The Spirit of Our Work

1. On Dopamine

“We need three things to survive (besides oxygen): food, water and dopamine. If you deprive study subjects of water for three days, then put them in a functional MRI and place water on their lips, the relative size of the craving is like a baseball. Do the same with food, and it is like a basketball. Then take someone with an addiction to opioids, up to one year after their last use, and talk about OxyContin while they are in a functional MRI, and the relative size of that craving is the size of a baseball field.” (Corey Waller MD, 2016)

2. Decreasing Stigma and Shifting Cultures

"Addiction is a chronic, progressive, relapsing disease."
– American Society of Addiction Medicine

- Often, patients presenting to Emergency Departments with opioid withdrawal or craving are not treated with respect or adequate care.
    - "Health professionals may have an avoidant approach to delivery of care with substance use disorder patients compared to other patient groups. This avoidance may result in shorter visits, expression of less empathy, and less patient engagement and retention." (Kelly, 2016)

    - Many problems cascade with this stigmatizing avoidant approach including risks of overdose/death and expense of untreated addiction.
- "What to do about stigma: education, personal witness, shift language/terminology." (Kelly,2016)

- Language can be pejorative and confusing.
    - Describing lab results, specifically Urine Drug Screens as 'clean' or 'dirty'. The correct language is Positive or Negative.
    - Using the word ABUSE in diagnosis. "Substance Abuse" is no longer a diagnosis and the term is outdated, though still common.
    - 'Misuse' or simply 'use' can replace the word 'abuse'.
    - Describing patients as 'drug seeking'. Relief-seeking is a better way to provide care, including intervention and referral.
    - "Persons with addictions "or "addicted people" rather than "addicts".
    - "Heroin users "rather than "heroin addicts".
- Misunderstanding among the 12 Step and Recovering community about medication-assisted treatment with buprenorphine can cause stable patients to taper off so that they can be considered 'sober' in their fellowship. The culture can inappropriately "practice medicine". One patient described his experience in NA as 'persecution' because he was prescribed Suboxone and in a MAT program. In some NA fellowships, a person prescribed methadone is not permitted to share in a meeting.
- Patients need to be educated to maintain their medical confidentiality. What their MD prescribes is between patient and MD. No one else needs to know, including sponsors.

Historically, 12 Step communities were equally resistant to the use of SSRI treatment when introduced in 1988.

Addictive Disease Concept (Medicine) and Substance Use Disorder concept (Psychiatry and Psychology)

- Many providers continue to view addiction as a moral failing, *this is often because of the moral compromise which occurs with a progressively compulsive disease which involves destructive, illegal substances*
- Alcoholics Anonymous did not officially accept 'disease concept' until late 1980's.
- In 1988, the US Supreme Court decided that it was not fully known if alcohol dependence is a disease and therefore ruled against the challenge to the Dept. of Veterans Affairs refusal to make alcohol dependence a service-connected disability. This ruling continues to the present. The correlation between military and combat trauma and substance use is well-researched.

3. Opioid Epidemic and how we got here

"The worse man-made epidemic in modern medical history."

- Center for Disease Control and Prevention (2016)

- OxyContin, developed by Purdue Pharmaceuticals introduced as new pain medication for malignant pain in 1996
- Long-acting oxycodone – advertised as *less addictive*
- Morphine Equivalent 1 ½ times of hydrocodone
- Binds to Kappa opioid receptor as well as Mu opioid receptor – offers more relief and more reward – *more addictive*
- Sackler Brothers (3 MDs) and the art of selling medications to America
- Aggressive marketing based on poor research.
- One letter to the editor in Journal of American Medical Association shows a small number of patients did not acquire addiction from opioids <u>prescribed while in hospital.</u>
- Hospice movement initiated new interest in improving pain management.
- VA introduced the 5th Vital Sign – measuring and treating pain with every visit.
- Joint Commission made 5th Vital sign a requirement of care.
- Physician surveys gave patients opportunity to score their providers based on how well pain was managed.

  As the river of pain pills began to dry up, heroin cheaper and easily available throughout America.

  Recommended Reading: Dreamland - Sam Quinones
  Drug Dealer MD – Anne Lemke MD

- Opioid Use Disorder –
  - Screening using the Opioid Use Disorder DSM-5 tool (see MAT Tools)
- Diversion
  - Selling, trading, borrowing of prescribed medications and illicit drugs
- Misuse
  - Loss of control in spite of consequences
  - Taking more than prescribed, running out early, combining prescribed medications with dangerous CNS suppressant medications not prescribed or alcohol

Switching from prescription pain medications to heroin escalates the problem.
Lack of access to care is at the heart of the epidemic.

4. Harm Reduction, Enabling and Abstinent-Directed Care

From the Harm Reduction Coalition -

Principles of Harm Reduction

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users "where they're at," addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

However, HRC considers the following principles central to harm reduction practice.

- Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being–not necessarily cessation of all drug use–as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.

- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

http://harmreduction.org/about-us/principles-of-harm-reduction/

From Hazelden Betty Ford

"Enabling is different from helping and supporting in that it allows the enabled person to be irresponsible."

Elina Kala, MA Mental Health Professional

Enabling behavior:

- Protects the addicted person from the natural consequences of his behavior
- Keeps secrets about the addicted person's behavior from others in order to keep peace
- Makes excuses for the addicted person's behavior (with teachers, friends, legal authorities, employers, and other family members)
- Bails the addicted person out of trouble (pays debts, fixes tickets, hires lawyers, and provides jobs)
- Blames others for the addicted person's behaviors (friends, teachers, employers, family, and self)
- Sees "the problem" as the result of something else (shyness, adolescence, loneliness, broken home, ADHD, or another illness)
- Avoids the addicted person in order to keep peace (out of sight, out of mind)
- Gives money that is undeserved or unearned
- Attempts to control that which is not within the enabler's ability to control (plans activities, chooses friends, and gets jobs)
- Makes threats that have no follow-through or consistency
- "Care takes" the addicted person by doing what she is expected to do for herself

https://www.hazeldenbettyford.org/articles/kala/enabling-fact-sheet

Abstinence-Directed Recovery

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The American Society of Addiction Medicine (ASAM)defined
recovery as:
"A process of sustained action that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction. This effort is in the direction of a consistent pursuit of abstinence, addressing impairment in behavioral control, dealing with cravings, recognizing problems in one's behaviors and interpersonal relationships, and dealing more effectively with emotional responses. Recovery actions lead to reversal of negative, self-defeating internal processes and behaviors, allowing healing of relationships with self and others. The concepts of humility, acceptance, and surrender are useful in this process."

Abstinence-directed patients often find safety, recovery support and stability in 12 Step Programs. The challenge is that patients who are taking prescribed medications for their addictions such as buprenorphine or methadone are not considered to be "clean and sober" in the 12 Step culture.

5. Whole Person Care, Level of Care and "What Did we Miss?"

Learn and Understand the 6 dimensions of whole person care and criteria for assessing needs.
ASAM Grid (see MAT Tools)

1. Detox needs
2. Medical Needs
3. Behavioral Health Needs
4. Readiness
5. Relapse
6. Environment

- In traditional treatment settings, the approach has been to blame the patient "They were not ready to get clean and sober."
  This may be true but our job as clinicians is to consider the level of care, access to appropriate level of care, identify real barriers for the person to succeed.
- The ASAM Grid is an excellent way to review the case of patient who has left treatment or fails to return. "what did we miss?" is a useful way to review a patient with repeated failed attempts. It often becomes clear as to what is driving treatment failures.

6. Heroin, Trauma and Resilience

"The first question—always—is not "Why the addiction?" but "Why the pain?"
~ Gabor Mate MD, author In the Realm of the Hungry Ghosts

- Self-harm behaviors –using a needle is a form of 'cutting'
- The numbing of all pain –physical, mental and emotional
- Opioids relieve symptoms of Post-Traumatic Stress Disorder.

Adverse Childhood Experiences (ACEs) screen (see MAT Tools) in early assessment process – ask permission of the patient to ask difficult questions, screen with sensitivity and respect. Patients often have a moment of insight into their addiction when guided through this screen.

Persistent poverty in childhood is traumatic and reflects in a child's life as neglect from society.

"Upon an assessment of individuals who had experienced childhood maltreatment, a study found that being mistreated during childhood caused frequent and *extremely high levels of stress that impeded normal brain development*. Continuous stress from experiencing frequent maltreatment initiated physiological stress responses that, over time, caused the structural disruptions that were observed in neurological scans and which are likely making victims of childhood trauma vulnerable to substance abuse disorders.[3]

Historical Trauma - is defined by Maria Yellow Horse Brave Heart, PhD as "cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma."

Indigenous people
Enslaved people
Holocaust Survivors
Undocumented immigrants/Dreamers/Latino communities

Intergenerational trauma - is trauma transferred from the first generation of trauma survivors to the second and further generations of offspring of the survivors via complex- post-traumatic stress disorder mechanisms.

Connected to historical trauma
Children and grandchildren of Native people kidnapped and abused in boarding schools
Children of Combat veterans
Children and grandchildren of addicted persons

Adult Children of Alcoholics is an example of healing response to intergenerational trauma

War and opioids

- Large upsurge in opioid use as Civil War veterans returned home after being treated by morphine on battlefields. Laudanum (tincture of opium), high potency opioid and highly addictive, was a drug of choice in the Wild West along with alcohol. The opium smoking Chinese laborers who worked on the Trans-Continental Railroad and in gold mining camps were the early opiate users in the west before the Civil War.
- After Vietnam War, increase of heroin use throughout general population. Some VN veterans have remained addicted to opioids for 40 + years. Many of them have acquired severe opioid pain medication addictions.
- High numbers of Iraq and Afghanistan War veterans with acute combat and military trauma are also opioid dependent. Many young people reportedly entered the military to get away from their opioid addictions.

Return of the Felt Experience and Resilience

Important: unlike the broad numbing of physical, emotional and psychological pain which comes from use of full agonist opioids, the partial opioid agonist buprenorphine allows *the return of the felt experience of life* - emotions and sensations. It is essential that we acknowledge this with our patients, prepare them for the return of feelings and a develop a treatment plan which supports the challenges and opportunities of this 'tingling to life'.

- One patient told how after many years on heroin and methadone maintenance, after transitioning to buprenorphine/naloxone therapy the surprise and delight of crying at a movie and laughing with his children.

Cultivating resilience in early recovery

- Introduce The Resilience Questionnaire (see Group addendum)
- Must be skills based and focused on self-regulation
- Mindfulness with emphasis on body-sensing and grounding techniques.

  Deep breathing can be activating and overwhelming for our patients with severe trauma.

Seeking Safety
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Dialectal Behavioral Therapy (DBT)
Acceptance *Commitment Therapy*

7. Diversion – what to consider

Diversion is a legal term which describes the common behavior of trading, selling, buying, sharing prescribed medications.

- Prescribed opioid medications have become a currency in the vast underground illicit drug economy. In the case of the opioid epidemic, the over-prescribing of opioids fueled the problem and the rampant criminal activity around the epidemic.
- As the prescribing of opioids began to slow down due to pressure on providers and the concerns about diversion, the costs of the diverted pills increased in value and the market forced changes in opioid using. As the flow of prescription opioids slowed to a trickle, many addicted persons found their way to heroin.
- "Pill Mills" advertised as Pain Clinics where large prescriptions for opioids were easy to obtain became a source for the river of opioid pain medications, often with minimal assessment or diagnosis for 'chronic pain' by unscrupulous medical providers. Many states looked the other way as this problem intensified. Anecdotally, the VA system across America also became a well-known source for the pills which became a source of income or a way to access other drugs of choice.
- The Pill Ladies – The Great Recession of 2008 triggered by the collapse of banks and the massive loss of jobs brought some unlikely participants into the underground diverted prescribed narcotics economy. With diverted opioids holding high value and incomes crashing, it was not uncommon for low-income senior communities to become the go-to place to buy OxyContin, Norco, Morphine Sulfate, Fentanyl at a good rate. This provided much-needed income for people. I once spoke with such a person who said they had to choose between managing their pain or buying food. A patient in one of our buprenorphine programs described the befriending of lonely seniors living in mobile home parks to gain access to their prescription opioids. This patient called these sources of diverted opioids "the Pill Ladies".
- The Prescription Drug Monitoring Program (PDMP) requires use of CURES – The Controlled Substance Utilization Review and Evaluation System (CURES) was certified for statewide use by the Department of Justice (DOJ) on April 2, 2018. Therefore, the mandate to consult CURES prior to prescribing, ordering, administering, or furnishing a Schedule II–IV controlled substance becomes effective on October 2, 2018. Visit www.mbc.ca.gov/CURES for detailed information regarding CURES 2.0. https://oag.ca.gov/sites/all/files/agweb/pdfs/pdmp/cures-mandatory-use.pdf

The CURES law applies to prescribing of buprenorphine/naloxone. As long as a patient continues with prescribed suboxone (buprenorphine/naloxone), the CURES must be run every 4 months.

- Diverted Suboxone – Because of poor access to prescribed suboxone with treatment care, many of those with opioid use disorders obtain their suboxone on the streets. The cost is anywhere from $10 -$25 for one suboxone 8/2 mg film or sublingual tab depending upon location. Many people have been self-treating their opioid addictions with diverted suboxone for years. We can safely assume that almost all of our patients have engaged in diversion of prescribed medications, it is part of the lifestyle and culture of using. One way of thinking about diverted suboxone is that it is safer for the addicted individual to be using suboxone than heroin.
- With patients entering programs with experience with suboxone, many have experienced or witnessed precipitated withdrawal. These patients may do well with home inductions because they understand the importance of discontinuing all opioids and waiting for withdrawal symptoms before taking their first suboxone doses. Some come into our programs with diverted suboxone on board so they do not require inductions.
- Once a patient with opioid use disorder has been admitted to the Medication-Assisted Treatment program, the behavior of diversion must stop. Recovery requires the person reclaim and invest in an honest, law-abiding lifestyle. Recovery is reflected in all relationships. A patient's relationship with their buprenorphine/naloxone provider must be one of honesty and trust. A provider cannot be viewed as a supplier of drugs by our patients or by the community.
- Ways an MAT program can limit and monitor for diversion of prescribed suboxone.
    1. MAT Treatment Agreement identifies diversion as a possible reason for discharge as this behavior *directly impacts the safety of the community*. The MAT team must be willing to act decisively when evidence of a patient diverting prescribed buprenorphine has emerged.
    2. Short suboxone prescriptions such as 7-day Rx until patient has stabilized also supports establishing trust. Increase lengths of prescriptions as appropriate until patient receives and manages a month's supply of prescribed suboxone.
    3. Random call backs for pill or film counts. This can be a requirement of the progression through the phases. For example, when a patient is ready to progress from Phase 2 (every 14-day Suboxone Rx) to Phase 3 (monthly Rx), they must have at least one successful callback.

8. Changing Clinic Culture

Often, we find the strongest stigma expressed towards person with addictions within the walls of care, within our clinic cultures. Most of us have been directly touched by alcoholism and addiction – there are often feelings of frustration, anger, grief and loss which can color an individual's attitudes towards our patients who suffer with the disease of addiction.

- A useful way to introduce and establish a Medication-Assisted Treatment program is to take opportunity to spend time with every department in your primary care clinic.
- Schedule a brief ½ hour meeting with each department.
- This gives every staff member an opportunity to learn about and understand buprenorphine/naloxone (Suboxone), injectable naltrexone (Vivitrol) and naloxone (Narcan).
- Staff members can learn about the program itself.
- A one-page handout can be helpful
    - How the medications work
    - Patient pathway of care
    - Inspire compassion
    - Discuss common stigmatizing language
- Each department – call center, front desk receptions, medical assistants, billing, coding, dental, etc. will require education on each department's role in MAT program specifics.
- Allow time for concerns and questions.
- Be available to clinic departments for check-ins as program gets up and running.

9. Motivational Interviewing – a few useful basics

- Motivational Interviewing is a way of helping people find *their own reasons* for change.
- Empathy – to accurately understand the client's meaning and then the ability to reflect that accurate understanding back to the client.
- The Paradox of change: when a person feels *accepted* for who they are and what they do – no matter how unhealthy – it allows them the *freedom* to consider change rather than needing to defend against it.

Spirit of Motivational Interviewing

- Dancing vs. Wrestling
- Exploring and resolving ambivalence
- Honors autonomy
- Collaborative
- Warm and friendly
- Respectful
- Stages of Change
- Pre-contemplation –the stage in which people are not considering changing or initiating a behavior. They may be unaware that a problem exists.
- Contemplation – characterized by ambivalence about changing or initiating a behavior.
- Preparation – characterized by reduced ambivalence and exploration of options for change.
- Action – characterized by taking action in order to achieve change.
- Maintenance – characterized by seeking to integrate and maintain a behavior that has been initiated.
- Relapse – characterized by a recurrence of the undesired behavior.

What are the Interviewer's tools?

- Validation
- Kindness
- Body language/ tone
- Listening
- Asking questions – use your OARS
- Acceptance
- Respect
- Sensitivity
- humor

Be Careful Of:

- Too much teaching and information

- Giving advice
- Challenging
- Offering personal perspectives
- The "righting reflex"
    - The need to…
        - Fix things
        - Set someone right
        - Get someone to face up to reality

OARS

- Open ended questions
    - "How concerned are you about your drinking?" rather than "Are you concerned about your drinking?"
- Affirmation
- Reflective Listening
- Summarizing

Listen With:

- Presence – undivided attention
- Eyes, ears and heart
- Acceptance and non-judgment
- Curiosity
- Delight
- No interruptions
- Silence

Change Talk

- Represents movement towards change.
    - Preparatory change talk:
- Desire: "I want to…"
- Ability: "I can…"
- Reasons: "There are good reasons to…"
- Need: " I really need to…"
    - Activating change talk: "I am going to…" "I intend to…" "I will…" "I plan to…"
- How important is it to you to make changes around your drinking?
- How confident are you that you can make changes around your drinking?
- How ready are you to change your drinking?

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10.Community Opioid Coalitions

- Many coalitions have formed spontaneously throughout the state and nation to address the opioid epidemic
- California Health Care Foundation sponsored a Safe Rx project in 2016 which supported the building of the coalitions
- CA Hub & Spoke System of Services grant specifically funds and supports the forming and sustaining of community opioid coalitions
- In Nevada County, a coalition to build a Crisis Stabilization Unit decided to continue as SUD Coalition.
    - Jail team
    - Chief of Police
    - Hospital CMO and other staff
    - FQHCs
    - County Behavioral Health
    - School Prevention Programs
    - Judges
- Opioid Coalitions improve:
  Education throughout the community
  Warm hand-offs between agencies
  Community specific problem solving such as improving Narcan access

11. Cultural Humility – the fundamentals

Brett Kuwada, PsyD. "Cultural Humility, Empathy & Compassion" (2017)

Three Dimensions of Cultural Humility

- Lifelong learning & critical self-reflection
- Recognize and challenge power imbalances
- Institutional accountability

Lifelong Learning & Critical Self-reflection

- Coming from a place of knowing that we don't know
- Being able to accept our own limitations
- Encouraged to be curious tied to that place of not knowing
- Openness - we can feel open to those around us who want to learn about us
- All leads to lifelong learning and ongoing critical self-reflection
- We hold ourselves accountable for constant learning and curiosity to understand those around us
- Frees us from feeling that we have to be experts on others and their culture

Recognize and Challenge Power Imbalances

- We attempt to recognize when we are in a position of power and make attempts to neutralize this imbalance
- We notice when there is a power imbalance in systems and acknowledge this difference, also taking responsibility to point out and advocate

Institutional Accountability

- At an institutional level, we need to encourage this philosophy/culture
- If the system has embraced this philosophy, it will be much easier for the individuals to feel safe with the practice