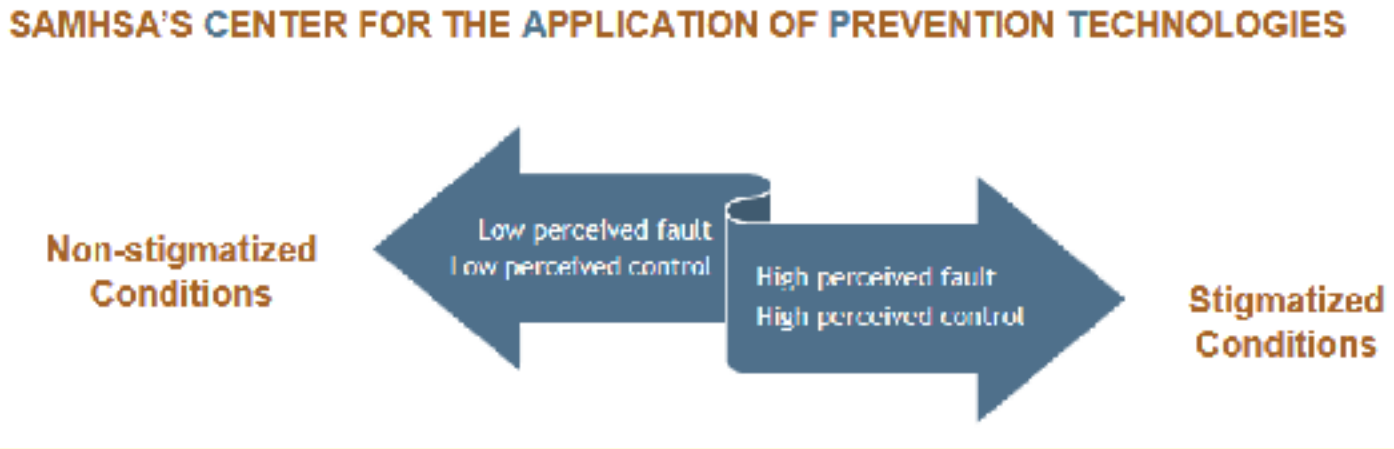
Thousands of people who need help are not getting it, even though there are effective addiction screenings, interventions, and treatment methods.

Do you know someone who has refused treatment because they don't want to be labeled, has overwhelming shame or guilt, or has been denied care because of lack of funding?

Models of Addiction: Choice vs. Disease

Choice: treatment is abstinence, message is “stop,” remedy is punitive.

Disease: treatment is based on evidence-based research, message is “address causes that led to disease,” remedy is medication, therapy, doctor’s visits.



Key Findings

Health Care Systems and SUD

- Separation of SUD treatment and mental health services from mainstream health care has created obstacles to successful care coordination.
- Individuals with SUD often access the health care system for reasons other than SUD. Many do not seek specialty treatment but they are over-represented in many general health care settings.
- Although it has a substantial health impact, physicians report low levels of preparedness to identify and assist patients with SUD.
    - In the largest study on how primary care physicians address SUD, less than 20% described themselves as very prepared to identify alcoholism or illegal drug use, and more than 50% of patients with SUD said their primary care physician did nothing to address their SUD.

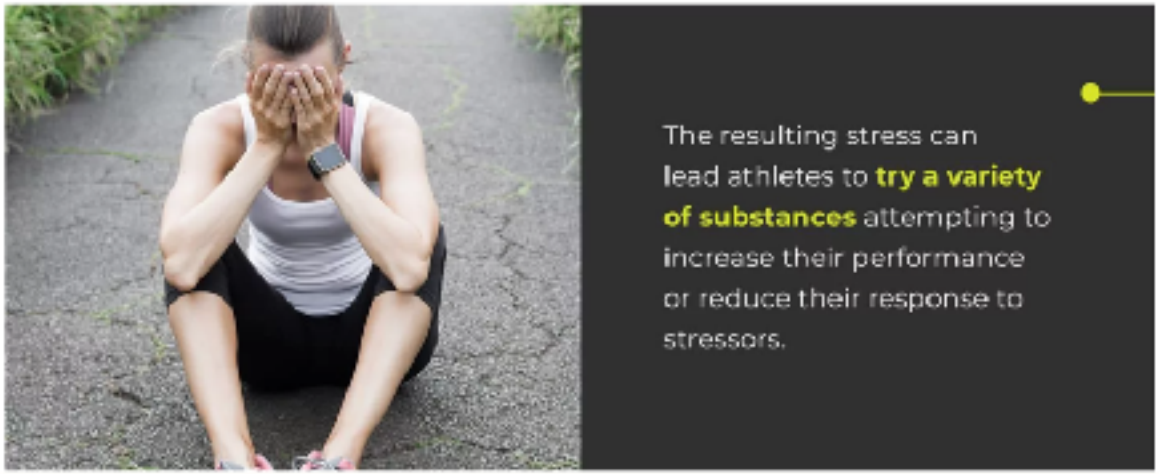
https://addiction.surgeongeneral.gov/key-findings/health-care-systems
Shaprio, Brad, M.D., et. al. "A Primary Care Approach to Substance Misuse." American Family Physician. July 15, 2013. https://www.aafp.org/afp/2013/0715/p113.html

Sports Medicine

Athletes at all levels and of all ages are susceptible to injury. The treatment method for those injuries can sharply increase the potential for addiction to prescription painkillers.

The most recent research from the National Collegiate Athletic Association sheds some light on how many athletes use drugs in the association:

- 44% of male student-athletes and 33% of female student-athletes reported binge drinking
- 22% of student-athletes reported past-year marijuana use
- 23% of student-athletes reported using pain medication in the past year



Sports, Drugs, and Addiction. Gateway Foundation. December 16, 2019. https://www.gatewayfoundation.org/addiction-blog/athletes-drug-abuse/

What Can You Do?

Uniquely Positioned

SUD and Healthcare

- In all likelihood, your patient panel includes one or more individuals with opioid use disorder (OUD), though you may not be aware of it — many people go to great lengths to hide their addiction.
- Only about 1 in 10 people with a SUD receive any type of specialty treatment. The great majority of treatment has occurred in specialty substance use disorder treatment programs with little involvement by primary or general health care. However, a shift is occurring to mainstream the delivery of early intervention and treatment services into general health care practice.
- Primary care physicians, especially those in family medicine, know many of their patients very well and have established a long-term relationship. That can be advantageous when a patient begins to show signs of a substance use disorder.
- Supported scientific evidence indicates that substance misuse and substance use disorders can be reliably and easily identified through screening and that less severe forms of these conditions often respond to brief physician advice and other types of brief interventions.
- Once the physician and patient have had a conversation about substance use and have determined that it would be best to seek treatment, the primary care setting can be a great place for that treatment to occur. Some patients feel more comfortable when their substance use disorder is treated in the same way as any other medical condition, which can also reduce the stigma.

Parks, Troy. “Treating substance use disorder as a family physician.” American Medical Association. August 17, 2016, https://www.ama-assn.org/delivering-care/opioids/treating-substance-use-disorder-family-physician

Self-Reflection

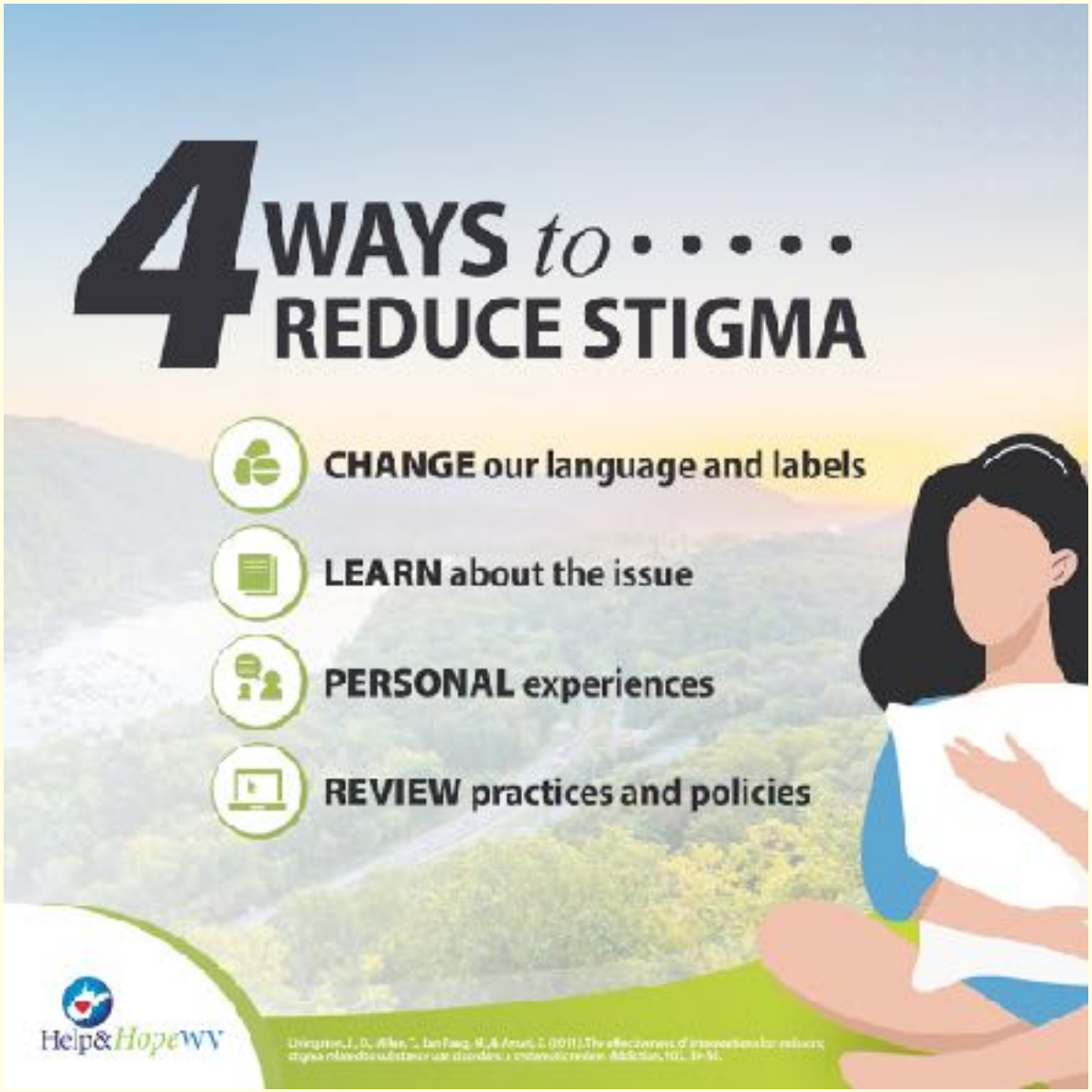
How do your beliefs about addiction impact your personal thoughts and actions?

How do your beliefs about addiction impact your workplace?

How do your beliefs about addiction impact your community?

What words do you commonly use when referring to someone struggling with addiction?

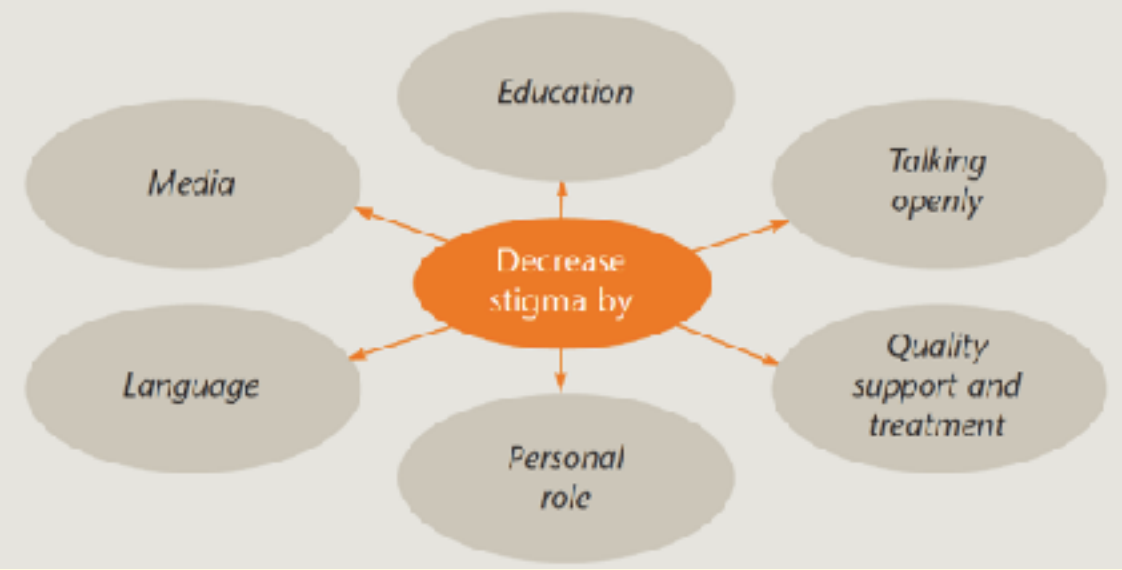
Stigma Reduction



Language as the Platform

Words Matter

- Small changes in language can influence how you perceive others and how they perceive themselves
- Use person-centered language
- Adjust your everyday usage and it will become more natural
- People are always listening, especially if they are assessing your ability to be a helper



Avoiding Stigmatizing Language

"Research shows that the language we use to describe this disease can either perpetuate or overcome the stereotypes, prejudice and lack of empathy that keep people from getting treatment they need. Scientific evidence demonstrates that this disease is caused by a variety of genetic and environmental factors, not moral weakness on the part of the individual. Our language should reflect that."

- Michael Botticelli, former Director of the White House Office of National Drug Control Policy (ONDCP) (2017)

Language Guidelines

Specifically, we make an appeal for the use of language that:

1. Respects the worth and dignity of all persons ("people-first language")
2. Focuses on the medical nature of substance use disorders and treatment
3. Promotes the recovery process
4. Avoids perpetuating negative stereotypes and biases through the use of slang and idioms (Broyles, Binswanger, Gordon, et al., 2014)

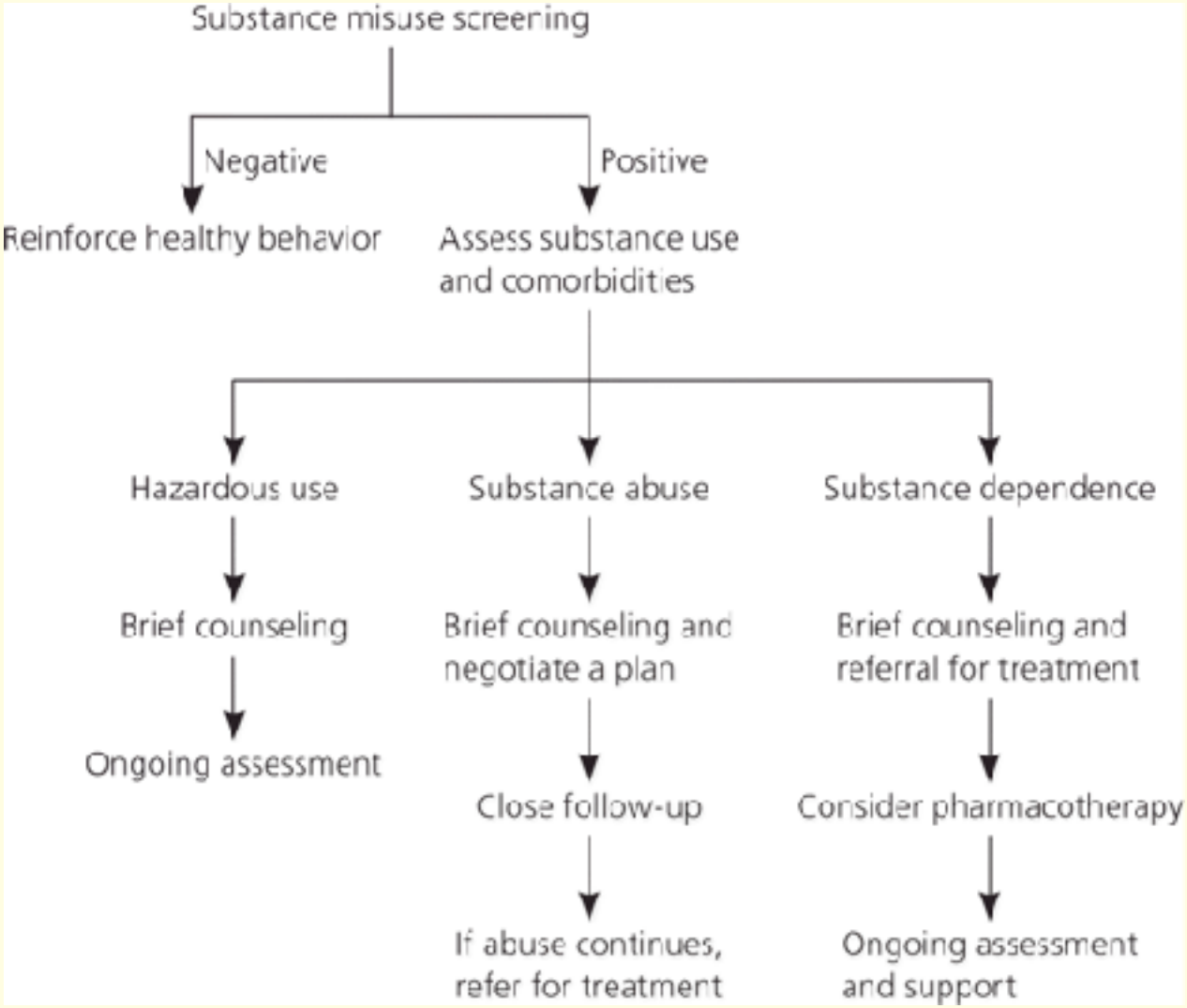
Reject “Substance Abuse”

Frame addiction as “substance abuse” and it is easy to see why it should be a crime, but call it “substance use disorder” and it sounds like something to be treated medically.

Szalavitz, 2014

Person-Centered Language

Screening & Intervention



https://addiction.surgeongeneral.gov/key-findings/health-care-systems

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MI Principles for Physicians

Principle/technique	Rationale	Less effective approach	More effective approach
Resist the righting reflex	Physicians want patients to change or correct unhealthy behaviors. Telling them to do so is a natural reflex, but it can generate resistance in patients. Instead, help them generate their own argument for healthy changes.	Physician: "You need to stop using cocaine. It's damaging your heart." Patient: "I don't think it's the cocaine. My friends use cocaine too, and they don't have heart problems."	Physician: "How does it feel when you hear that cocaine may be causing your chest pain?" Patient: "I don't know what to think about it, but it's got me thinking."
Understand the patient's motivations	Patients are more likely to change for reasons that they value highly. By eliciting these reasons, physicians can be more effective.	Physician: "Now that you are pregnant, you need to stop abusing pain pills for your developing baby." Patient: "I'll do the best I can."	Physician: "Is there anything about your use of pain pills that you are concerned about?" Patient: "Yes, my husband told me he would leave me if I started taking pain pills again."
Listen to the patient	Physicians need to listen to patients to find the best path to behavior change.	Physician: "I'm going to refer you to a special program for people with addiction to pain pills." Patient: "I told you [illegible], drug treatment isn't for me."	Physician: "We talked a little about some possible treatment options, but I'm interested in hearing what you think would work for you." Patient: "I won't go to drug treatment, but if there is a medicine I could take that would help me stop, I would do that. Also I used to go to NA, and that seemed to help."
Empower the patient	Physicians can help patients take an active role in their health care and support self-efficacy.	Patient: "I almost didn't come in to see you. I just can't stop using cocaine." Physician: "Did you go to the NA meetings and see a therapist like we discussed?"	Patient: "I almost didn't come in to see you. I just can't stop using cocaine." Physician: "Quitting cocaine is difficult for most people, and I've been impressed by how hard you have worked to cut back."
Elicit-provide-elicit	A nonconfrontational approach to advice or information giving that allows the patient to express his or her feelings about change and assists the physician in assessing readiness for change.	Physician: "Using cocaine can cause heart attacks. You are putting yourself at risk each time you use, and you need to stop."	**Elicit knowledge and opinions:** Physician: "What do you know about how cocaine affects your health?" Patient: "Well, some people get holes in their noses, but I don't use that much, so I don't think it's a big issue." **Provide tailored information and advice:** Physician: "I'm glad you haven't used enough to have that problem. You might be surprised to know that even small amounts of cocaine increase your risk of heart attack, stroke, and high blood pressure. Sometimes people have heart attacks from using cocaine just one time." **Elicit response and feelings:** Physician: "How does that new information strike you?" Patient: "I don't know, I guess it might be more dangerous than I thought."
Decision analysis ("pros and cons")	Physicians can help patients make changes by articulating the advantages and disadvantages of the changes.	Physician: "Don't you see that your cocaine use is hurting your whole family?" Patient: "What do you know about my family?"	Physician: "What do you like about using cocaine?" Patient: "It helps me forget all the things that are bothering me, and it gives me energy to get things done." Physician: "And what do you not like about cocaine use? What makes you think about stopping?" Patient: "I don't want my kids to see me high, and it's definitely starting to get in the way of work. I'll have to stop someday or it will be hard to keep this job."
Reflections	Physicians can identify statements that the patient makes in support of change and reflect them back to the patient, highlighting the patient's reasons for change.	Patient: "I don't want to be using cocaine when I'm 80. That would be crazy." Physician: "So why don't you stop?" Patient: "I'm just not ready yet, OK?"	Patient: "I don't want to be using cocaine when I'm 80. That would be crazy." Physician: "You want to stop using cocaine someday." Patient: "Yes, I do. I guess the question is when."
Affirmations	Most patients with substance abuse and dependence feel guilt and shame about their drug use, and may lack confidence that they can make changes. Physicians can promote self-efficacy with honest and meaningful affirmations.	Patient: "I can't believe I relapsed again. It's so frustrating." Physician: "You've just got to get up and try again."	Patient: "I can't believe I relapsed again. It's so frustrating." Physician: "You're frustrated, but the fact that you came back to talk about it tells me that you're determined. You've quit before, and I'm confident you can do it again."

Shaprio, Brad, M.D., et. al. "A Primary Care Approach to Substance Misuse". American Family Physician. July 15, 2013. https://www.aafp.org/afp/2013/0715/p113.html

Treatment and Recovery

SUD Status and Care Continuum

Positive Physical, Social, and Mental Health	Substance Misuse	Substance Use Disorder
A state of physical, mental, and social well-being, free from substance misuse, in which an individual is able to realize his or her abilities, cope with the normal stresses of life, work productively and fruitfully, and make a contribution to his or her community.	The use of any substance in a manner, situation, amount, or frequency that can cause harm to the user and/or to those around them.	Clinically and functionally significant impairment caused by substance use, including health problems, disability, and failure to meet major responsibilities at work, school, or home; substance use disorders are measured on a continuum from mild, moderate, to severe based on a person's number of symptoms.

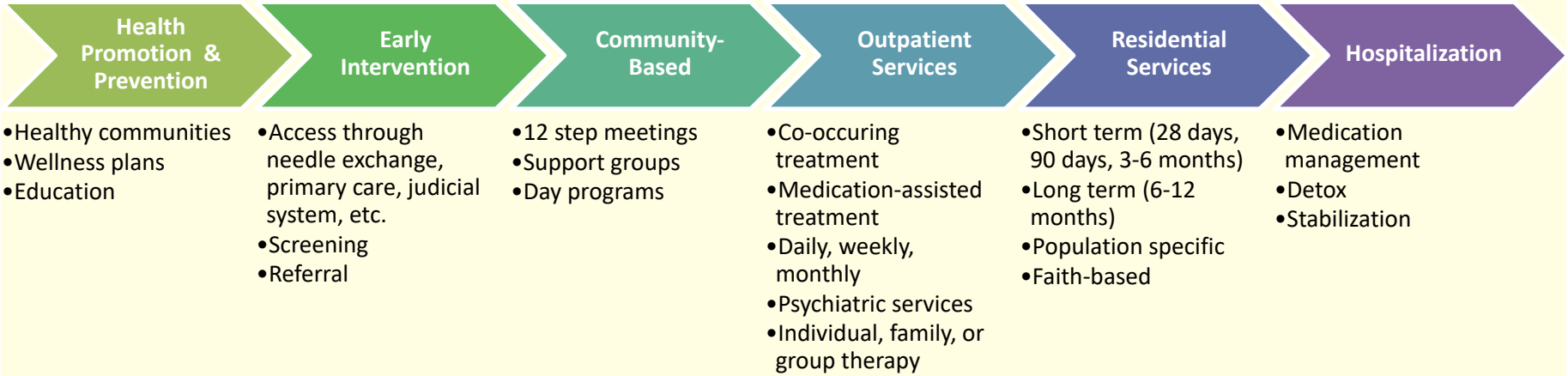
Substance Use Status Continuum

Substance Use Care Continuum

Enhancing Health	Primary Prevention	Early Intervention	Treatment	Recovery Support
Promoting optimum physical and mental health and well-being, free from substance misuse, through health mmunications and access to health care services, income and economic security, and workplace certainty.	Addressing individual and environmental risk factors for substance use through evidence-based programs, policies, and strategies.	Screening and detecting substance use problems at an early stage and providing brief intervention, as needed.	Intervening through medication, counseling, and other supportive services to eliminate symptoms and achieve and maintain sobriety, physical, spiritual, and mental health and maximum functional ability. Levels of care include: • Outpatient services; • Intensive Outpatient/ Partial Hospitalization Services; • Residential/ Inpatient Services; and • Medically Managed Intensive Inpatient Services.	Removing barriers and providing supports to aid the long-term recovery process. Includes a range of social, educational, legal, and other services that facilitate recovery, wellness, and improved quality of life.

Continuum of Care

CONTINUUM OF CARE: INTENSITY SPECTRUM OF SERVICES



SAMHSA; http://www.alcoholandcrime.org/the-voice/issues/jun13/Continuum-of-Care-The-Voice-June2013.pdf

Making a Referral

No single treatment is appropriate for all individuals, however, if someone is asking or willing – time is of the essence!

You have a brief window to engage them in services so move quickly to increase chances of success.

Successful treatment must address individual's drug use, medical, psychological, vocational, and legal problems.

https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/what-drug-addiction-treatment

Medication for OUD Saves Lives

Methadone: 3.2x less likely to die in methadone treatment than out of treatment (n=122885, 16 studies)

Buprenorphine: 2.2x less likely to die in buprenorphine treatment than out of treatment (n=15931, 3 studies)

Sordo Luis, Barrio Gregorio, Bravo Maria J, Indave B Iciar, Degenhardt Louisa, Wiessing Lucas et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies BMJ 2017; 357 :j1550

Referral Sources

Overview of Residential Treatment

ASAM Level	Bed Capacity
3.1	344
3.5	594
3.7 (Community)	128
3.7 (Hospital)	36
Total	**1102**

Population	Bed Capacity
Mothers & Children	52
Mothers, Children & Pregnant Women	53
Non-Specific	983
Pregnant Women	14
Total	**1102**

Referral Sources

Overview of Residential Treatment

County	Number of Recovery Residences	Number of Recovery Residences Reporting Bed Capacity	Bed Capacity as of January 2021
Boone	2	1	6*
Cabell	60	53	818*
Greenbrier	2	1	8*
Hampshire	2	2	16
Hancock	1	0	0*
Harrison	4	2	20*
Jackson	1	1	1
Kanawha	52	49	746*
Logan	2	2	32
Mason	4	4	107
McDowell	1	1	8
Mercer	8	7	158*
Mineral	1	1	19
Mingo	3	2	52*
Monongalia	8	5	72*
Ohio	7	6	118*
Raleigh	3	2	25*
Upshur	5	5	39
Wayne	1	1	8
Wirt	1	1	12
Wood	12	8	161*
Wyoming	3	3	35
Total	**183**	**157**	**2461***

*Some recovery residence bed capacity was unknown at the time of this report.

Resources for Treatment Access

- ATLAS - Addiction Treatment Locator Assessment and Standards Platform
- ODCP Treatment and Recovery Resource Map
- HELP4WV

844 HELP4WV
WV's Addiction & Mental Health Helpline

Diversion - Halo Initiative

A compliment to the Angel Initiative, the Halo Initiative provides a second avenue of treatment entry via medical providers and pharmacies. As patients visit their primary care physicians, local medical treatment facilities or their neighborhood pharmacist, they enter a “zero repercussion” fast-track to one of the many regional comprehensive treatment centers for help addressing their addictions.

Goals:

- Address SUD at its source
- Provide fast track entry into comprehensive behavioral health treatment
- Provide zero repercussion SUD referral service to rural areas with limited resources

MOUD Access Expansion

Access to evidence-based addiction care has never been more important.

- Medication for OUD (MOUD) provider expansion
- ED MOUD - linkage to care expansion
- Telehealth for MOUD services
- Quick access to MOUD pilots
- Guidelines on same day MOUD access https://dhhr.wv.gov/office-of-drug-control-policy/news/Pages/MOUD-Guidelines.aspx
- Expansion of coverage of long acting buprenorphine formulations

Naloxone Access Expansion

Standing order update:

- Covers all formulations
- Allows for distribution by community groups

Pharmacy Pilot Program on naloxone education:

To encourage pharmacies to offer naloxone to patients by prompting them with a drug utilization edit in the following circumstances:

- An incoming opioid claim has an Milligram Morphine Equivalent over 50
- A patient is filling any type of medication-assisted treatment (MAT)
- A member is filling a benzodiazepine or a sedative hypnotic and also has a current prescription for an opioid

Continued partnership with University of Charleston School of Pharmacy

Next Steps and Final Thoughts

- Addressing polysubstance use disorder and stimulant use disorder
- Stigma reduction
- Prevention
  - Identification of early risk markers risk for SUD
  - Building residency
  - Creating protective factors
- Using data to inform programming
- Building out the continuum of care
- Evolving payment models
- Local assessments – ODCP regional coordinators, county-based models, telehealth

Recovery from addiction is a lifelong process.

Contact

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