Opioid Epidemic, Cultural Considerations, and Changes in SUD Treatment.

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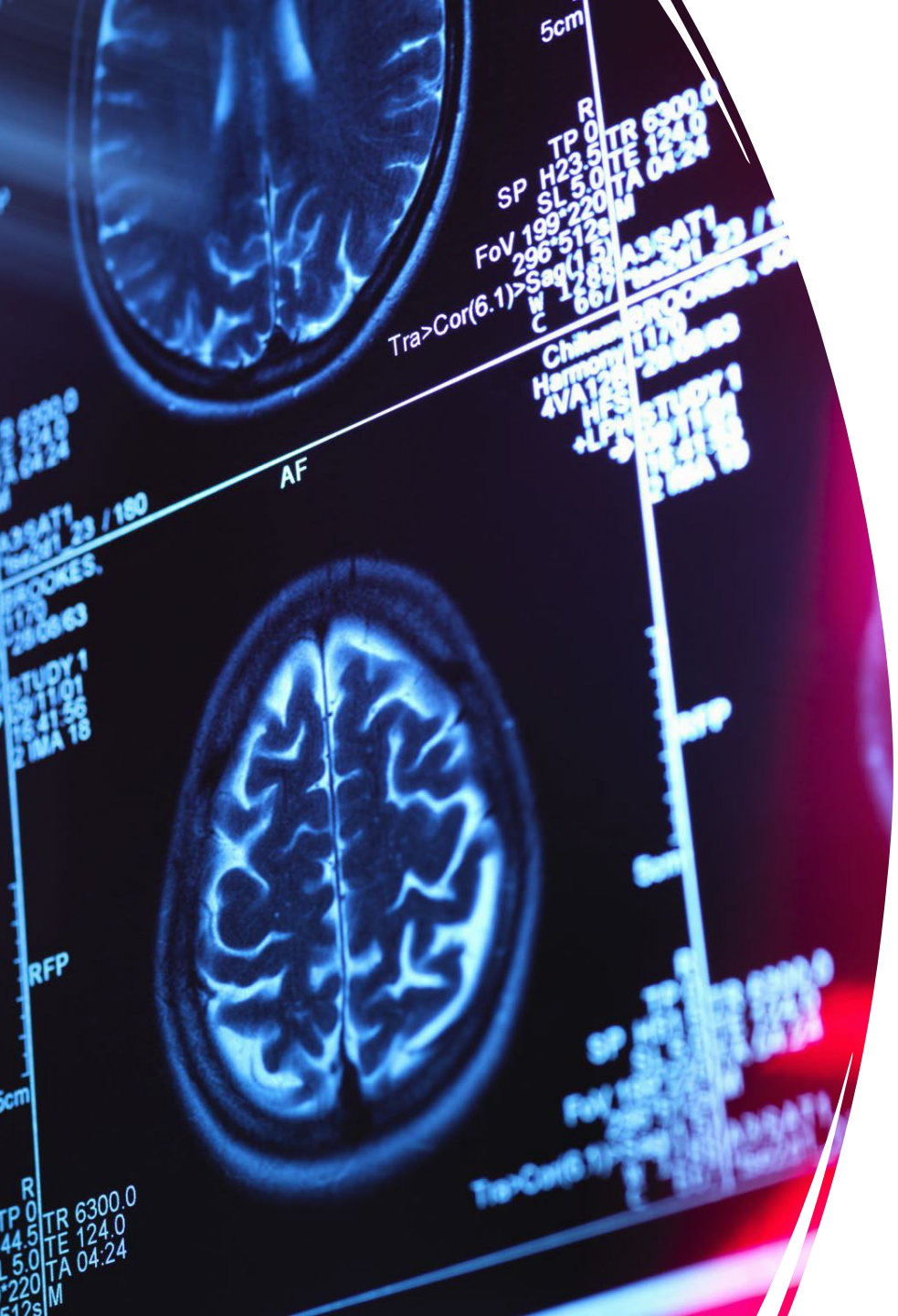
Changes We Have Had To Adapt To

- Family involvement in treatment
- Managed care determining LOC and LOS
- Dual diagnosis, dyslexia, trauma informed, culturally competence , etc
- Year long programs
- Therapeutic Communities
- Mental Health v Substance Abuse v Prevention
- No counselor certification requirements
- 12 Step was the best and only way
- You have to be one to help one
- Others?



Times have Changed Again: Is Abstinence Based Treatment Obsolete?

- I predict that by 2030 abstinence-based treatment will be considered obsolete or at the very least the exception rather than the rule. As the Medication Assisted Treatment movement has been gathering more and more momentum over the past few years, more people seeking Recovery are opting for and advised to take medications to help them manage withdrawal symptoms, cravings, feelings and other issues. Opioid replacement medications include Buprenorphine (Suboxone, Subutex) and Methadone are seen to be the answer to the “Opioid Crisis”. Each of these drugs is in fact an opioid, which brings certain risks.

Harm Reduction and MAT

Assess and Address any Provider Bias

- Do you have a strong yay or nay opinion about Harm Reduction and/or MAT?
- Do you discriminate against the client and/or providers.
- Is your opinion well informed?
- What's in the best interest of the client?
- Are you aware of the cultural related issues/challenges?
- Address your own prejudices ad bias like you would in a cultural situation.
- Your "issues" can cause harm.

Relapse Prevention Strategies with Harm Reduction Clients

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What is Harm Reduction?

- Harm reduction is an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services.

- Harm reduction is an important part of the current Administration’s comprehensive approach to addressing substance use disorders through prevention, treatment, and recovery where individuals who use substances set their own goals.
- Harm reduction organizations incorporate a spectrum of strategies that meet people “where they are” on their own terms, and may serve as a pathway to additional prevention, treatment, and recovery services. Harm reduction works by addressing broader health and social issues through improved policies, programs, and practices.

Participant Shares

- What is your opinion about Harm Reduction?
- What is your personal and/or professional experience?
- What have you seen regarding Harm Reduction?
  - Good experiences?
  - Not so good experiences?

Challenges

- Huge division amongst providers
- Deciding who is a good candidate for harm reduction
- Doesn’t fit/connect in most self help-support groups
- Forces a user to manage/moderate AOD use
- Most users fantasy is to be able to control their using
- Failure can be fatal

- Other challenges?

Treatment Plan

- Assess Stages of Change
- Define what would/are they willing and able to do
- What would it look like for this person to be in Recovery
- What would the Relapse Process look like
- Monitor and report
- Have a back up plan
- Be clear about your recommendations and concerns
- Acknowledge victories and setbacks
- Slow motion beats no motion

Relapse Prevention Strategies for Clients on Medication Assisted Treatment

What is Medication Assisted Treatment

MAT is the use of medications in recovery to keep brain chemistry stable. The medications aid in managing cravings and withdrawal symptoms to reduce instances of relapse and enhance overall recovery. MAT helps people maintain recovery, saves money, reduces crime, and helps people regain their health and their lives. These are just some of the reasons why the U.S. surgeon general's Spotlight on Opioids report calls MAT the "**gold standard**" for **treatment**.

Medication-Assisted Treatment is the use of medications with counseling and behavioral therapies to treat substance use disorders and prevent opioid overdose

- MAT is often used for the treatment of addiction to opioids such as heroin and prescription pain relievers that contain opiates. The prescribed medication operates to normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings, and normalize body functions without the negative effects of the abused drug. Medications used in MAT are approved by the Food and Drug Administration (FDA), and MAT programs are clinically driven and tailored to meet each patient's needs. Combining medications used in MAT with anxiety treatment medications can be fatal. Types of anxiety treatment medications include derivatives of Benzodiazepine, such as Xanax or valium.

Medications Used in MAT

- FDA has approved several different medications to treat alcohol addiction and opioid dependence:

- **Alcohol Use Disorder Medications**
  - Disulfiram (Antabuse)
  - Acamprosate (Campral)
  - Naltrexone (Vivitro)
- **Opioid Dependency Medications**
  - Methadone
  - Buprenorphine (Suboxone and Subutex)
  - Naltrexone (Vivitrol)
- **Opioid Overdose Prevention Medication**
  - Naloxone (Narcan)

The Following Medications Containing Buprenorphine Are FDA-approved For Opioid Dependence Treatment:

- Subutex: sublingual tablet
- Sublocade: extended-release injection
- Probuphine: subdermal implant
- Cassipa: buprenorphine/naloxone sublingual film
- Suboxone: buprenorphine/naloxone film or tablet
- Bunavail: buprenorphine/naloxone buccal film
- Zubsolv: buprenorphine/naloxone sublingual tablet

Suboxone or Subutex?

- To understand the difference between ***Suboxone®*** and Subutex®, you must first understand the difference between methadone and ***buprenorphine***. Before the year 2000 the primary drug used to treat those with the disease of opioid addiction was methadone. In 2000, however, an additional medicine to treat opioid addiction called buprenorphine was approved by the FDA. While methadone is a Schedule II substance, buprenorphine is a Schedule III substance. Schedule III has a lower potential for abuse than Schedule II. As a result of the FDA approval, buprenorphine is an alternate treatment medication for opioid addiction alongside methadone.

The Similarities

- Both Suboxone® and Subutex® are medications used in treatment to help individuals with the disease of ***opioid addiction***. Suboxone® and Subutex® interact with the same receptors in the brain that are affected by opioids, such as heroin, but without causing the euphoria that results from opioid use. Because of this, individuals who take Suboxone® or Subutex® under professional supervision can live their lives without experiencing the cravings or withdrawals that would normally occur in the absence of opioids.

The Differences

- The main difference between Suboxone® and Subutex® is that Suboxone® contains naloxone and Subutex® doesn't. The naloxone component of Suboxone® is not active when absorbed in the mouth. Naloxone is mixed with the buprenorphine to prevent misuse. Normally naloxone is a medication designed to rapidly reverse opioid overdose. It is an opioid antagonist—meaning that it binds to opioid receptors and can reverse and block the effects of other opioids. It can quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of overdosing with heroin or prescription opioid pain medications. Suboxone® contains **both buprenorphine and naloxone** while Subutex® **only contains buprenorphine.**

What is your opinion about MAT?

What is your personal and/or professional experience?

What have you seen regarding MAT?

Good experiences?

Not so good experiences?

Client Testimony

“Methadone kept me alive long enough to get clean and sober”

Challenges

- Huge division and contention among providers.
- Which MAT? And which provider? Not all are the same. Do your research.
- Maintenance or Detox?
- Doesn’t fit/connect in most self help-support groups.
- Medicating normal responses, i.e cravings, anxiety, etc.
- Not promoting abstinence.
- Inadequate focus on mandatory support.
- Magic pill mentality.
- Recovery limbo, “Am I clean and sober?” “Am I in Recovery?”
- Client receiving mixed messages from peers and providers.

- Other Challenges?

Narcotics Anonymous Statements

- “NA as a whole has no opinion on outside issues, including prescribed medications. Use of psychiatric medication and other medically indicated drugs prescribed by a physician and taken under medical supervision is not seen as compromising a person’s recovery in NA.”
- “The only way to keep from returning to active addiction is not to take that first drug. If you are like us you know that one is too many and a thousand never enough. We put great emphasis on this, for we know that when we use drugs in any form, or substitute one for another, we release our addiction all over again”.
- “We are people with the disease of addiction who must abstain from all drugs in order to recover.” ~NA, How it Works

Alcoholics Anonymous Statements

- “...just as it is wrong to enable or support any alcoholic to become readdicted to any drug, it’s equally wrong to deprive any alcoholic of medication, which can alleviate or control other disabling physical and/or emotional problems.”
- “No A.A. member should ‘play doctor;’ all medical advice and treatment should come from a qualified physician.”

- --A.A. General Service Office
- (Member Medications & Other Drugs brochure)

Recovery Limbo

- People on these medications are sometimes left in a Recovery limbo, not sure if they are really “clean and sober”and lacking a Recovery community of support. Since they often don’t feel welcome in 12 Step meetings they tend to miss out on the fellowship aspect of Recovery.

Treatment Plan

- Assess Stages of Change
- Define what would/are they willing and able to do
- What would it look like for this person to be in Recovery
- What would the Relapse Process look like
- Monitor and report
- Have a back up plan
- Be clear about your recommendations and concerns
- Acknowledge victories and setbacks
- Slow motion beats no motion

- Develop a MAT support group/network.
- Create a treatment plan with assignments.
- Always present total abstinence as an option.
- Explain the 12 Step program’s opinion on MAT.
- Acknowledge that the client went to a professional seeking help and was advised to begin MAT.
- Address mixed and confusing messages to the client

Negative and Potentially Dangerous Messages

Federal law requires patients who receive treatment in an OTP to receive medical, counseling, vocational, educational, and other assessment and treatment services, in addition to prescribed medication.

“Buprenorphine treatment works alone, even without behavioral health services. Access to medication treatment is better than no access at all”.

A “medication-first” model allows people to access medication treatment without requiring lengthy assessments and participation in counseling, which may increase access to care.

Benefits of Medication-Assisted Treatment

- Safe.
- Cost-effective.
- Reduce The Risk Of Overdose.
- Increase **Treatment** Retention.
- Improve Social Functioning.
- Reduce The Risks Of Infectious Disease Transmission.
- Reduce Criminal Activity.

- The ultimate goal of MAT is full recovery, including the ability to live a self-directed life. This treatment approach has been shown to:
- Improve patient survival
- Increase retention in treatment
- Decrease illicit opiate use and other criminal activity among people with substance use disorders
- Increase patients' ability to gain and maintain employment
- Improve birth outcomes among women who have substance use disorders and are pregnant

The Opioid Epidemic Viewed from a Cultural Persprective

The Cultural Considerations of the Opioid Epidemic

The current opioid epidemic is one of the largest drug epidemics recorded in U.S. history for all racial and ethnic groups.

Black and Brown communities have been experiencing an Opioid crisis for decades, it became an “Epidemic” when it reached the suburbs.

The Opioid Crisis/Epidemic

- Opioid addiction and related deaths increased at an alarming and unprecedented rate over the past 15 years in the United States. In fact, opioid overdoses have quadrupled since 1999.Pain medications such as methadone, oxycodone, and hydrocodone, and illicit opioids such as fentanyl, account for 1 in 6 drug overdose deaths in the United States.In 2016, nearly 43,000 people died from opioid-related deaths.
- Without strategic action and intervention, this number is projected to rise to nearly 100,000 per year by 2027. At the current rate, the crisis may result in more than 500,000 deaths over the next decade,largely due to the accessibility of synthetic variants such as fentanyl, and delays in addiction treatment. In addition to opioid overdose, misuse, addictions, and use disorders pose significant public health challenges, to say nothing of the suffering affecting families and communities nationwide.

PRESCRIPTION OPIOIDS

- At the forefront of the crisis is the supply of prescription opioids, in addition to the ready availability of heroin and fentanyl on the streets. In 2015 alone, more than 20,000 people died from overdoses involving prescription opioids. Sales of prescription opioids in the United States more than tripled from 1999 to 2014. Between 2007 and 2012, the rate of prescribing opioids increased among surgeons, pain management and emergency room physicians, and other specialists who manage pain regularly. Primary care providers accounted for nearly 50% of opioid pain medications prescribed.

Heroin use has changed from an inner-city, minority- centered problem to one that has a more widespread geographical distribution, involving primarily white men and women in their late 20s living outside of large urban areas.

In 2014 for the first time, new initiation to misused opioids occurred via Rx pain pills, not heroin.

Strong Policy Response

- Champion-led task forces and stakeholder engagement were key to opioid policy passage.
- Leveraging personal stories to garner buy- in helped propel state opioid efforts.
- A disjointed state legislature presented challenges in passing state opioid policies.
- Physician pushback and technical complications challenged policy implementations.
- Lack of appropriated funding for naloxone kits was a challenge to implementation.

2019 American Medical Association Recs:

To address the Opioid Epidemic

- Improving access to MOUD. (Medications For Opiate Use Disorder)
- Enforcing parity laws.
- Addressing network adequacy and enhancing workforce
- Expanding pain management options.
- Improving access to naloxone.
- Evaluating policy success and barriers.

The National Response re: the Black Community

- Black patients are 77 percent less likely to be prescribed buprenorphine and more likely to receive methadone treatment.
- They are both FDA-approved to treat opioid use disorder (OUD)
- This creates issues with access

Initial Stages of the Epidemic

- Lack of access to prescription pain medication
- Black/brown people prescribed pain meds less than white counterparts
- Preconceptions, racial biases and stereotyping of Black people seeking pain relief:
- Black/brown people are perceived as drug seeking
- More likely to abuse drugs

DRUG ADDICTION IS NOW CONSIDERED A PUBLIC HEALTH ISSUE

- In October 2017, the opioid epidemic in the U.S. was declared a national public health emergency
- Attention was focused primarily on White suburban and rural communities.
- The rate of increase of Black American drug overdose deaths between 2015-2016 was 40 percent compared to the overall population increase at 21 percent.
- From 2011-2016, African Americans had the highest increase in opioid

Solution Strategies

Acknowledge the systems that have disproportionately harmed historically marginalized persons who use drugs, and implement programs that reorient those systems towards service and treatment

Increase access to comprehensive, culturally competent, and linguistically appropriate drug user health services for Historically Marginalized Populations (HMPs)

Higher Mortality Rate Less Focus

- Attention to this epidemic has focused primarily on White suburban and rural communities. Less attention has focused on Black and Brown communities which are similarly experiencing dramatic increases in opioid misuse and overdose deaths. The rate of increase of African American drug overdose deaths between 2015-2016 was 40 percent compared to the overall population increase at 21 percent. This exceeded all other racial and ethnic population groups in the U.S. From 2011-2016, compared to all other populations, African Americans had the highest increase in overdose death rate for opioid deaths involving synthetic opioids like fentanyl and fentanyl analogs.

Different Pathways

- For African Americans, the current rise in opioid misuse and overdose deaths involves multiple pathways. One route to opioid misuse and overdose death is initiated through excessive prescribing and use of prescription opioids leading to OUD. For some individuals, as dependency grows on these pain medications, this evolves into the use of heroin, a cheaper and more readily accessible illicit opioid.
- Yet another pathway is initiated through the use of illicit drugs, i.e. heroin and cocaine, which has a history in low-income African American communities dating back to the drug epidemics of the 1960s and 1970s. What is particularly dangerous now, is that these street drugs are increasingly laced with fentanyl and fentanyl analogues leading to more opioid-related overdose deaths.7

Misconceptions Lead to Lack of Access

- The lack of access to prescription opioids is rooted in misperceptions and biases in the health care system including the undervaluing of African Americans' self-reports of pain and stereotyping by providers. A study of emergency departments found that African Americans are significantly less likely to be prescribed opioid prescriptions for pain from medical providers than White patients.
- A recent meta-analysis found that compared to Whites, African Americans were 29 percent less likely to be prescribed opioids for pain. Racial and ethnic minorities are more likely to experience miscommunication or misinterpretation about their pain with their medical providers. For example, African Americans have higher self-reported pain scores when compared to Whites, yet some doctors choose to believe that pain levels are lower for African Americans compared to Whites or that African Americans are drug seekers.

Negative Representations, Stereotyping And Stigma.

- African Americans with SUDs are doubly stigmatized by their minority status and their SUD. Negative images of African Americans with SUD contribute to mistreatment, discrimination and harsh punishment instead of treatment and recovery services. Mostly absent from this narrative are opportunities for compassion, understanding, treatment and recovery.

Intergenerational Substance Use And Polysubstance Use.

- For many families in the U.S., substance misuse is passed on from generation to generation and opioids are not the first or only drug being used. In some cases, multi-generational households are misusing opioids and other substances together. In communities with high poverty and economic disinvestment, intergenerational and polysubstance use are not uncommon nor unique to African American communities.
- For many in these poor and low-income communities, using and/or selling drugs is a means of survival. Opioids are not the only substances of concern and are likely not being misused in isolation. An understanding that intergenerational and polysubstance use are common among some impoverished communities, and that disentangling the behaviors of a person's social network, including their family, are challenging yet critically necessary.

Fear Of Legal Consequences.

Only 10 percent of people with a SUD in the general population seek treatment. This is magnified in the African American community where there is significant historical mistrust of the health care, social services, and the justice system. For men, there is the looming fear that seeking treatment will result in severe sentencing and incarceration reminiscent of the harsh policies of the past.

African Americans represent a substantial percentage of drug offenders in federal prison despite Whites representing the majority of illicit drug users in the U.S. African American women fear losing their children to the foster care system if they acknowledge a substance use problem and seek treatment.

We Must Understand the Cultural Context

- Engaging in treatment is a difficult task for all populations. When the cultural context is ignored or misunderstood, respect for the patient is lacking, little hope is provided, and a lack of African American practitioners who treat SUD exists, it becomes very difficult for an African American with SUD to engage in treatment.

Unequal Treatment and Limited Access

- Unequal treatment is common in many African American communities, where access to treatment options is more dependent on race, income, geography, and insurance status, rather than individual preferences, or medical or psychiatric indicators. Research suggests that African Americans with OUD have experienced limited access to the full range of medication-assisted treatment (MAT) when compared to Whites.

- One study based in New York City found that the residential area with the highest proportion of African American and Latino low-income individuals also had the highest methadone treatment rate, while buprenorphine and naloxone were most accessible in residential areas with the greatest proportion of White high-income patients.

Methadone Most Frequently Utilized

- Methadone, while an effective treatment, places more burdens on the patient such as daily clinic visits, regular and random drug testing, employment disruptions, required counseling, etc. Thus, methadone —stigmatized in many African American communities and as one key informant noted, “ *just doing one drug for another drug*”—is often viewed as the default treatment for African Americans and often the only treatment option.
- Essentially, a two- tiered treatment system exists where buprenorphine is accessed by Whites, high-income, and privately insured, while methadone is accessed by people of color, low-income, and publicly insured.

Disparity to Access

- This disparity in access to buprenorphine by race/ ethnicity, geography, income, and insurance status, may be related to barriers for both the patient and clinician. Buprenorphine is generally a less stigmatizing treatment for people with SUD compared to methadone. It is an office-based treatment available for general/primary care practitioners to prescribe and administer. Office-based treatment programs only work for patients with access to primary care, something that may be inaccessible to many low-income or uninsured people of color.

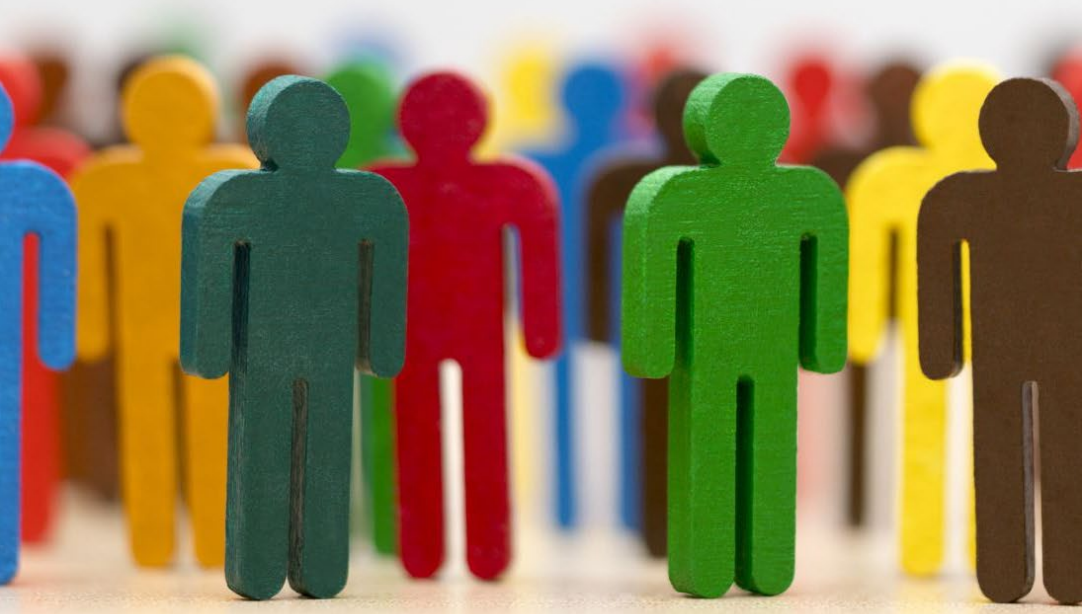
Community-Informed Strategies To Address Opioid Misuse And OUD In African American Communities

1. Implement A Comprehensive, Holistic Approach —“Addiction Is Beyond The Neuroreceptor Level.”

2. Involve The Community And Develop Multi- Sectoral, Diverse Community Partnerships— “Community-based Organizations Are The Engines Managing Crises Before They Get To The Hospital.”

3. Increase Culturally Relevant Public Awareness--*"campaigns Are White-washed And Make No Sense In Black Communities."*

4. Employ Culturally Specific Engagement Strategies--*"the Opposite Of Addiction Is Not Abstinence, It's Connection."*



5. Create A Culturally Relevant And Diverse Workforce--*"[we] Have Trained Black Peers, But Not A Black Supervisor."*

6. Meet People Where They Physically Are, Again And Again.

Closure

- Q &A
- What Stood Out For You The Most And What If Anything Are You Going To Do Differently?

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