How to Talk to Patient Living with Substance Use Disorders

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Disclosures

I have no financial conflicts of interest to disclose

My background

- Trained hundreds of clinical team members in Screening, Brief Intervention, Referral to Treatment (SBIRT) 2008 – present
- Primary care, Pediatrics, women's heath clinics, ERs
- Built EHR tools, screening app
- Currently consult

Why this presentation?

- Substance Use Disorders (SUDs) are prevalent
- People living with SUDs bear greater risk of morbidity and mortality
- People living with SUDs do seek healthcare, but often for other reasons
- PWIDs cite poor rapport with a health care provider as main barrier to care
- Most providers feel unprepared on how to meaningfully address injection drug use

Outline:

- Discuss the role of stigma
- Describe principles of a Harm Reduction approach
- Describe a model of conversation with patients living with SUDs

Meanwhile, in the U.S:

- 10% of adults have substance use disorder at some point in their lives
- 88,000 die from alcohol-related causes annually, making alcohol the third leading preventable cause of death
- Prevalence of injection drug use:
  Last 12 months: 750,000. Lifetime: 6.5 million
- 42,000 die from opioid overdoses annually

National Institutes of Health; Lansky et al, 2014; DHHS.

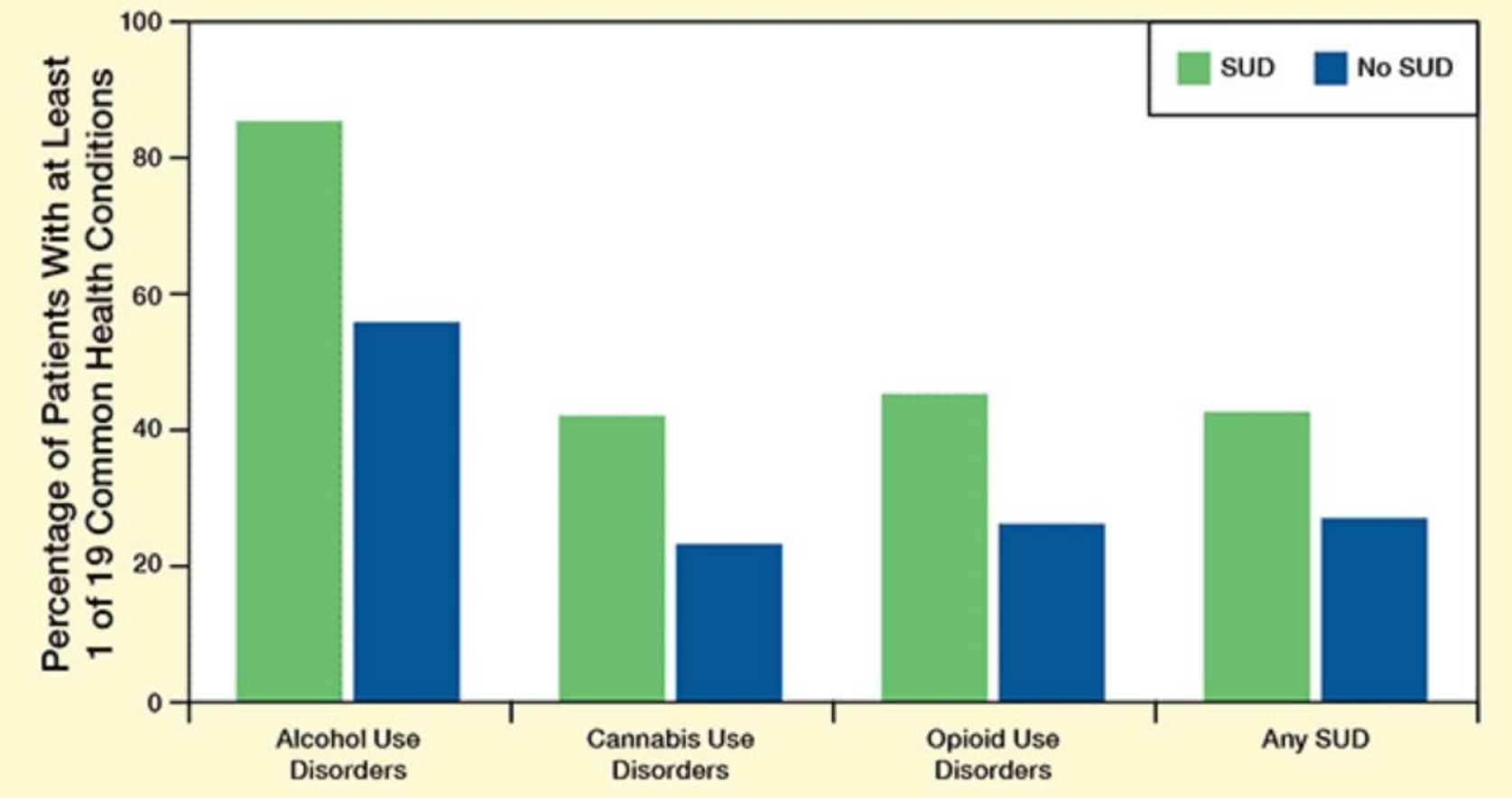
Study of patients with SUDs

	Any SUD %	Alcohol Use Disorders %	Cannabis Use Disorders %	Opioid Use Disorders %
Alcohol	57.6	-	32.3	21.6
Cannabis	14.9	8.3	-	12.5
Opioid	12.5	4.7	10.5	-
Amphetamine	5.8	3.4	9.3	6.2
Cocaine	3.5	3.2	6.2	3.9
Barbiturate	2.1	1.6	2.9	9.5
Hallucinogen	0.2	0.1	0.8	0.3

45,461 patients diagnosed with SUDs at Kaiser Permanente Northern California health care system

NIDA, 2017

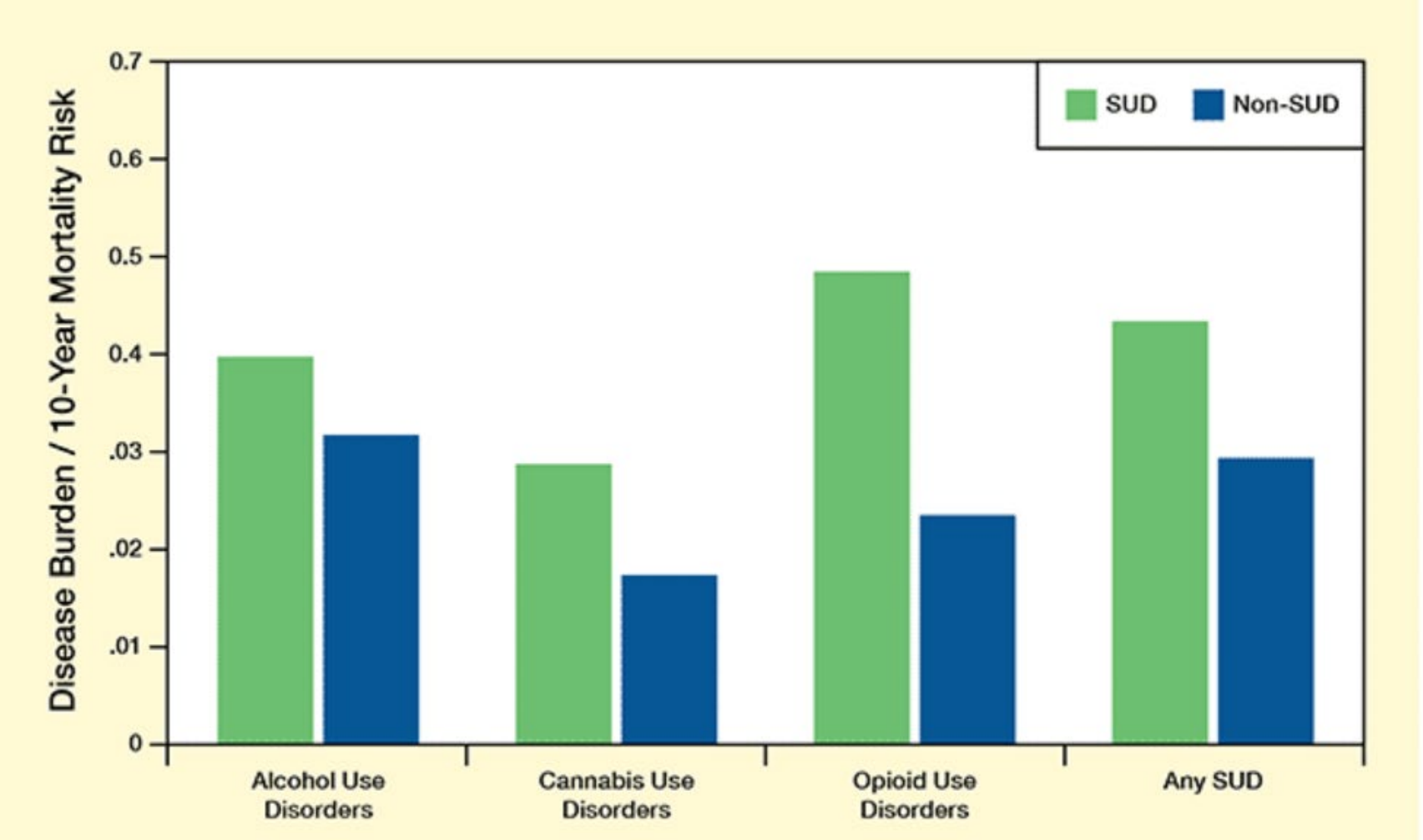
Increased risk of major medical conditions



Conditions: acid-peptic disorders, arthritis, asthma, chronic kidney disease, chronic obstructive pulmonary disease, chronic pain, congestive heart failure, coronary atherosclerosis, diabetes mellitus, end-stage renal disease, headaches, hepatitis C, hypertension, injury (including poisoning and overdose), ischemic heart disease, pneumonia, obesity, osteoporosis, and stroke.

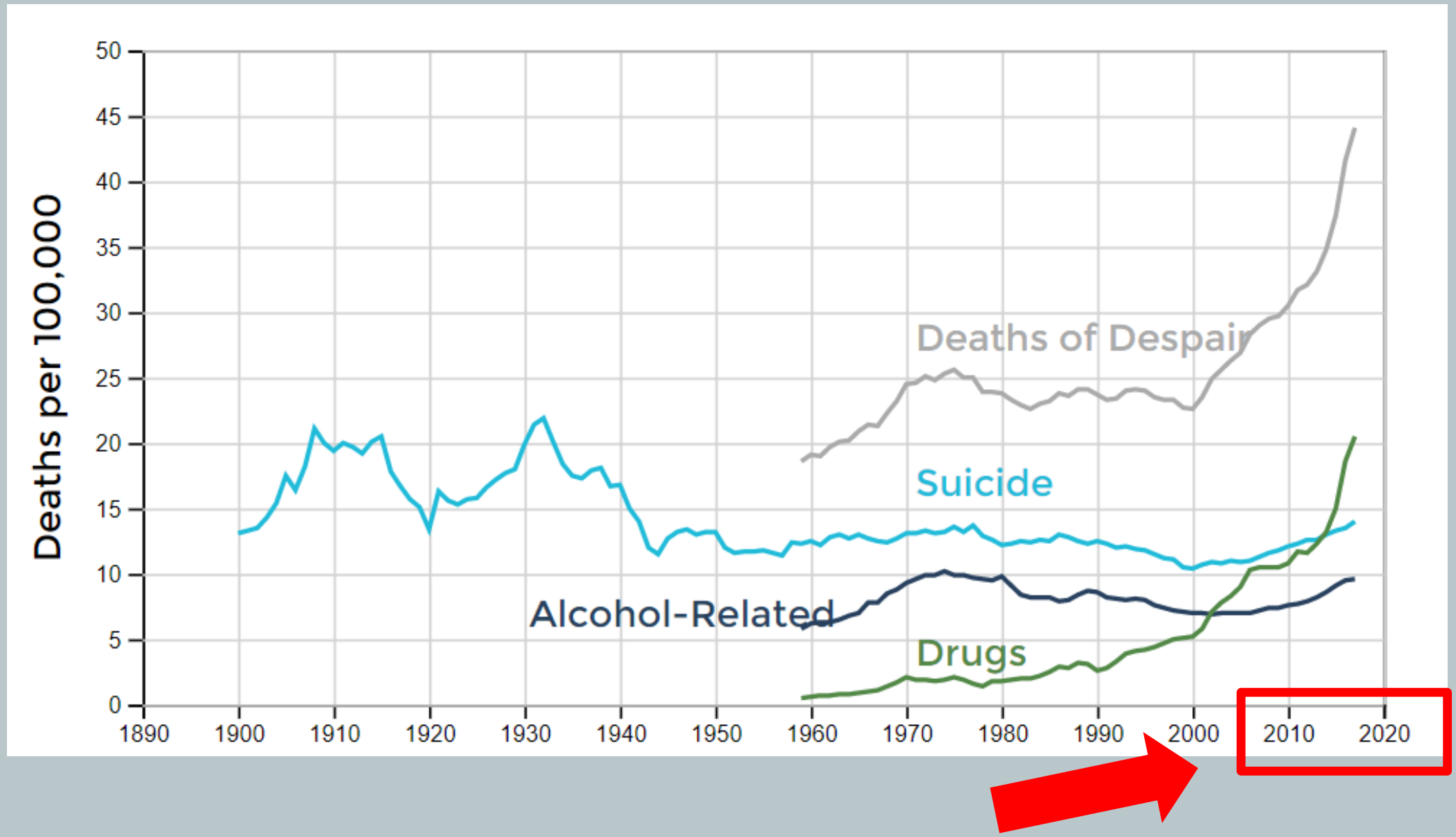
NIDA, 2017

Increased risk of death in 10 years



NIDA, 2017

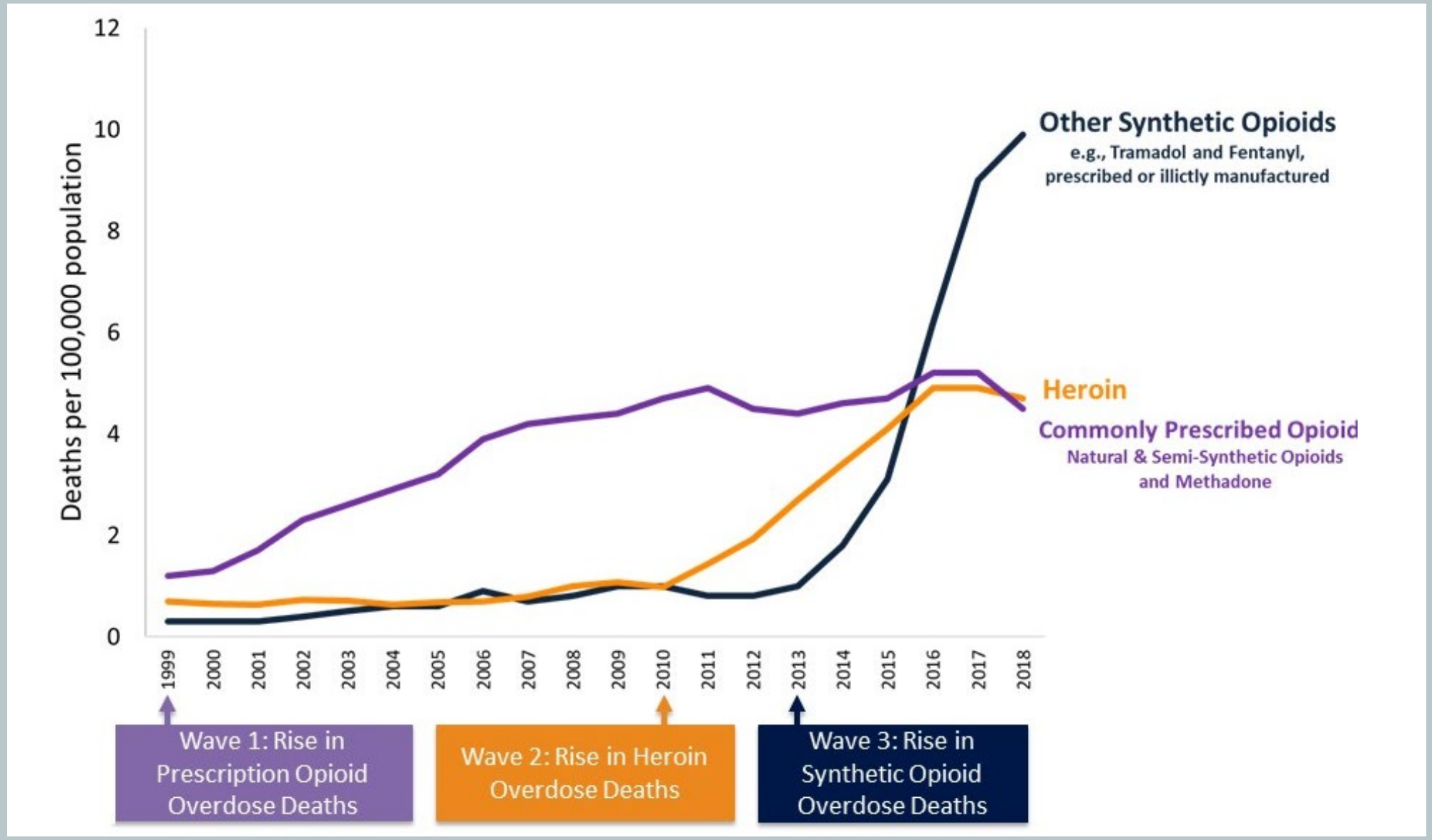
Deaths of Despair*, 1900-2017, Age-Adjusted Rates



*among white non-Hispanic Americans in midlife

Social Capitol Project, 2019

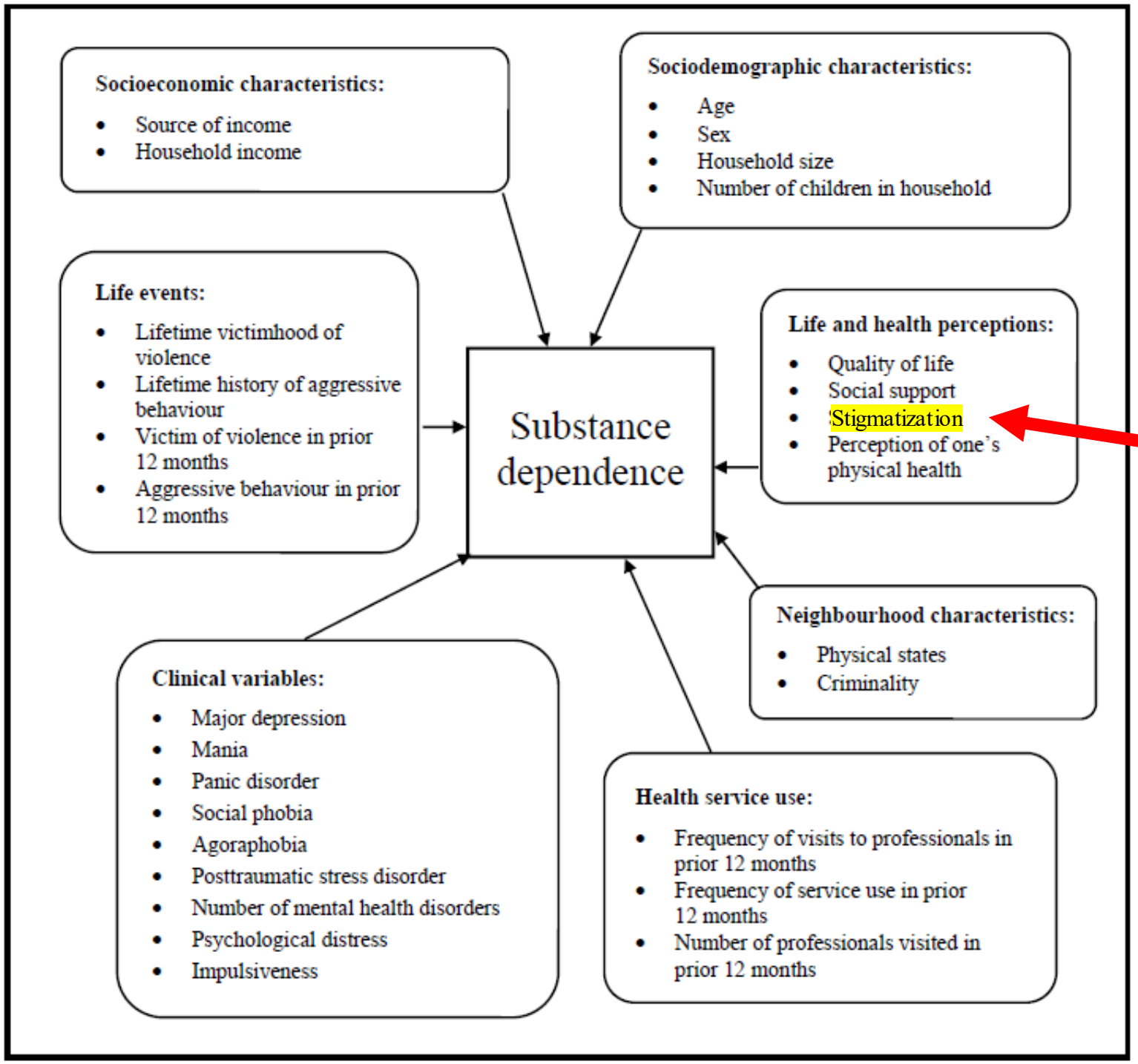
Three waves of opioid overdose deaths



National Vital Statistics System Mortality File, 2020

What health providers can offer PWIDs

- Provide general care
- Treat complaints related to use
- Help pt reduce harm from use
- Offer PrEP
- Offer Medication for Opioid Use Disorder (MOUD)
- Help patients forge a path to recovery



Conclusion: "Stigmatization was the strongest predictor of substance dependence"

Figure from:

Fleury, M; Grenier, G; Bamvita JM, Perreault, M; Caron, J. Predictors of Alcohol and Drug Dependence. CanJPsychiatry 2014

Slide: OHA HOPE Project

Stigma and substance use

- Internalized stigma diminishes self-worth and self-esteem
- Stigma may inflict greater psychological pain than SUD itself
- Stigma acts as a barrier to reducing harm from use
- May increase substance use as a way of coping with internalized stigma and to boost self-esteem

Harm Reduction Coalition. Rivera et al, 2014.

Impact of stigma on patients

Pts who perceive stigma are more likely to:

- Fail to overcome barriers to accessing health care
- Conceal their substance use from providers
- Report poor rapport with their provider
- Avoid or interrupt treatment
- Not come back for follow up

Neale et al, 2008. Ball et al 2006, Eaton et al 2004.

Provider stigma towards pts with SUDs

Common, and more highly stigmatized than with pts with other health conditions

Pts with SUDs are more likely to be perceived by providers as:

- Less honest or trustworthy
- More likely to overuse system resources
- Less vested in their own health, adhere to care

van Boekel et al, 2013. Westergaard et al, 2012.

Patient perspectives

"The minute they find out that you're [an] injection user, the doctors, you can see it right in their face. They change their whole attitude. They don't want to help you. It's weird. I hate telling the doctor that I use drugs. Hate it. Their whole attitude changes…"

"Donna"

"When it comes down to it, a lot of the times that I need to get medical attention, I put it off and put it off and put it off, because I don't want to face the embarrassment that they make me feel, and that's not fair. It's not."

"Stacey"

Biancarellia et al, 2019.

Patient perspectives

"I don't want to tell them I'm a drug user if there's something really wrong with me. You know, I need that issue taken care of…It makes me want to lie and not be honest."

"Mary"

"She wouldn't keep my appointments. She would care less. She wouldn't go the nine yards or go out the way for me."

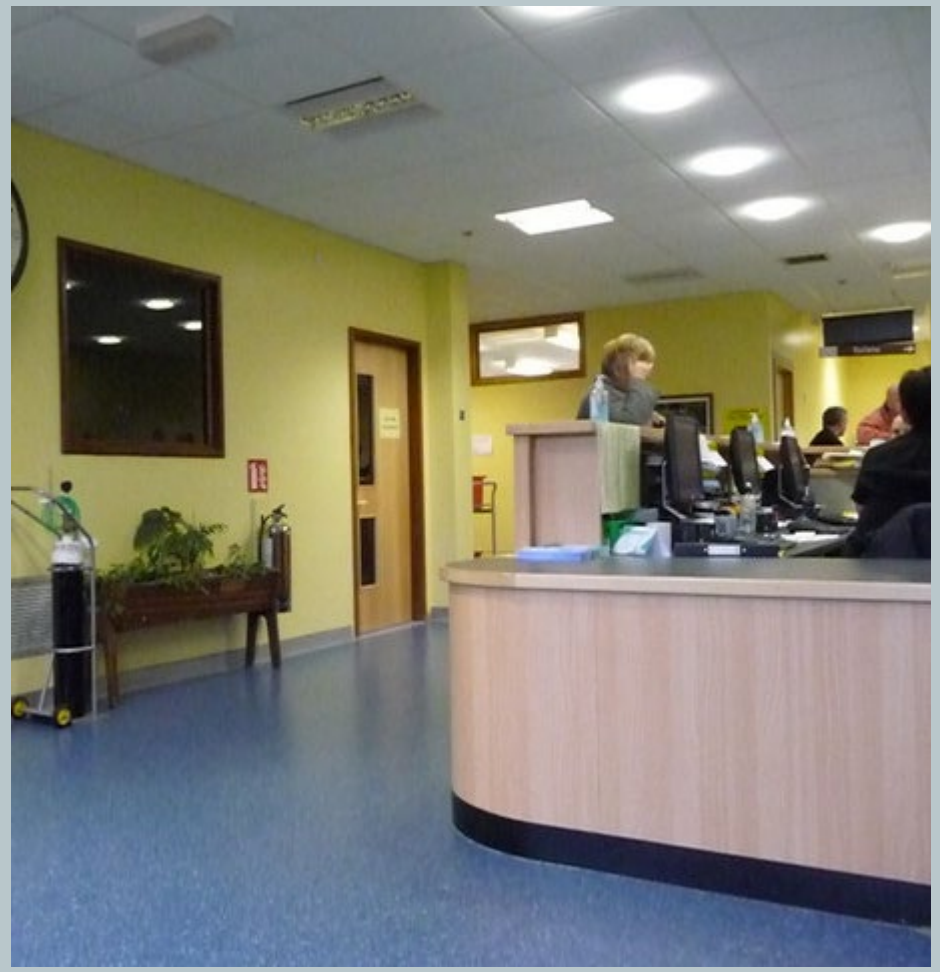
"Richard"

"There's just some things I wouldn't tell a doctor."

"Aaron"

Biancarellia et al, 2019.

Stigma conveyed non-verbally



Common theme in PWID focus groups—looks from clinicians and staff:

- Being "looked down on" by medical personnel
- "Look at [us] like we're garbage"
- "They give you dirty, snotty looks"

Paquettea et al, 2018.

Provider stigma leads to worse care

Providers with stigma towards pts with SUDs less likely to:

- Offer harm reduction services
- Offer ART with HIV+ pts
- Personally engage and empathize
- Identify and address problematic substance use

Ding et al, 2005. Weiss et al, 2006. Henderson et al, 2008.

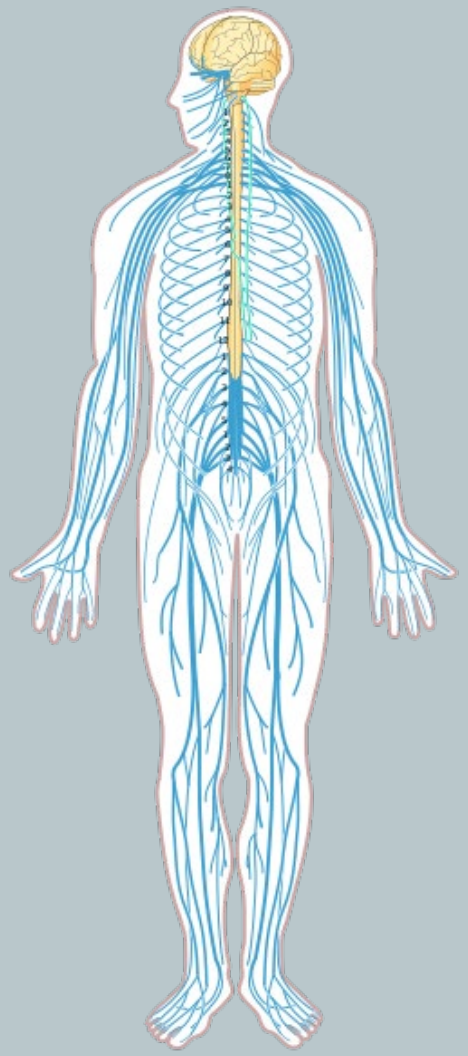
Where does stigma come from?

Two main factors:

- When people perceive an individual is responsible for **causing** his/her problem
- And when he or she is able to **control** the problem
- Another contributory factor: the type of language we use

Kelly et al, 2015.

Research and addiction:



- Half the risk for addiction is associated with genetics
- "The effects of substances on the central nervous system produce profound changes in brain structure and function that **radically impair efforts to control use**."

Kelly et al, 2015.

Overdose, Morbidity, Incarceration, Healthcare costs, Disrupted family structures, Homelessness, Unemployment, Crime

Consequences

Substance Use Disorder

Main Problem

Physical, emotional, sexual abuse; stress; early exposure to substances; low self esteem; mental health disorders; marginalized population; family history of addiction; trauma; poverty; absence of social support

Causes

NIDA, 2018.

Cause of OUDs: role of the drug industry

Original Investigation | Substance Use and Addiction

Association of Pharmaceutical Industry Marketing of Opioid Products With Mortality From Opioid-Related Overdoses

Scott E. Hadland, MD, MPH; MS, Ariadne Rivera-Aguirre, MPP; Brandon D. L. Marshall, PhD; Magdalena Cerdá, DrPH, MPH

Abstract

IMPORTANCE Prescription opioids are involved in 40% of all deaths from opioid overdose in the United States and are commonly the first opioids encountered by individuals with opioid use disorder. It is unclear whether the pharmaceutical industry marketing of opioids to physicians is associated with mortality from overdoses.

OBJECTIVE To identify the association between direct-to-physician marketing of opioid products by pharmaceutical companies and mortality from prescription opioid overdoses across US counties.

DESIGN, SETTING, AND PARTICIPANTS This population-based, county-level analysis of industry marketing information used data from the Centers for Medicare & Medicaid Services Open Payments database linked with data from the Centers for Disease Control and Prevention on opioid prescribing and mortality from overdoses. All US counties were included, with data on overdoses from August 1, 2014, to December 31, 2016, linked to marketing data from August 1, 2013, to December 31, 2015, using a 1-year lag. Statistical analyses were conducted between February 1 and June 1, 2018.

MAIN OUTCOMES AND MEASURES County-level mortality from prescription opioid overdoses, total cost of marketing of opioid products to physicians, number of marketing interactions, opioid prescribing rates, and sociodemographic factors.

RESULTS Between August 1, 2013, and December 31, 2015, there were 434 754 payments totaling $39.7 million in nonresearch-based opioid marketing distributed to 67 507 physicians across 2208 US counties. After adjustment for county-level sociodemographic factors, mortality from opioid overdoses increased with each 1-SD increase in marketing value in dollars per capita (adjusted relative risk, 1.09; 95% CI, 1.05-1.12), number of payments to physicians per capita (adjusted relative risk, 1.18; 95% CI, 1.14-1.21, and number of physicians receiving marketing per capita (adjusted relative risk, 1.12; 95% CI, 1.08-1.16). Opioid prescribing rates also increased with marketing and partially mediated the association between marketing and mortality.

CONCLUSIONS AND RELEVANCE In this study, across US counties, marketing of opioid products to physicians was associated with increased opioid prescribing and, subsequently, with elevated mortality from overdoses. Amid a national opioid overdose crisis, reexamining the influence of the pharmaceutical industry may be warranted.

JAMA Network Open. 2019;2(1):e186007

Corrected on March 22, 2019. doi:10.1001/jamanetworkopen.2018.6007

Key Points

Question To what extent is pharmaceutical industry marketing of opioids to physicians associated with subsequent mortality from prescription opioid overdoses?

Findings In this population-based, cross-sectional study, $39.7 million in opioid marketing was targeted to 67 507 physicians across 2208 US counties between August 1, 2013, and December 31, 2015. Increased county-level opioid marketing was associated with elevated overdose mortality 1 year later, an association mediated by opioid prescribing rates; per capita, the number of marketing interactions with physicians demonstrated a stronger association with mortality than the dollar value of marketing.

Meaning The potential role of pharmaceutical industry marketing in contributing to opioid prescribing and mortality from overdoses merits ongoing examination.

+ Invited Commentary

+ Supplemental content and Audio

Author affiliations and article information are listed at the end of this article.

JAMA:

- "The pharmaceutical industry invests tens of millions of dollars annually in direct-to-physician marketing of opioids."
- "Marketing of opioid products to physicians was associated with increased opioid prescribing and, subsequently, with elevated mortality from overdoses."

Hadland et al, 2019. Slide: OHA HOPE Project

Surgeon Generals report

- Latest science defines SUDs as a chronic brain disease
- "Brain imaging shows physical changes that are critical to judgment, decision-making, and behavior control"
- Changes in the brain persist long after substance use stops
- Influenced by genetic, developmental, behavioral, social, and environmental factors

Office of the Surgeon General, 2016.
Slide: OHA HOPE Project

Stigma and the role of language

Research shows language can perpetuate or alleviate stigma

Characteristics of affirming language:

- Person-first
- Technical language with a single, clear meaning instead of colloquial definitions
- Non-sensational and non-fear-based

Kelly et al, 2015.
Slide: OHA HOPE Project

Examples

Outdated language	Person-first, affirming language
Injection Drug Users (IDU)	People who inject drugs (PWID)
Drug abuse, dependence, drug habit	Substance use disorder
Drug abuser, addict, alcoholic	Person with a substance use disorder
Clean and sober	Person in recovery
Dirty or clean needles	Used or new needles
Dirty or clean urine	Positive or negative urine drug screen
Medication-Assisted Treatment (MAT)	Medication for Opioid Use Disorder (MOUD)
High risk	Individuals at risk of acquiring HIV, Hep C, etc.

Office of National Drug Control Policy, 2017. Slide: OHA HOPE Project

Factors that mitigate provider stigma

- Existing knowledge about SUDs
- Existing beliefs about attribution
- Personal experience working with PWIDs
- Training and education on attitudes and knowledge

Howard and Holmshaw, 2010. Ding et al., 2005; May et al., 2002. Slide: OHA HOPE Project

Harm Reduction and substance use

- Abstinence is neither prioritized nor assumed to be the goal of the patient
- Result: HR broadens the spectrum of patients we can engage with and help
- <u>"Meeting the patient where they're at"</u>

Hawk et al, 2017.

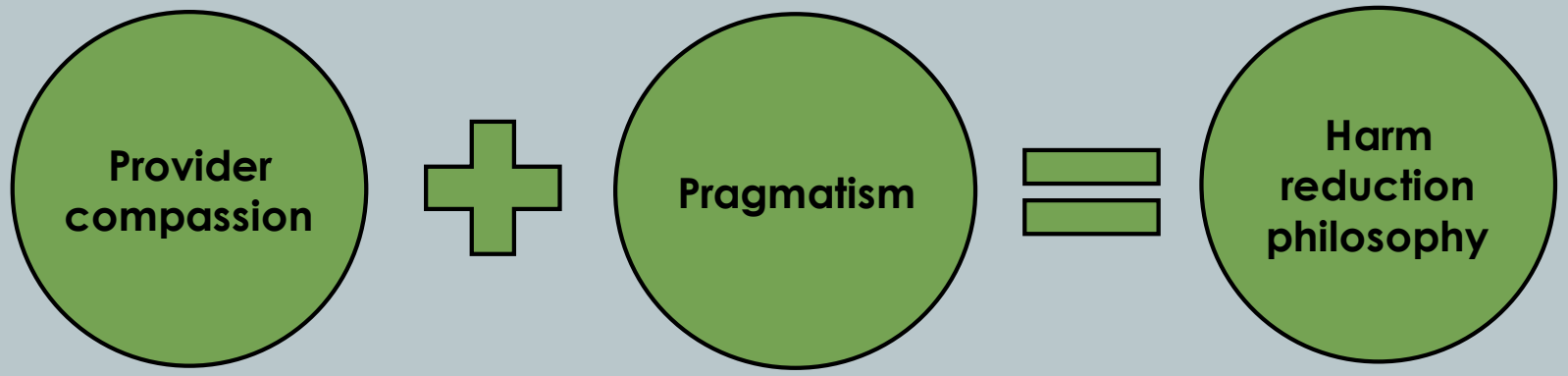
Some harm reduction beliefs

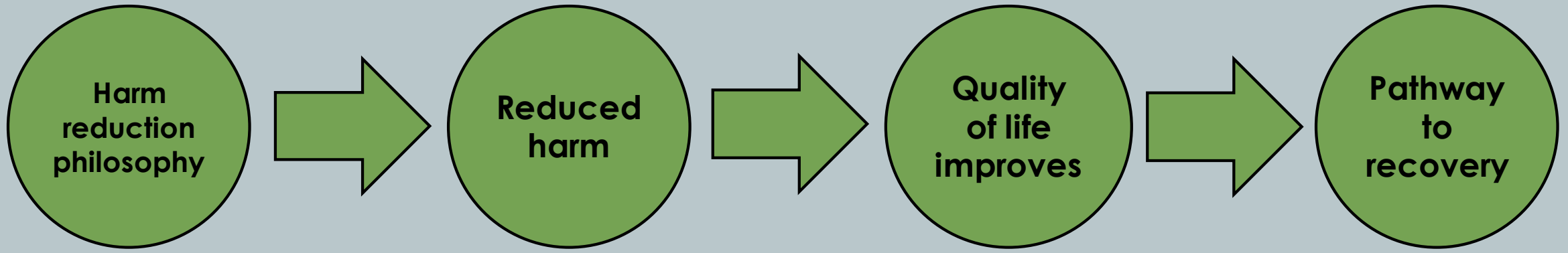
Substance use:

- Has pros and cons
- Is here to stay
- Is complex
- Exists in social context
- Is not the client

Slide: HaRRT Center

Harm Reduction theory and practice





Slide: HaRRT Center

Different approaches with pts with SUDs

Traditional practice	Harm reduction
Ultimate goal: abstinence	Goal: reducing harm
Perceives use and problems are in 1:1 agreement	Recognizes risk of problems is variable and individually based
Provider "prescribes" treatment	Provider offers science and knowledge to help patient assess their own risk of harm
Provider knows best	Patient knows better
Abstinence is the only, or best way forward	Keeping the pt alive and on a path towards reducing harm is the best way forward

More characteristics of a HR approach

- Respect for patient autonomy, goals, and values
- Accepting ambivalence
- Recognizing the patient is the expert
- Empathy, non-judgment, respect

Steps of the brief intervention

Raise subject

Share information

Enhance motivation

Identify plan

Steps of the brief intervention

Raise subject

- Ask permission to discuss patient's substance use
- Be transparent about your role
- Ask the patient to describe their use

Transparency example

Thank you for giving me permission to discuss your substance use with you. Just so you know, I will not ask or advise you to stop or change your use in any way you do not want to. Instead, my focus is to understand what **your** goals or visions for your future are. I can share information with you so you can improve your quality of life on your own terms and on your own timeline.

How does that sound to you?

Steps of the brief intervention

Share information

- Explain any association between substance use and health complaint
- Share information about of risks of use. Ok to express concern
- Ask the pt what they think of the information

Pitfalls of giving advice or recommendations

- Implies judgement, risks furthering stigma
- Clinician-driven rather than patient-driven
- Patients with SUDs may already feel trapped
- Advice is different than offering options

Steps of the brief intervention

Enhance motivation

- Ask patient what they like about their use, and what they don't like, then summarize
- Ask what change the pt would like to see

Examples that elicit patient goals

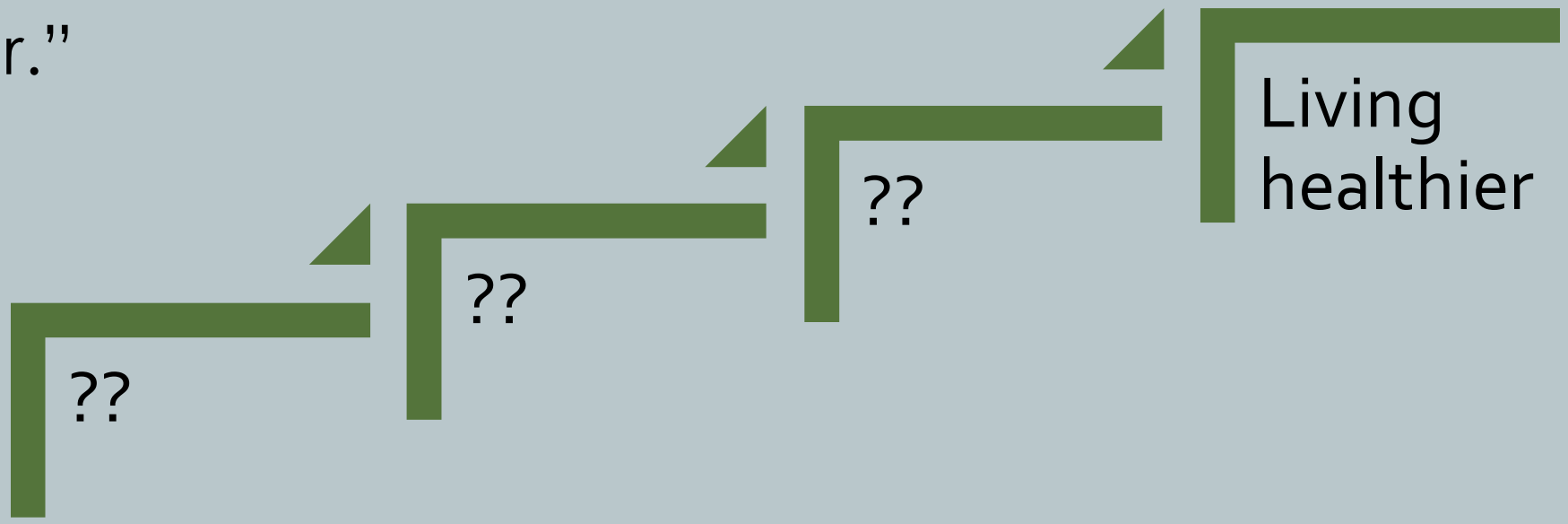
- "Over the next few (weeks, months) what would you like to see happen for yourself?"
- "What would you like to do about your use?"
- "Is there anything you'd like to change about your drinking/drug use?"
- "Where would you like to go with your drinking/drug use?"

Goals are more achievable when they are:

- Well defined
- Focused on reducing harm or improving quality of life
- Doable in a timeframe
- Patient-driven

Helping pts with abstract, or large goals

Patient: "I want to live healthier."



Clinician: "That's a great goal. It's also a big goal. So, let's put that up here on the top step. What could be the first step towards living healthier?"

Slide: HaRRT Center

Examples of pt-driven goals of PWIDs

- Injecting more safely
- Minimizing sharing works or needles
- Carrying Naloxone
- Using less
- Accept MOUD or other treatment
- Learning abscess care
- Getting more regular medical care and/or mental health care

Steps of the brief intervention

Enhance motivation

- Ask patient what they like about their use, and what they don't like, then summarize
- Ask what change the pt would like to see
- Gauge pt readiness/confidence to achieve goal

Readiness Ruler

- “On a scale of 0 to 10 . . .”
- “Why not a lower number?”
- Gauges level of motivation
- Answering the question enhance existing motivation

Steps of the brief intervention

Identify plan

- If patient sounds ready, ask: "What would a plan of change look like for you?"
- Affirm pt's readiness to change
- Ask to schedule follow-up

Raise the subject

- ‘‘Thanks for filling out this form – is it okay if we briefly talk about your substance use?”
- “My role is to help you assess the risks so you can make your own decisions. I want to help you improve your quality of life on your own timeline.”
- “What can you tell me about your substance use?”

Share information

- Explain any association between the patient’s use and their health complaint, then ask, “Do you think your use has anything to do with your [anxiety, insomnia,, etc,]?”
- Share information about the risks of using alcohol, drugs, and misusing prescription drugs. Ask the patient: “What do you think of this information?”

Enhance motivation

- Ask pt about perceived pros and cons of their use, then summarize what you heard.
- “Where do you want to go from here in terms of your use? What’s your goal or vision?”
- Gauge patient’s readiness/confidence to reach their goal. If using Readiness Ruler: “Why do did you pick ___ on a scale of 0-10 instead of ____ [lower number]?”

Identify plan

- If patient is ready, ask: “What steps do you think you can take to reach your goal?”
- Affirm the patient’s readiness/confidence to meet their goal and affirm their plan.
- “Can we schedule an appointment to check in and see how your plan is going?”

Remember:

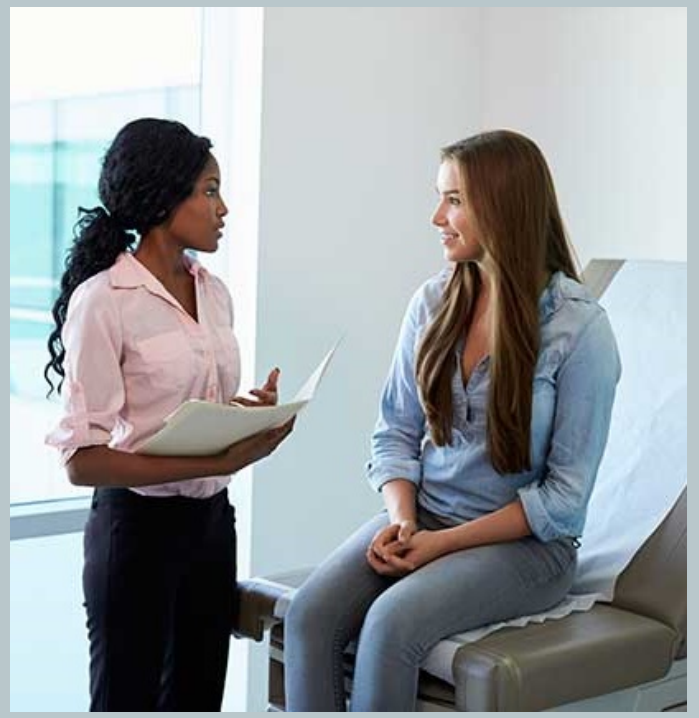
Defer to the patient's wisdom

The more responsibility, autonomy and respect people feel they have, the more they will step up and forge their own pathway.

Follow up

A continuing cycle of:

- Collaborative tracking of patient-selected goals
- Sharing information about risks
- Eliciting pt-driven harm reduction goals
- Discussing safer-use strategies



Stages of change

- Patients typically move sequentially on their path to maintenance
- One session unlikely to immediately produce action
- Triggering events can set patient back to earlier stage

More reasons pts with SUDs may not accept treatment

Want to keep use hidden from partner

Privacy concerns

Excessive paperwork

Fear of losing job while in treatment

Long waiting lists

Language barriers

Costs

Fear stigma from society, friends and loved ones

Fear of withdrawal

Fear of relapse

Treatment not available

Lack of child care

Lack of transportation

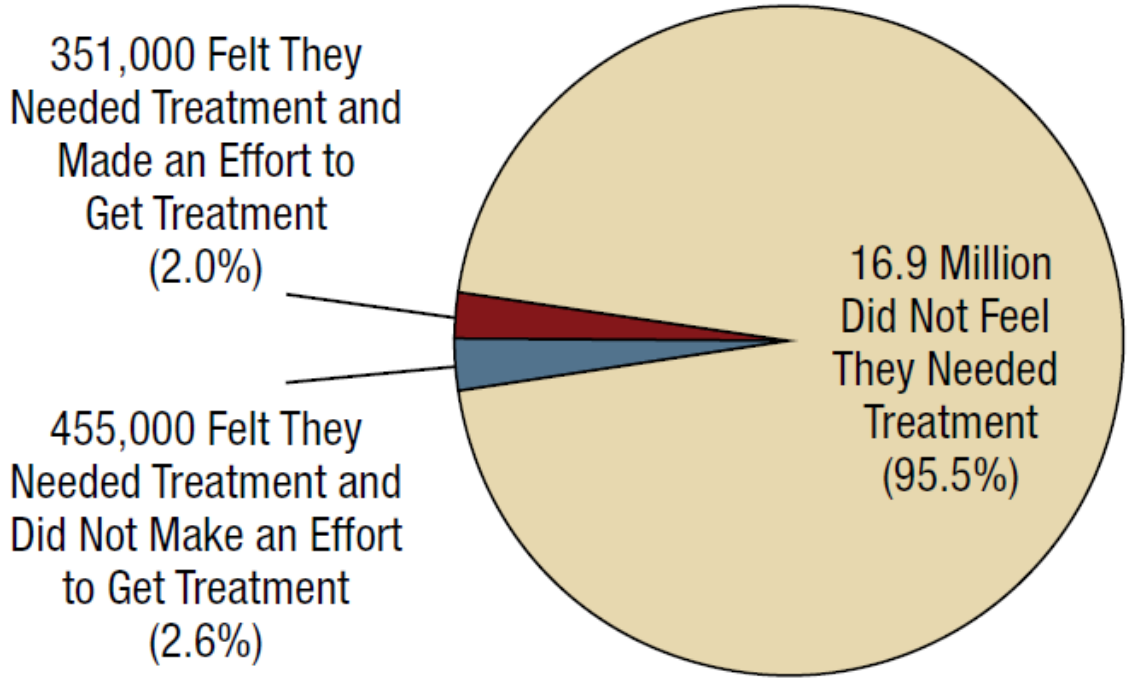
Instable housing

The pros of use outweigh the cons

Not ready to quit

Time conflicts

Figure 14. Perceived Need for Substance Use Treatment among Adults Aged 18 or Older Who Needed but Did Not Receive Substance Use Treatment in the Past Year: 2016



17.7 Million Adults Needed but Did Not Receive Substance Use Treatment

Note: The percentages do not add to 100 percent due to rounding.

Most people with SUDs do not believe they need treatment!

Park-Lee et al, 2017.

Takeaways

We can more effectively serve PWIDs by:

- Being mindful of stigma
- Adopting a HR philosophy
- Use a HR-informed brief intervention

Thanks!

Questions or comments?

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SBIRT OREGON

T-shirt available at Iowa Harm Reduction Coalition