NH BEHAVIORAL HEALTH INTEGRATION LEARNING COLLABORATIVE

Stigma as Discrimination: Impact on Treatment and Strategies for Success

April 1, 2019

REMINDERS

FOR ZOOM CALLERS

- Review sign-on instructions carefully to assure a good audio experience.
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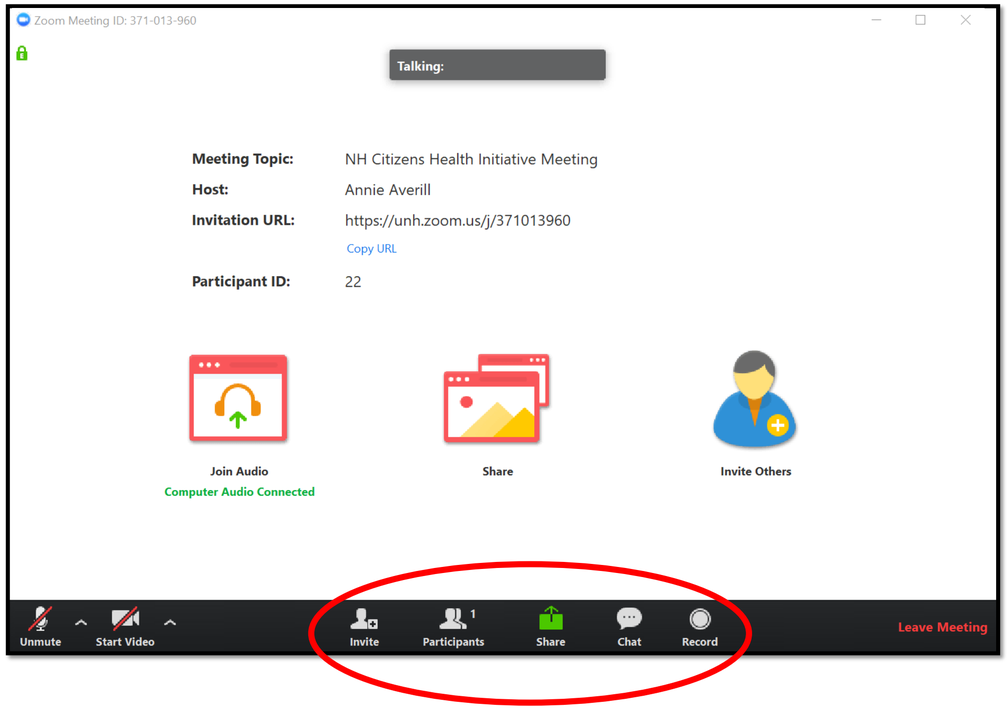
- **Please mute audio**
- **Please note your name**, then add your comment or question

FOR IN-PERSON ATTENDEES

- Please speak towards the microphones

Use the Zoom Mute, Start/Stop Video, and Chat Box if needed



WELCOME

FELICITY BERNARD, LCMHC, MA
Project Director, NH Citizens Health Initiative

AGENDA

WELCOME & INTRODUCTION
Felicity Bernard, LCMHC, MA, NH Citizens Health Initiative

ADDRESSING STIGMA TO IMPROVE THE TREATMENT OF OPIOID USE DISORDER
Lisa Letourneau, MD, MPH, Senior Advisor, Delivery System Change, Maine DHHS

HARM REDUCTION APPROACHES IN ADDRESSING SUBSTANCE USE
Kerry Nolte, PhD, FNP-C, Department of Nursing, University of New Hampshire

QUESTIONS & ANSWERS
Felicity Bernard, LCMHC, MA, NH Citizens Health Initiative

CLOSING REMARKS
Felicity Bernard, LCMHC, MA, NH Citizens Health Initiative

PLANNING & PRESENTER DISCLOSURES

The following individuals have responded that they have nothing to disclose:

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- **Planner: Frederick Kelsey**, **MD, FACP***, retired Medical Director,* Mid State Health Center
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- **Planner: Jill Gregoire, RN, MSN**, *Lead Nurse Reviewer*, North Country Health Consortium
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- **Presenter: Lisa Letourneau, MD, MPH, FACP** Senior Advisor, Delivery System Change, Maine DHHS
- **Presenter: Kerry Nolte, PhD, FNP-C**, Assistant Professor of Nursing, UNH

LEARNING OBJECTIVES

After participating in this activity, learners will be able to:

Recognize the importance of addressing stigma to promote access to and quality of integrated care delivery for patients and families affected by behavioral health (BH) challenges, especially opioid use disorder (OUD).

Summarize current evidence about the etiology and effective treatment of OUD and how stigma can impact delivery of evidence-based care.

Describe strategies to reduce stigma in BH/OUD care delivery such as changes in language and addressing misconceptions about BH/OUD causes and recovery.

FELICITY BERNARD, LCMHC, MA
Project Director, NH Citizens Health Initiative

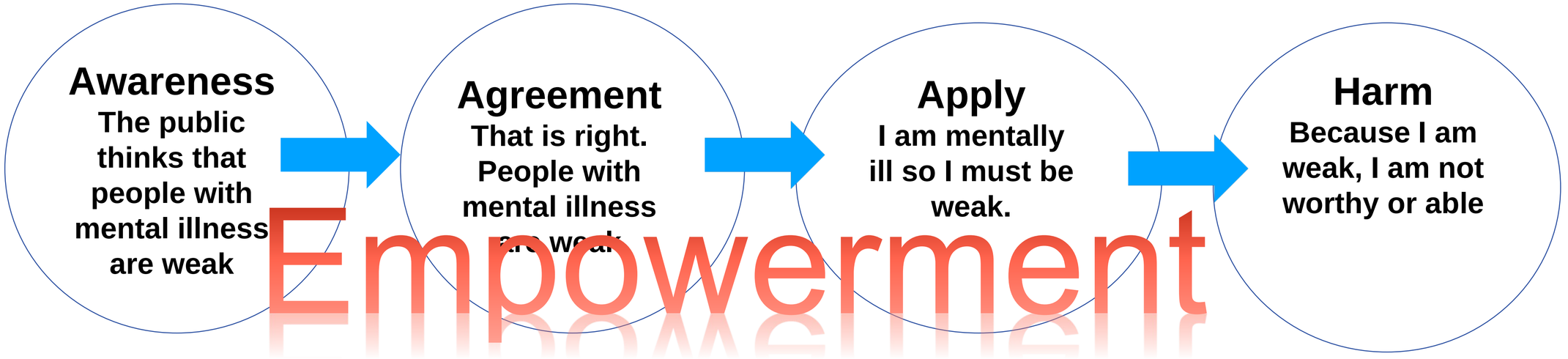
NH CITIZENS HEALTH INITIATIVE

STIGMA

PREJUDICE

DISCRIMINATION

Self - Stigma



SO WHY TRY…

(Corrigan and Rao, 2012)

NH CITIZENS HEALTH INITIATIVE

LISA LETOURNEAU, MD, MPH
Senior Advisor, Delivery System Change, Maine DHHS

Addressing Stigma to Improve the Treatment of Opioid Use Disorder

Lisa M. Letourneau MD, MPH

April 1, 2019

A Tri-State Collaborative Program
Managed by Maine Quality Counts




Disclosures

- No commercial interests

Learning Objectives

1. Understand role of stigma in caring for people with SUD
2. Recognize neurobiology of addiction in treating SUD with chronic disease model
3. Identify role of stigmatizing language and compassion fatigue as potential barriers in caring for people with SUD

Who's Heard?…

- He's just another addict…
- She doesn't deserve another chance…
- You're just substituting one drug for another…
- You're just another drug dealer…
- Is he going to be on Suboxone forever?....
- Medications aren't recovery…

Where You Stand Depends…

Moral Model of Drug Use

- Drugs are bad
- People choose to use drugs
- People who use drugs are bad
- Drug use is moral failure
- People who use drugs can choose to stop
- We can make people stop using drugs if we make their lives uncomfortable (e.g. jail)
- Medications to treat SUD are just trading one addiction for another

Behavioral/Med Model Drug Use

- People learn to use drugs to cope with suffering
- Early exposure & trauma are strongly related to dev of SUD
- SUD alters brain structures & chemistry & becomes med condition
- Physical dependence/cravings with some drugs (e.g. opioids) creates neg cycle of cont'd use
- Medications are effective in treating SUD; abstinence only is often ineffective

Current State of Affairs: Do Clinicians…

- Think SUD is different from other chronic conditions because using substances is a choice?
- Think treatment with opioid agonist is replacing one drug w/ another?
- Feel people who use drugs are committing crime & deserve punishment?

Current State of Affairs?

- 31% felt SUD is different from other chronic conditions because using substances is a choice
- 14% thought treatment with opioid agonist is replacing one drug w/ another
- 12% said people who use drugs are committing crime & deserve punishment

Wakeman S et al, Attitudes, practices & preparedness to care for SUD: Results from survey general internists, *Sub Abuse,* 2016

Stigma

- Strong feelings of disapproval or disgrace that sets a person apart from others
- Associated with negative attitudes & beliefs
- Can lead to negative actions, discrimination
- Self-stigma also significant challenge in SUD

Stigma & SUD: Many Targets

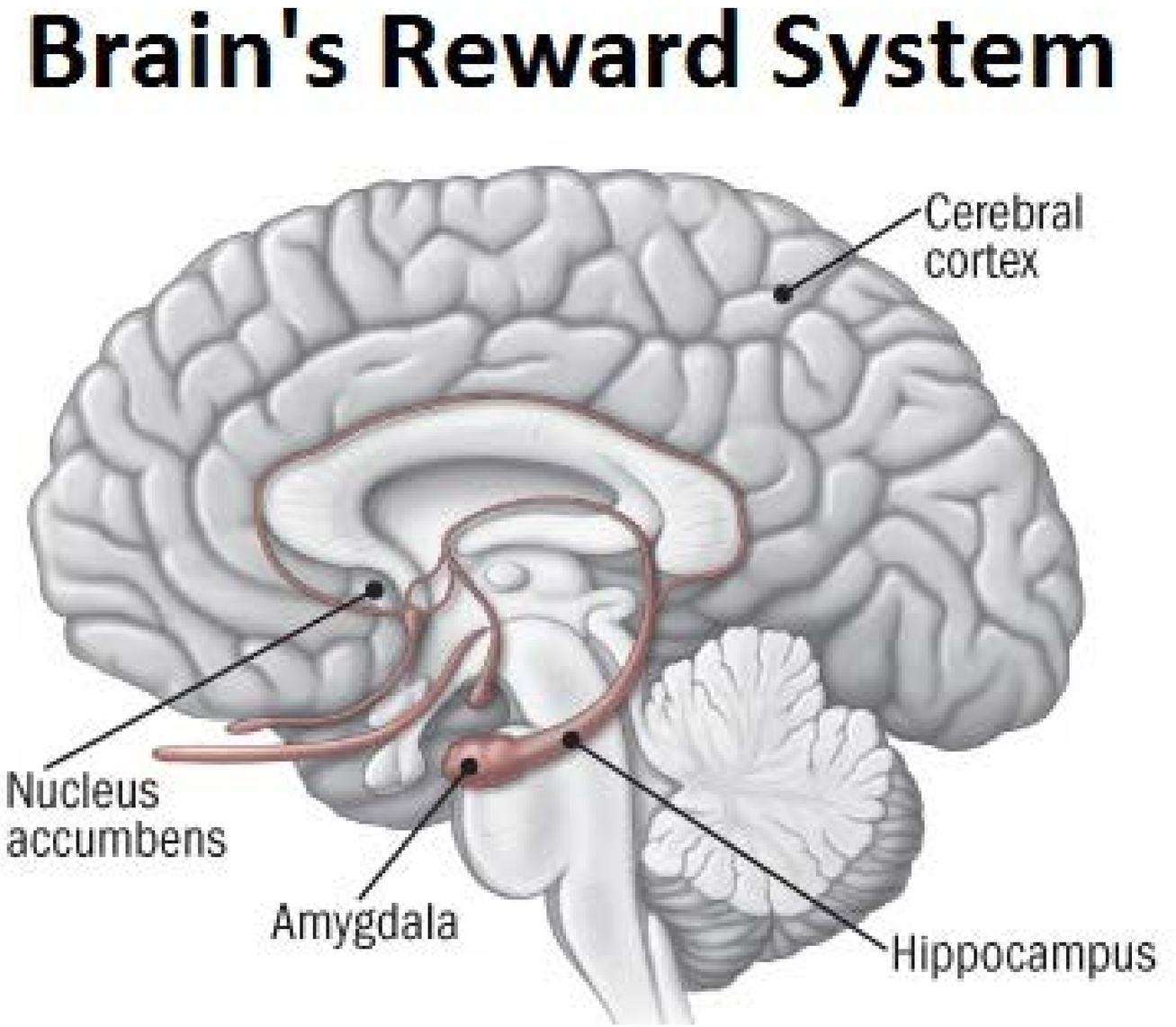
- The person
- The disease
- The treatment
- Overdose rescue
- The “right” pathway to recovery…

Neurobiology of Addiction

- Stages of addiction:
  - Use/ binge → intoxication, dopamine release ("reward system")
  - Withdrawal → negative effect
  - Preoccupation / anticipation → pursuit
- Addiction changes brain structures & neurochemistry, resets brain's reward system
- Depicting addiction:

[Nuggets]

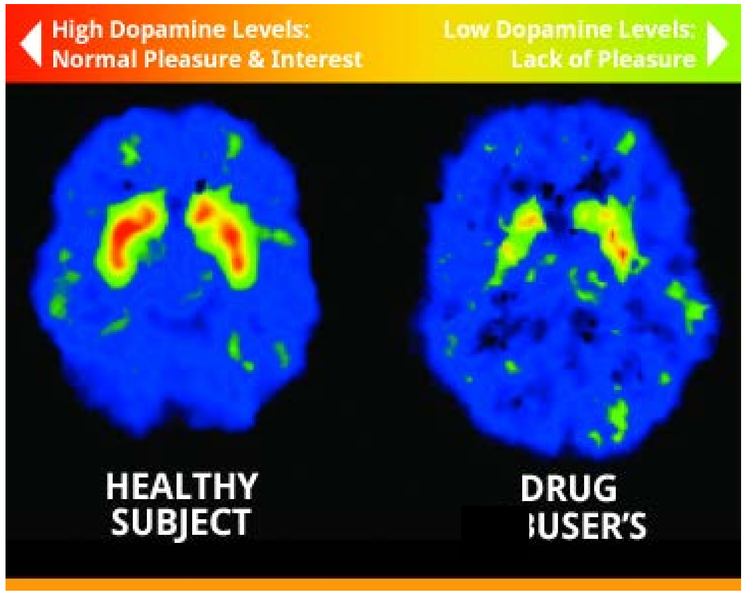
Anatomy of Addiction



www.drugabuse.gov

Neurobiology of Addiction

- Addiction changes brain structures, brain chemistry
- Resets brain's reward system
  - Over time, drug consumption triggers less dopamine, more reactivity to stress, negative emotions
- Changes disrupt…
  - Executive functioning
  - Decision making
  - Self-regulation



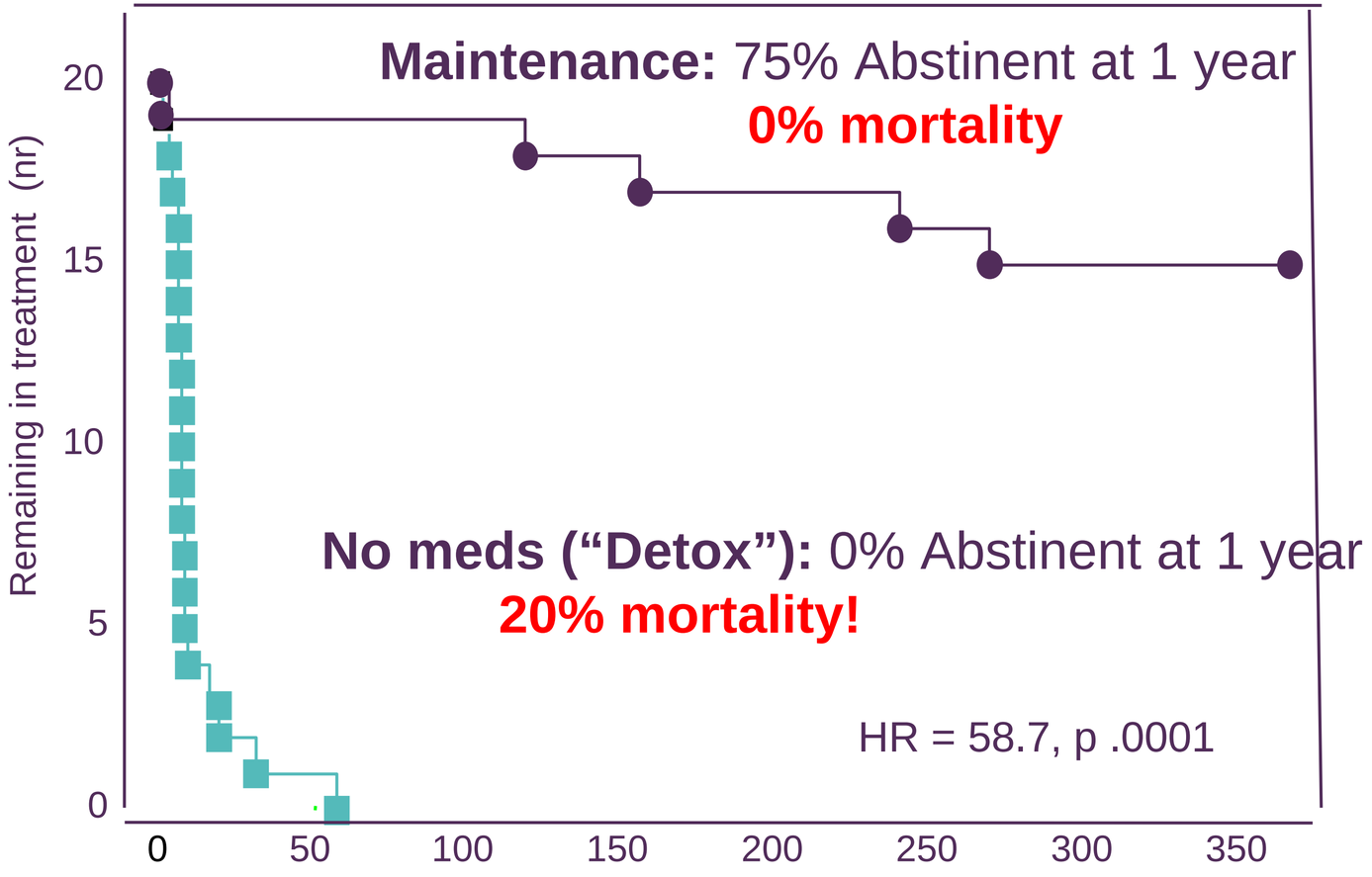
SUD Treatment with Medications (MAT) Works, AND Still Greatly Underused

- Strong evidence for effectiveness of medications for OUD treatment - i.e. methadone, buprenorphine, naltrexone
  - Save lives, decreases OD deaths
  - Reduce harm from illicit drug use
  - Reduce craving, allowing more focus on recovery
  - Decrease risk of relapse, increases rates of recovery
- AND, strong evidence that MAT still widely under-utilized – in Maine & nationally

FDA-Approved Medications for OUD

- **Methadone**
  - Opioid agonist, FDA-approved since 1971
  - Can only be administered by federally-recognized “Opioid Treatment Program” (OTP/methadone clinic)
- **Buprenorphine**
  - Partial opioid agonist, FDA-approved in2002
  - Can be administered in office-based treatment programs by prescribers with DEA X-waiver or OTP
  - Can be prescribed X3 doses by any DEA licensed physician
- **Naltrexone**
  - Opioid antagonist/blocker, FDA-approved in 1984 (tabs), 2010 (IM)
  - Can be administered by any prescribing clinician
  - Available as IM, tablet (poor adherence, not widely used)

“Abstinence” vs. Buprenorphine



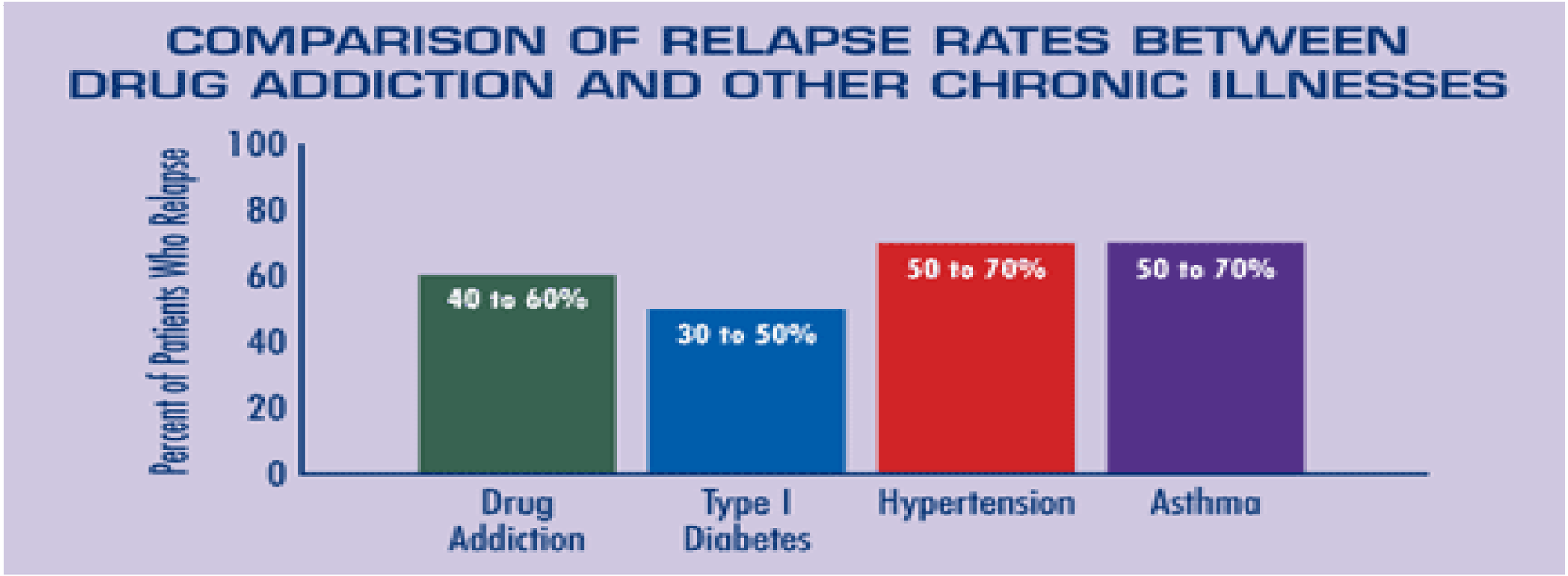
Kakko, Lancet 2003

Defining Addiction

- "A chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences
- Considered brain disease because drugs change the brain… structure and how it works… that can be long lasting and lead to many harmful, self-destructive behaviors"*

*NIH National Institute of Drug Abuse

Addiction is Chronic Disease



JAMA, 284:1689-1695, 2000

Does Language Matter?

- Randomized trial used case vignettes test impact of specific language on clinicians' assessment of pts
- Using "substance abuse" vs. "SUD" strongly correlated with negative clinician beliefs - i.e.
  - Individuals personally culpable for their disease
  - Punitive measures should be taken
- Many words can trigger negative associations – e.g.
  - Relapse vs. recurrence of use
  - Pharmacotherapy vs. Medication Assisted Therapy

Kelly J, et al, "Does it matter how we refer to individuals with substance-related conditions A randomized study of two commonly-used terms, *Interntl Journ Drug Policy,* 2010.

Ashford RD, et al, "Substance use, recovery, & linguistics: The impact of words on explicit and implicit bias", *Drug & Alcohol Dependence,* 2018.

Language Matters

SAY THIS	NOT THAT
Person with a substance use disorder	Addict, junkie, druggie
Person in recovery	Ex-addict
Person living with an addiction	Battling/suffering from an addiction
Person arrested for a drug violation	Drug offender
Chooses not to at this point	Non-compliant / bombed out
Medication is a treatment tool	Medication is a crutch
Had a setback	Relapsed
Maintained recovery	Stayed clean
Positive drug screen	Dirty drug screen

IN YOUR CONVERSATIONS

Frame the conversation as a health issue

❖

Use examples of people who have reached long-term recovery

❖

Discuss the fact that people can and do change.

❖

Share Hope!

☑ USE	☒ DON'T USE
Person who uses drugs	Drug user
Person with non-problematic drug use	Recreational, casual, or experimental users
Person with drug dependence, person with problematic drug use, person with substance use disorder; person who uses drugs (when use is not problematic)	Addict; drug/substance abuser; junkie; dope head, pothead, smack head, crackhead etc.; druggie; stoner
Substance use disorder; problematic drug use	Drug habit
Has a X use disorder	Addicted to X
Abstinent; person who has stopped using drugs	Clean
Actively uses drugs; positive for substance use	Dirty (as in "dirty screen")
Respond, program, address, manage	Fight, counter, combat drugs and other combatant language
Safe consumption facility	Fix rooms
Person in recovery, person in long-term recovery	Former addicts; reformed addict
Person who injects drugs	Injecting drug user
Opioid substitution therapy	Opioid replacement therapy

QC Substance Use Conversation Guide

- Effort to address stigma by improving care conversations
- Promotes…
  - Language that promotes self-esteem and self-efficacy
  - Use of motivational Interviewing to engage patients with SUD
  - Use of scripting to support better conversations
  - Coordination of treatment providers
- Suggested uses:
  - Introduce in staff meetings
  - Laminate tools and hang in break rooms
  - Identify practice team to pilot scripts

Sample Scripts

3) Office Visit Conversations Specific to Health Risks

Situation	Provider Response
Communicating that a procedure may be affected by substance use	"When I do this procedure, I want to be sure you will have the best possible outcome. My worry is that there are signs that your procedure may be complicated by (substance x) use. I'd like to explain what these signs are and have you weigh in so we can best plan your procedure."
High health risks of using a substance	"Based on the screening results, you are at high risk of having a substance use disorder. It is medically in your best interest to stop your use of (substance X). I am concerned that if you do not make a change, the consequences to your health may be serious."
Moderate health risks of using a substance	"Based on the screening results, you are at moderate risk of having or developing a substance use disorder. It is medically in your best interest to change your use of (substance x)."
Low health risks of using a substance	"Your screening results show you are unlikely to have a substance use disorder. However, people with any history of substance use can be at some risk of developing a disorder especially in times of stress or if they have just started to use recently. It is impossible to know in advance whether or not a person who will develop a severe substance use disorder. As your health provider, I encourage you to only use alcohol moderately (e.g. # number of drinks a week) and avoid using other substances"

Addressing Compassion Fatigue

- Use the team
- Have a partner
- Build in time for relationship
- Use trauma-informed approaches
- Celebrate the victories (recovery is energizing!)
- Recognize the humanity in everyone

Obituary: Madelyn Linsenmeir, 1988-2018

"Our beloved Madelyn Ellen Linsenmeir died on Sunday, October 7. While her death was unexpected, Madelyn suffered from drug addiction, and for years we feared her addiction would claim her life. We are grateful that when she died, she was safe and she was with her family…

…If you are reading this with judgment, educate yourself about this disease, because that is what it is. It is not a choice or a weakness. And chances are very good that someone you know is struggling with it, and that person needs and deserves your empathy and support.

If you work in one of the many institutions through which addicts often pass — rehabs, hospitals, jails, courts — and treat them with the compassion and respect they deserve, thank you. If instead you see a junkie or thief or liar in front of you rather than a human being in need of help, consider a new profession."

https://www.sevendaysvt.com/vermont/madelyn-linsenmeir-1988-2018/Content?oid=21797604

What if We Treated Diabetes Like Addiction?

Would we…

- Imply (or say) that poor lifestyle choices have caused the disease?
- Say elevated blood glucose makes blood “dirty”?
- Plan to treat with insulin for only 2 years, then insist on changing lifestyle enough to taper off?
- Or… decline to treat at all?
- Insist that patients must go to diabetes education classes to continue treating them?
- Discharge patients from treatment if they choose to eat poorly, don’t lose weight, and/or have a persistently high blood sugar?

Busting the Myths

- SUD/OUD is hopeless – there's no point in treating it
  - SUD/OUD is chronic condition that responds to tx
  - Recovery is possible
- I/We don't believe in MAT
  - Evidence is strong for effectiveness of MAT
  - This is science, not a religion
- Isn't it just substituting one drug for another?
  - Recognize huge difference between addiction and physical dependence
  - SUD tx/MAT allows people to return to functional lives

Changing Hearts & Minds

- The illness is not the person
  - Remember the humanity in everyone
  - No one would choose a life of addiction
  - This could be your son or daughter
- Treatment works & recovery is possible
  - Evidence for MAT effectiveness better than most other chronic conditions we treat

Addiction as Chronic Disease

- Comments?
- Questions?
- Suggestions?

NNE-PTN Organizational Partners

Maine Quality Counts
Better Health Care. Better Health.

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Jeanne Ryer, MS

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ENGLAND ON NETWORK
NNE PTN

KERRY NOLTE, PHD, FNP-C

Assistant Professor of Nursing, University of New Hampshire

Harm Reduction Approaches in Addressing Substance Use

University of New Hampshire
College of Health and Human Services
Nursing

NHHRC
NH Harm Reduction Coalition

NH Citizens Health Initiative

Institute for Health Policy and Practice

Presented By:

KERRY NOLTE, PhD, FNP-C

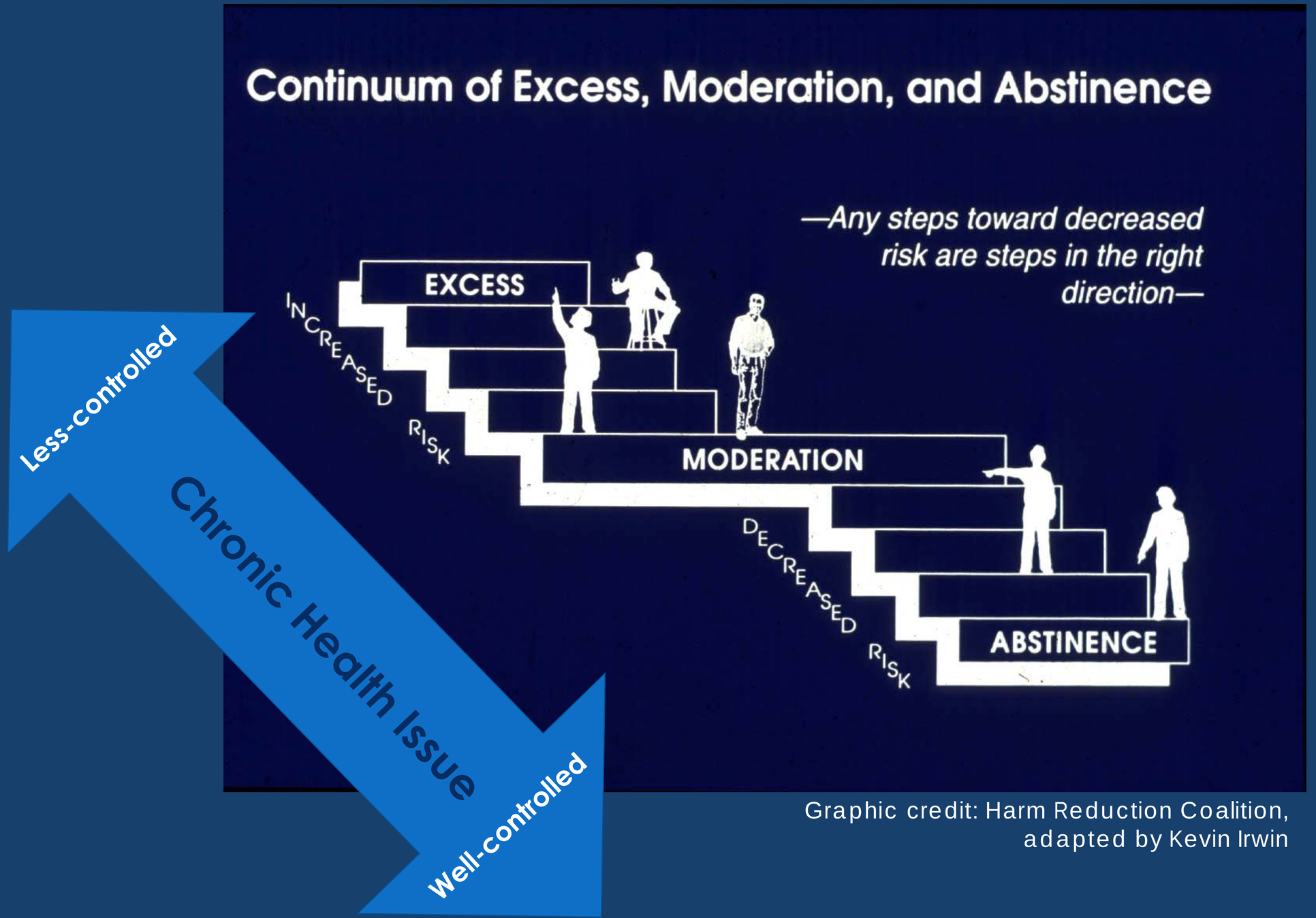
Disclosures

The following individuals have responded that they have nothing to disclose:

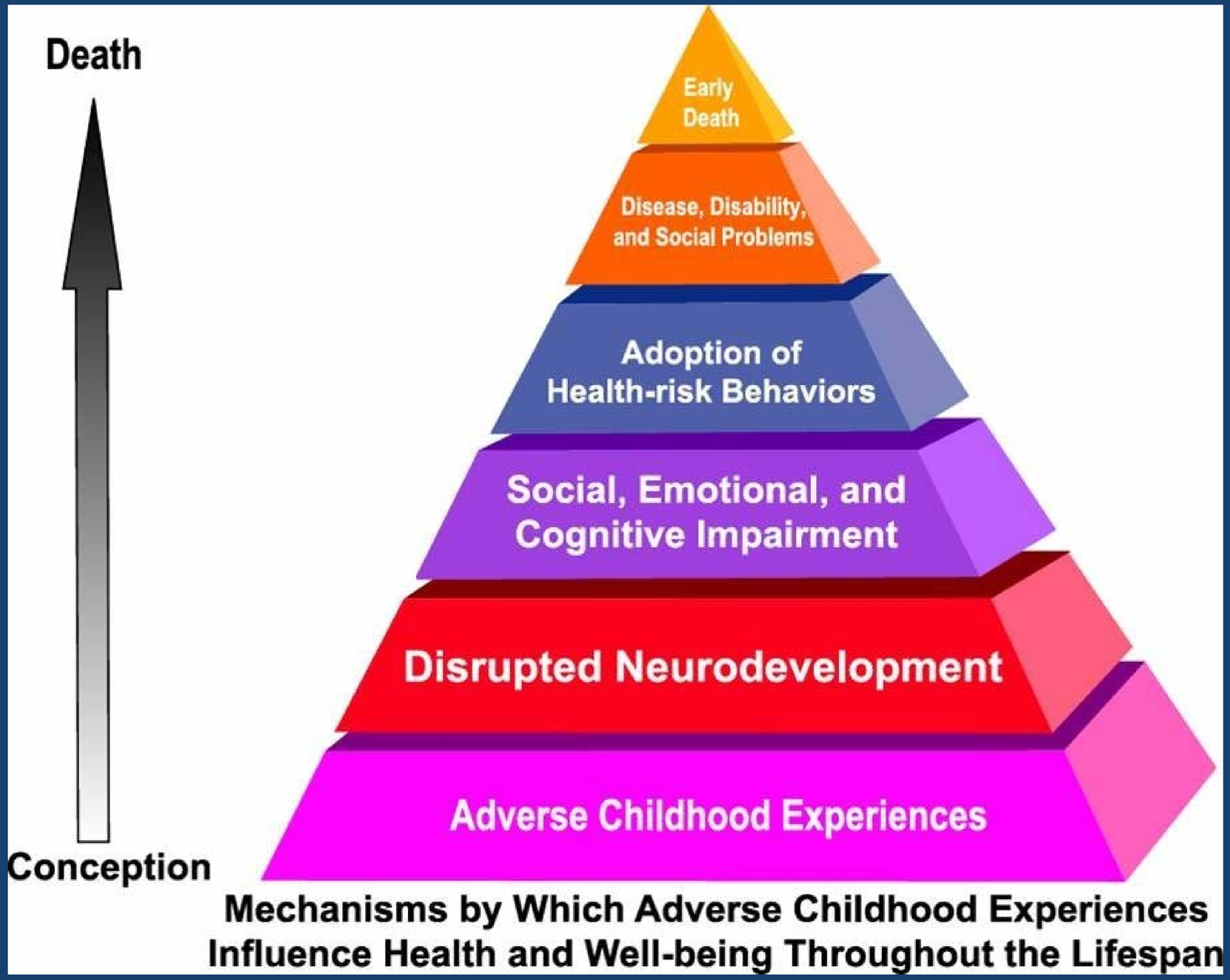
- **Kerry Nolte**

Objectives

- Recognize multiple pathways into substance use and into recovery
- Describe harm reduction approaches to effectively support people who use drugs

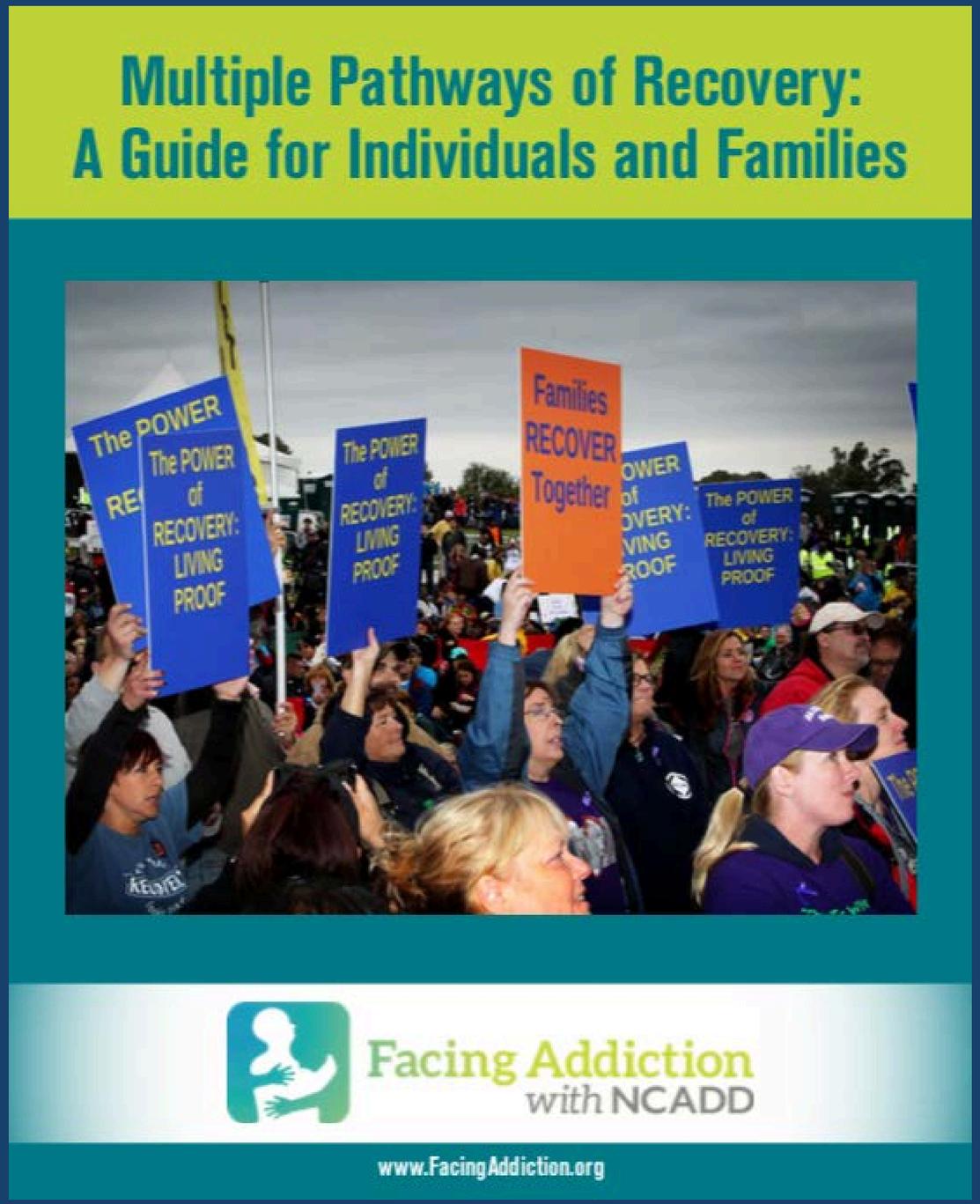


Graphic credit: Harm Reduction Coalition, adapted by Kevin Irwin



Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Image Source: https://aabeyondbelief.org/2018/12/09/the-multiple-pathways-to-addiction-and-recovery/



Mutual Support

- 12 Step Fellowships (Gamblers Anonymous, Narcotics Anonymous, Alcoholics Anonymous)
- Celebrate Recovery
- Faith Based Recovery
- Fit 2 Recover
- Life Ring Secular Recovery
- Moderation Management
- Nature & Buddhism
- Phoenix Multisport
- Red Road to Wellbriety
- SMART Recovery
- Volunteerism
- Women for Sobriety
- Yoga

Medication Assisted Recovery

- Methadone
- Buprenorphine
- Naltrexone
- Acamprosate
- Disulfiram
- Functional Medicine, NTR, and Nutrient Therapies

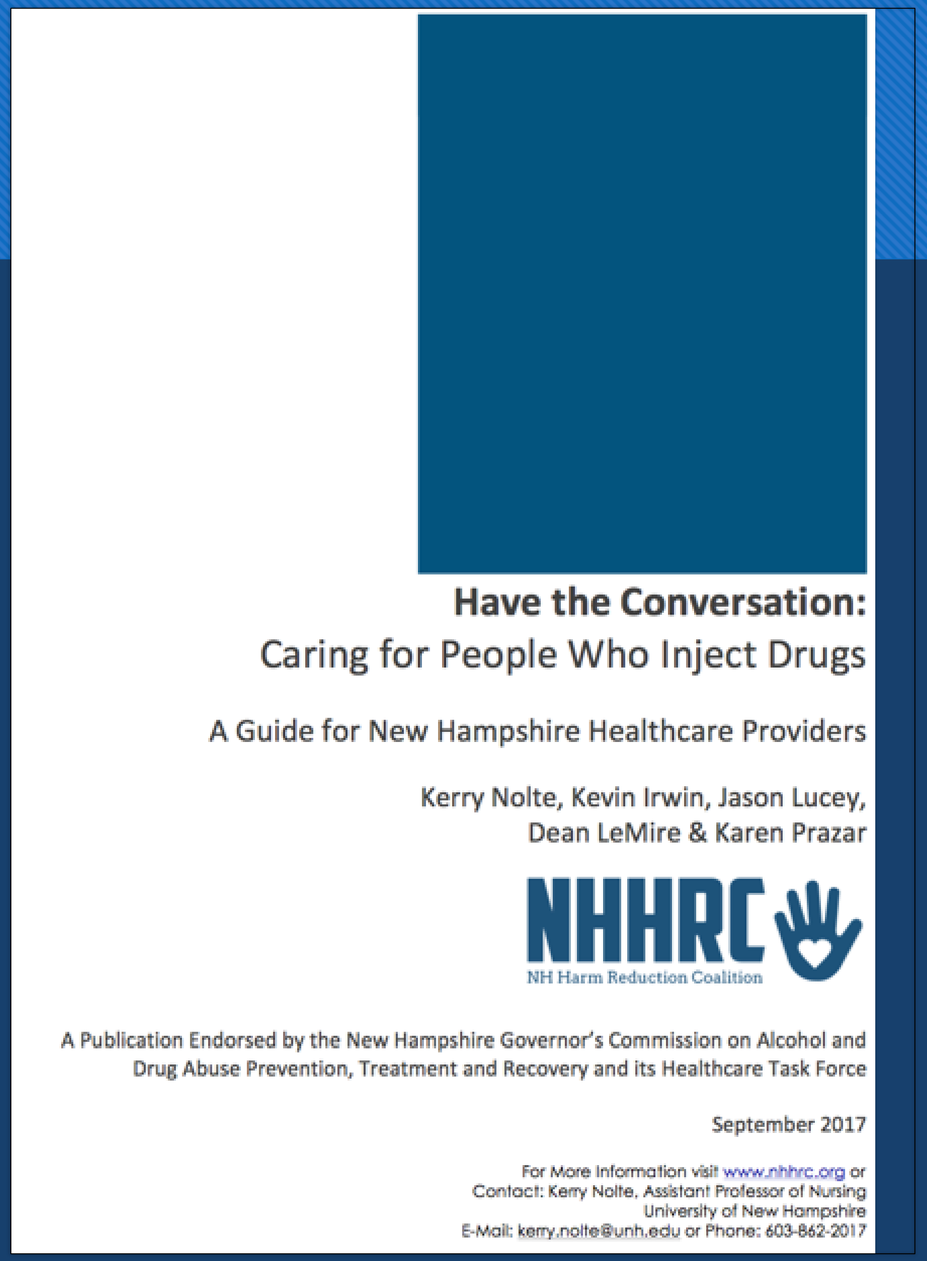
A Continuum of Substance Use

Adapted Graphic credit: Kevin Irwin

Reframing the Starting Point: Engagement in Care

- Acceptance
- Provider Humility
- Curiosity to Learn About SUD

➔ Supportive and Pragmatic Conversation



Less About What You Say

More About Your Approach

Every Interaction Can Be An Opportunity to Engage

- Client goals are most likely be achieved
- Untimely push for abstinence only goals is likely to result in lower engagement
- Goal: provide support and resources for client's self defined goals
- PWUD are interested and capable of making changes to improve health and safety
  - Safety messages shared could be rapidly spread through a social network
- Recognize and support readiness to change, whether safer injecting or recovery

LOCATING HARM

Drug

The drug itself: what it does and how potent it is
What it is cut with
How it is used: smoke, snort, absorbed, swallowed, injected
Whether it is illegal or legal

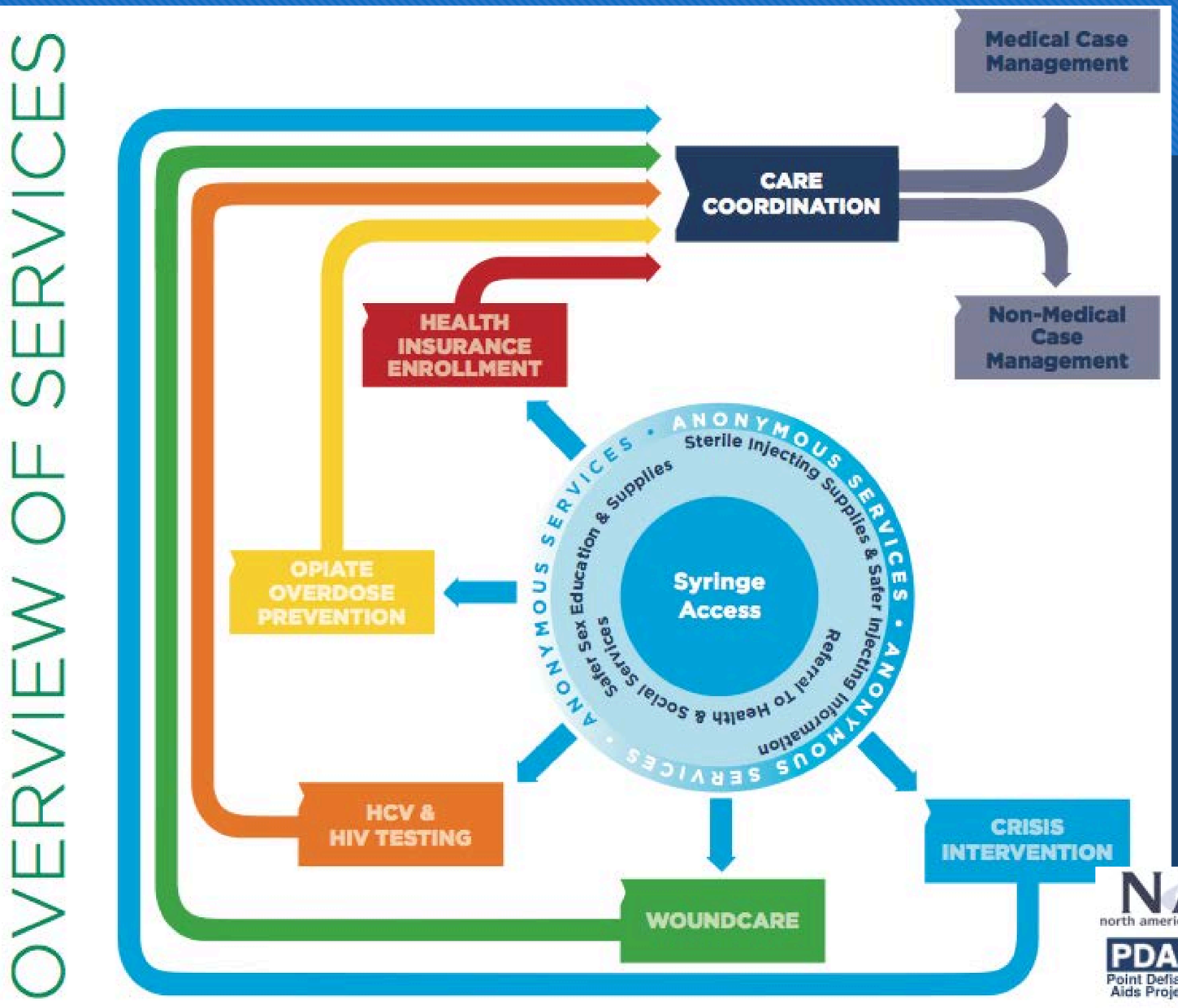
Set

Person's unique physiology
Person's physical health
Person's mental or emotional state
Person's cultural identity, culture of origin, sense of belonging
Expectation of the drug and motivation for using the drug

Setting

Stressors in a person's life: Social, Economic, Environmental
Support in PWUD's life
With whom and where a person uses
Social and cultural attitudes toward the drug and its users

Syringe Service Program Engagement



NASEN
north american syringe exchange network

PDAP
Point Defiance Aids Projects

WASSP
Washington Syringe Service Programs

Evidence for Syringe Service Programs and Harm Reduction

How Do SSPs Benefit Communities and Public Safety?

SSPs Increase Entry Into Substance Use Disorder Treatment:

SSPs **reduce drug use**. People who inject drugs (PWID) are 5 times as likely to enter treatment for substance use disorder and more likely to reduce or stop injecting when they use an SSP.

SSPs Reduce Needlestick Injuries:

SSPs **reduce needlestick injuries** among first responders by providing proper disposal. One in three officers may be stuck with a needle during their career. Increasing safe disposal also protects the public from needlestick injuries. SSPs do not increase local crime in the areas where they are located.

SSPs Reduce Overdose Deaths:

SSPs **reduce overdose deaths** by teaching PWID how to prevent and respond to drug overdose. They also learn how to use naloxone, a medication used to reverse overdose.

3,600 HIV Diagnoses Among PWID In 2015:

SSPs **reduce new HIV and viral hepatitis infections** by decreasing the sharing of syringes and other injection equipment. About 1 in 3 young PWID (aged 18–30) have hepatitis C.

Prevention Saves Money:

SSPs **save health care dollars** by preventing infections. The estimated lifetime cost of treating one person living with HIV is more than $400,000. Testing linked to hepatitis C treatment can save an estimated 320,000 lives.

SSPs DON'T INCREASE DRUG USE OR CRIME.

Safer Supplies

- Ask: “Are you able to get clean supplies (needles, cookers, cottons)?”
  - If needles have to be reused, HCV can be reduced and HIV eliminated with bleach.[7]
    - Risk dramatically reduced with rinsing 3 times with water
  - Advise using clean, single use works
    - Cottons, cookers, and clean water (sterile)

DISCERNNE Preliminary Results

Drug Injection Surveillance and Care Enhancement for Rural Northern New England

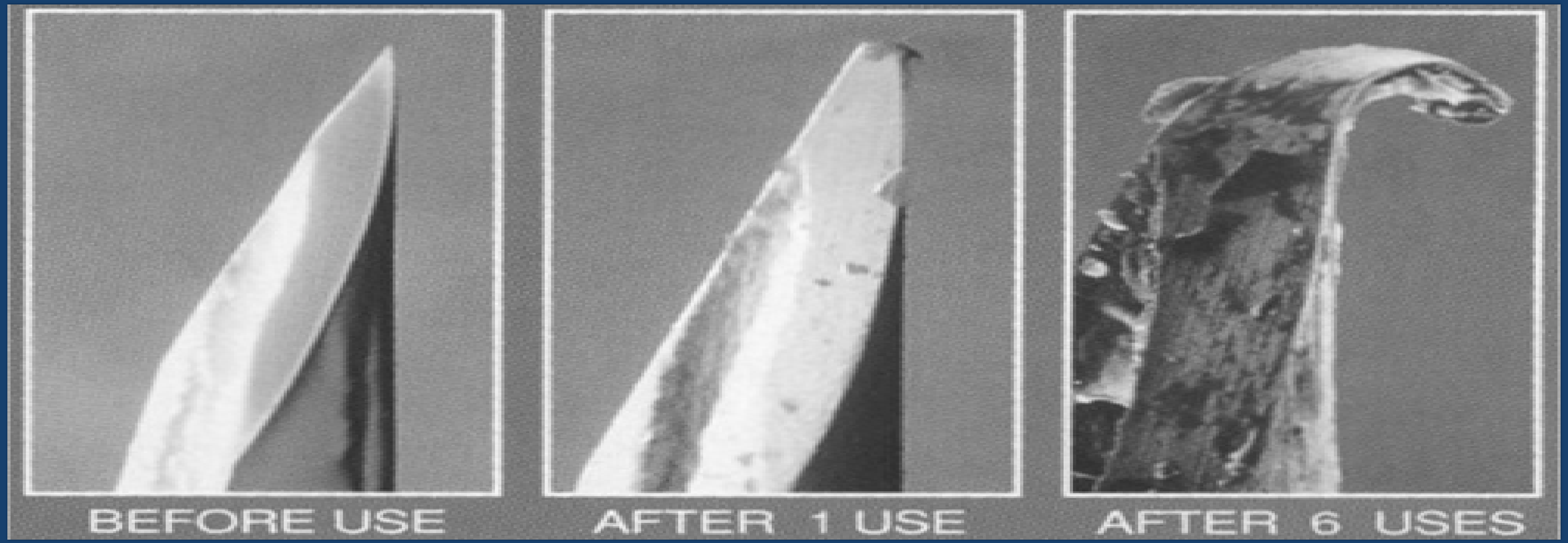
N = 421

- 52% Shared Injection Equipment
- 44% Obtaining Syringes from Dealer, Street Seller, or Friend (NH)
  - 15% in VT
  - 13% in MA
- 42% in NH reported easy access to clean syringes
  - 80% in VT
  - 92% in MA

Safer Use

- Ask: “What steps do you take to keep yourself safe when using?”
  - Advise to not use alone and only with trusted people who can provide care if needed
  - Caution with all drug supplies and new sources
  - Avoiding taking all the drug at once and avoid rushing
    - Starting with a “test shot” may help prevent overdose as drug cannot be taken back once injected.[6]
  - Problem solve around a safer environment and/or opportunities to decrease frequency.

Microscope View of Needle After Use



https://imgur.com/Rh7RY

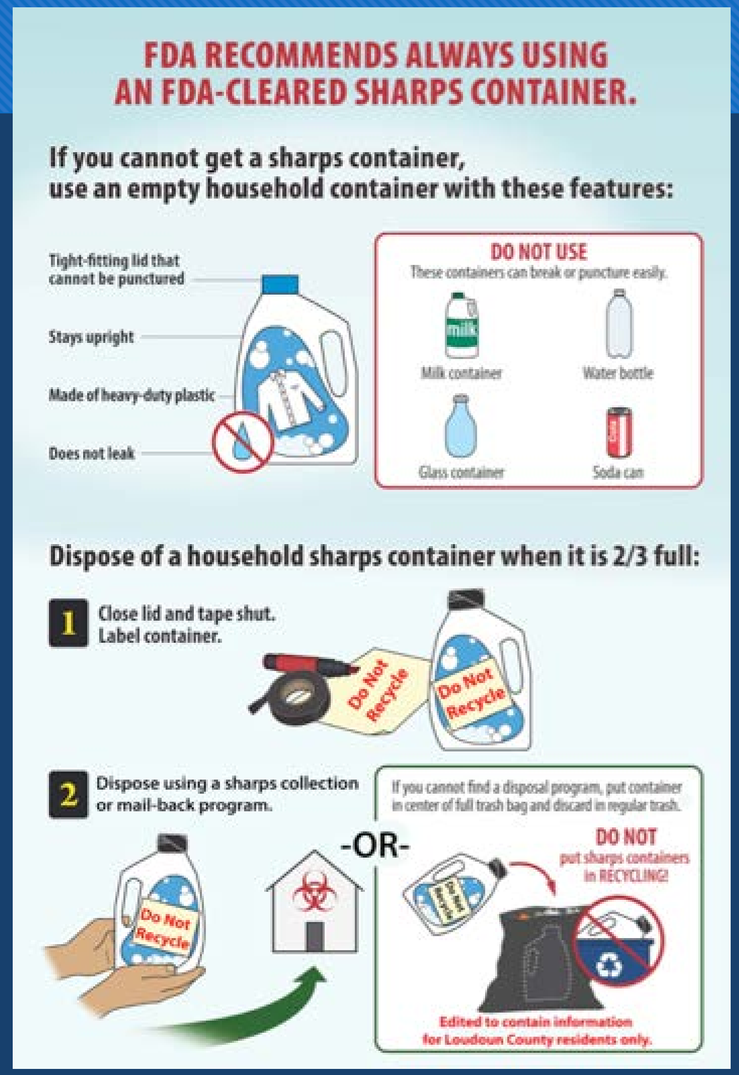
Safer Injecting Practices: Safer Use

Ask: “How do you prevent injury to your veins and infections?”

- Wash hands or use hand sanitizer/ alcohol
- Tourniquet improves vein access (fewer needle sticks, less risk for infection)
- Bevel up to avoid going through the vein
- Recognize valves in veins and inject above
- Recognize infections and when to seek care for wound/ illness/ infection

Safer Injecting Practices: Safer Disposal

- Bring them back to SSP!
- Some health, fire departments, and transfer stations provide safe places to dispose of syringes
- If sharps container unavailable use hard plastic detergent bottles, seal, and mark “DO NOT RECYCLE”



Overdose Prevention

- 68,000 OD deaths 2017 (U.S.)
- 2017 OD Deaths: 488 in NH and 418 in ME

Overdose Prevention

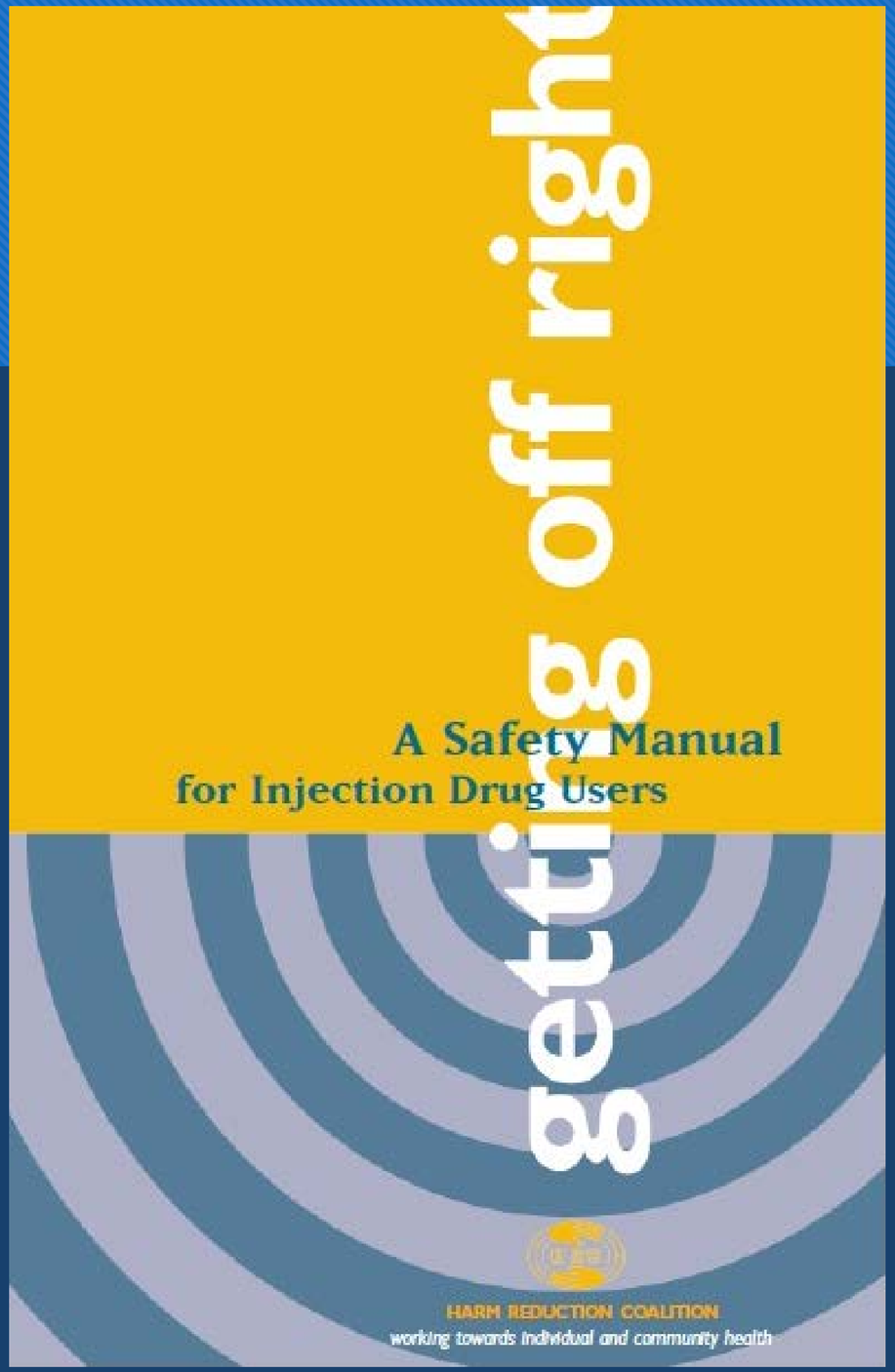
- Fentanyl Test Strips
  - Much of the opioid supply in the area has fentanyl
  - Great for those want to check their heroin supply or other drugs
  - Approx 68% with a positive test took measures to reduce risk and 23% who were negative also took measures to reduce risk

Health Promotion

- Offer Preventative Care: Screening, Testing, and Education
  - HIV testing is recommended at least annually for PWID
    - Include HIV 1/2 antibody and HIV 1 p24 antigen testing (positive 21 days after infection).[9]
    - Consider discussing PreExposure Prophylaxis (PrEP) for HIV prevention.
      - (CDC, 2017)
  - Hepatitis C antibody testing is recommended periodically for PWID.[10]
  - Check immunization status
  - Discuss safe sexual practices
  - Review pregnancy prevention options

FOR MORE ON SAFER INJECTION PRACTICES

Find at
HarmReduction.org



Approaches to PWUD

OBJECT

ATTITUDE

”I know best for person/group”

”I have the right to determine circumstances for P/G”

RECEPTION


ACTION

Deny care
Narrow the scope of care
Provide substandard care
Target for arrest/ harass

OUTCOMES

RECIPIENT

ATTITUDE

”I know best” for person or group

(But I’ll ‘give’ opportunity to participate in my decision)

RECEPTION

ACTION

‘Sell’ on particular ‘product’/idea
Offer narrow scope of options
Lying/withholding truths

OUTCOMES

RESOURCE

ATTITUDE

“You know better than me. Let me help you decide/improve/get you where you want to be.”

“I can learn from you.”

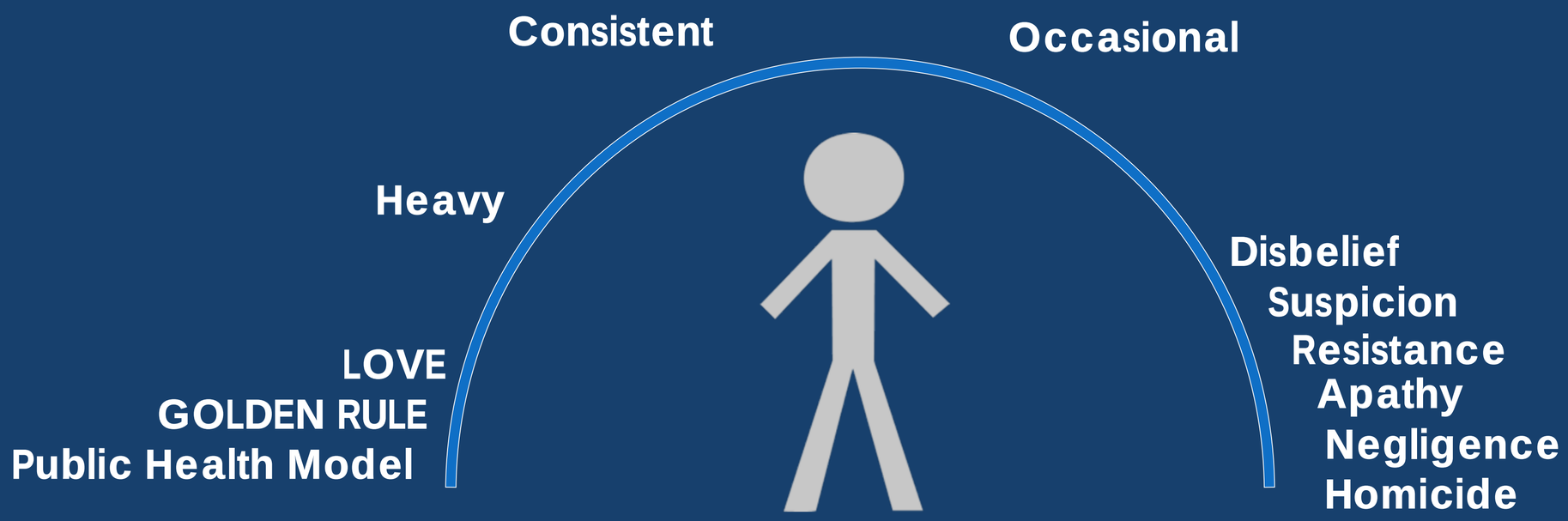
RECEPTION

ACTION

Educating
Goal-Setting
Offer accountability

OUTCOMES

A Continuum of Harm Reduction Integration



QUESTIONS

- ANSWERS

Harm Reduction Education and Technical Assistant Project

Provide education and support to NH providers on integrating harm reduction in practice

- Academic detailing 1-on-1 visits with providers who connect with people who use drugs
  - 150-200 providers in healthcare, community service agencies
- Provide technical assistance on integrating harm reduction
  - 1 hour trainings at practice sites led by NHHRC
  - Resource provision and research
  - Biweekly case conferencing sessions
- Beginning June 2019
- Recruiting for:
  - Advisory group members
  - Academic detailers
  - Practice site participants
- For more info email HRETA.Project@unh.edu

Interested in Learning More?
Getting Involved?

www.nhhrc.org **info@nhhrc.org**

QUESTIONS & ANSWERS

CLOSING REMARKS

RESOURCES

Corrigan, P. W., & Rao, D. (2012). On the Self-Stigma of Mental Illness: Stages, Disclosure, and Strategies for Change. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, 57(8), 464–469

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