Update on local ATOD statistics in San Antonio and Bexar County

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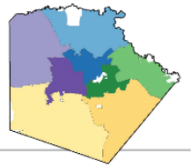
Topics for today's session

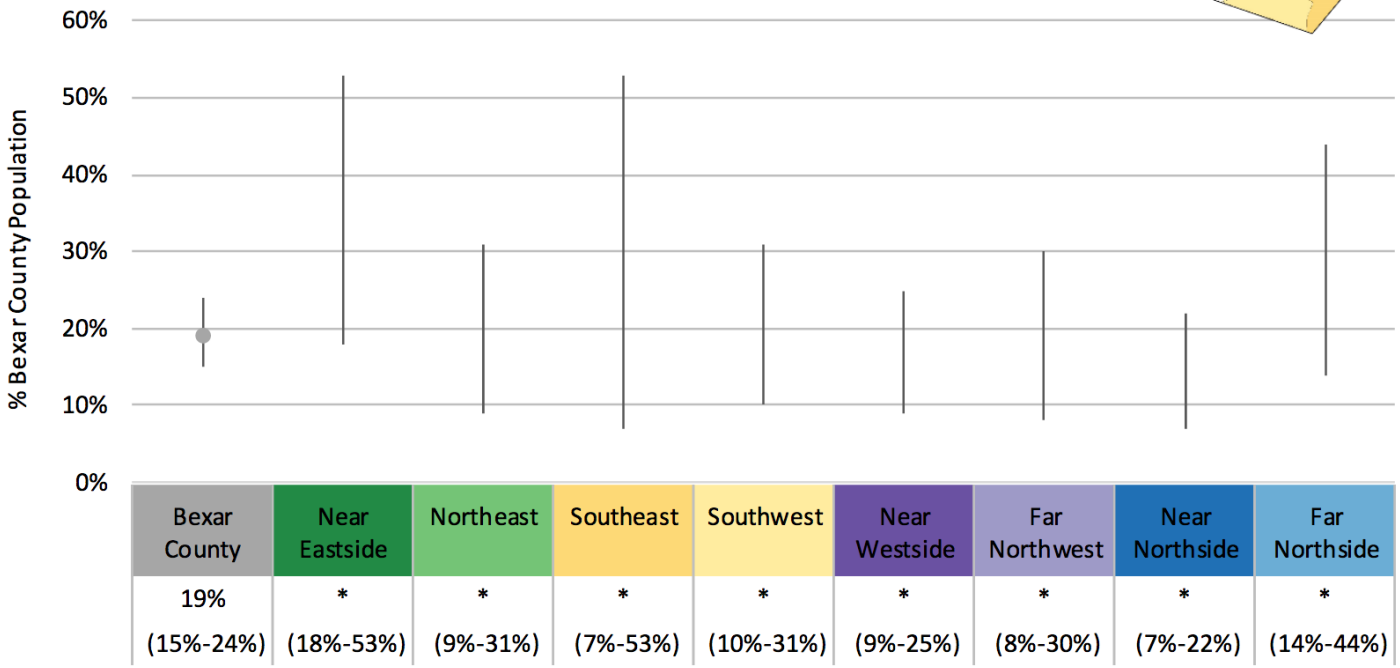
1. The BIG 3 (Tobacco, Alcohol, Marijuana)
2. What's happening with opioids?
3. Drug poisoning mortality
4. Substance use related problems
5. Takeaways
6. A lesson learned
7. Region 8 Epidemiology workgroup

Current smoking among adults in Bexar Co.

Adult Smokers

Figure 4.3 Percentage of adults who currently smoke





Bexar County	Near Eastside	Northeast	Southeast	Southwest	Near Westside	Far Northwest	Near Northside	Far Northside
19% (15%-24%)	* (18%-53%)	* (9%-31%)	* (7%-53%)	* (10%-31%)	* (9%-25%)	* (8%-30%)	* (7%-22%)	* (14%-44%)

Source: Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011-2014 3-Year Average (with 90% CI).
*90% confidence interval too wide to display estimate.

National rate: 16.8% (2014)

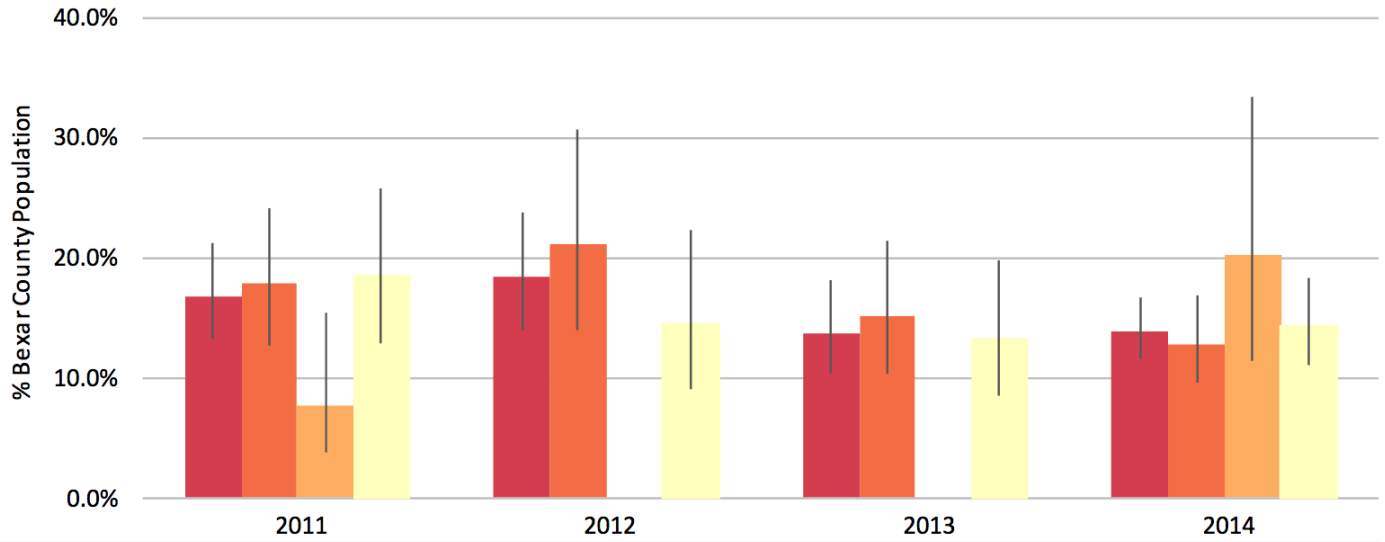
Texas state: 15.2% (2016)

Source: Health Collaborative, 2016

Racial/ethnic differences in smoking in Bexar Co.

Adult Smokers

Figure 4.4 Percentage of adults who currently smoke by race/ethnicity

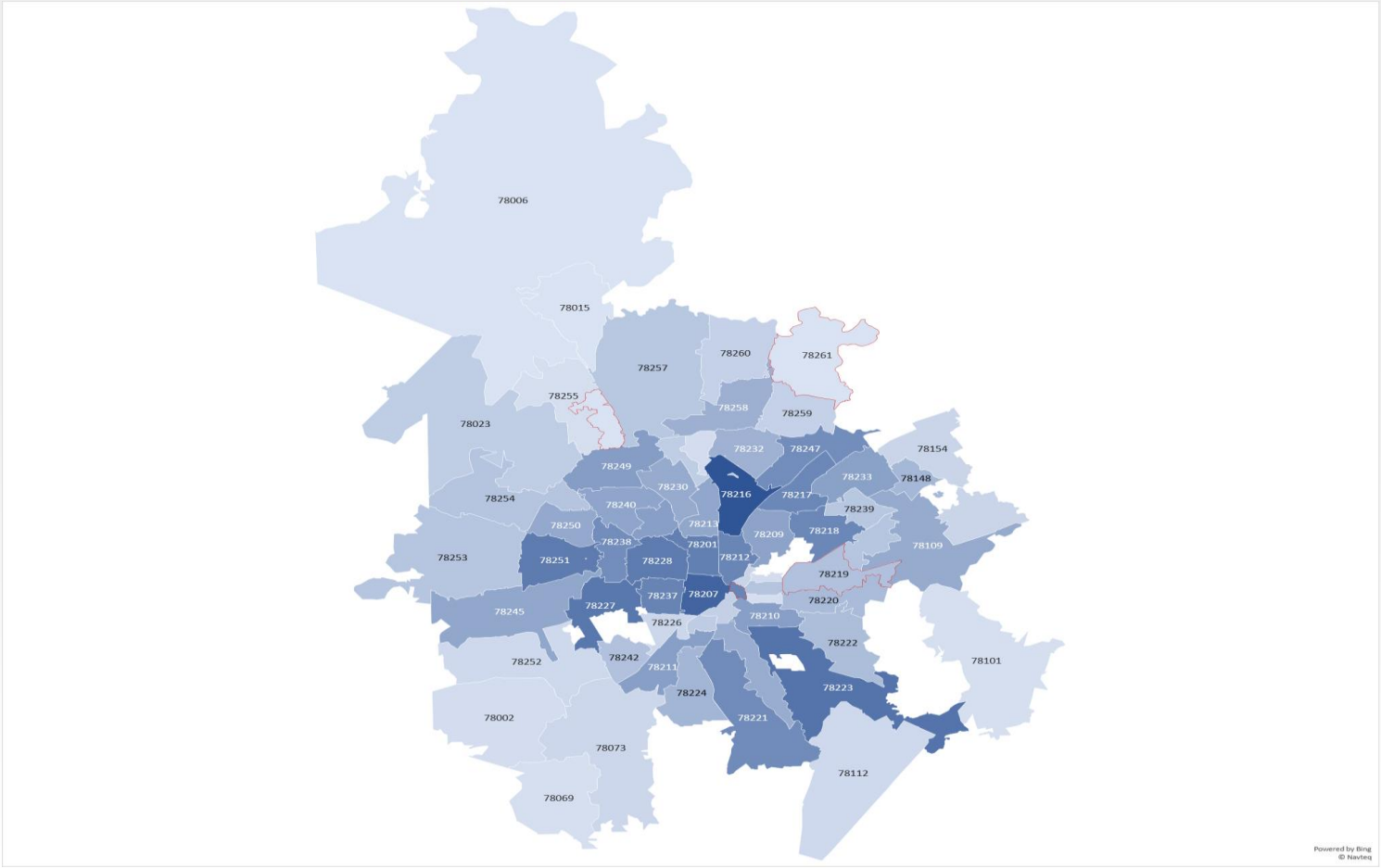


	2011	2012	2013	2014
Overall	**16.8% (13.3%-21.2%)**	**18.5% (14.0%-23.9%)**	**13.8% (10.4%-18.1%)**	**14.0% (11.7%-16.7%)**
White	17.9% (12.8%-24.2%)	21.1% (14.0%-30.7%)	15.1% (10.3%-21.5%)	12.9% (9.7%-17.0%)
Black	7.8% (3.8%-15.5%)	**	**	20.3% (11.5%-33.5%)
Hispanic	18.6% (13.0%-25.9%)	14.5% (9.1%-22.3%)	13.2% (8.6%-19.8%)	14.4% (11.1%-18.4%)

Source: Texas Behavioral Risk Factor Surveillance System; Statewide BRFSS Survey, 2011-2014. **Sample too small to report.

Source: Health Collaborative, 2016

Tobacco Retailer Density: Range 3-78

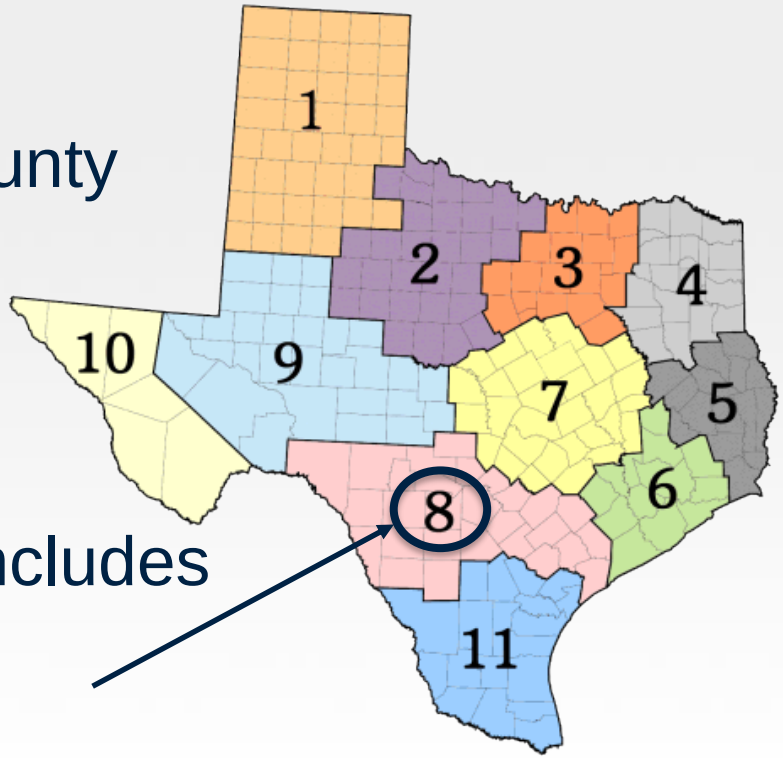


Lowest (3)
78261

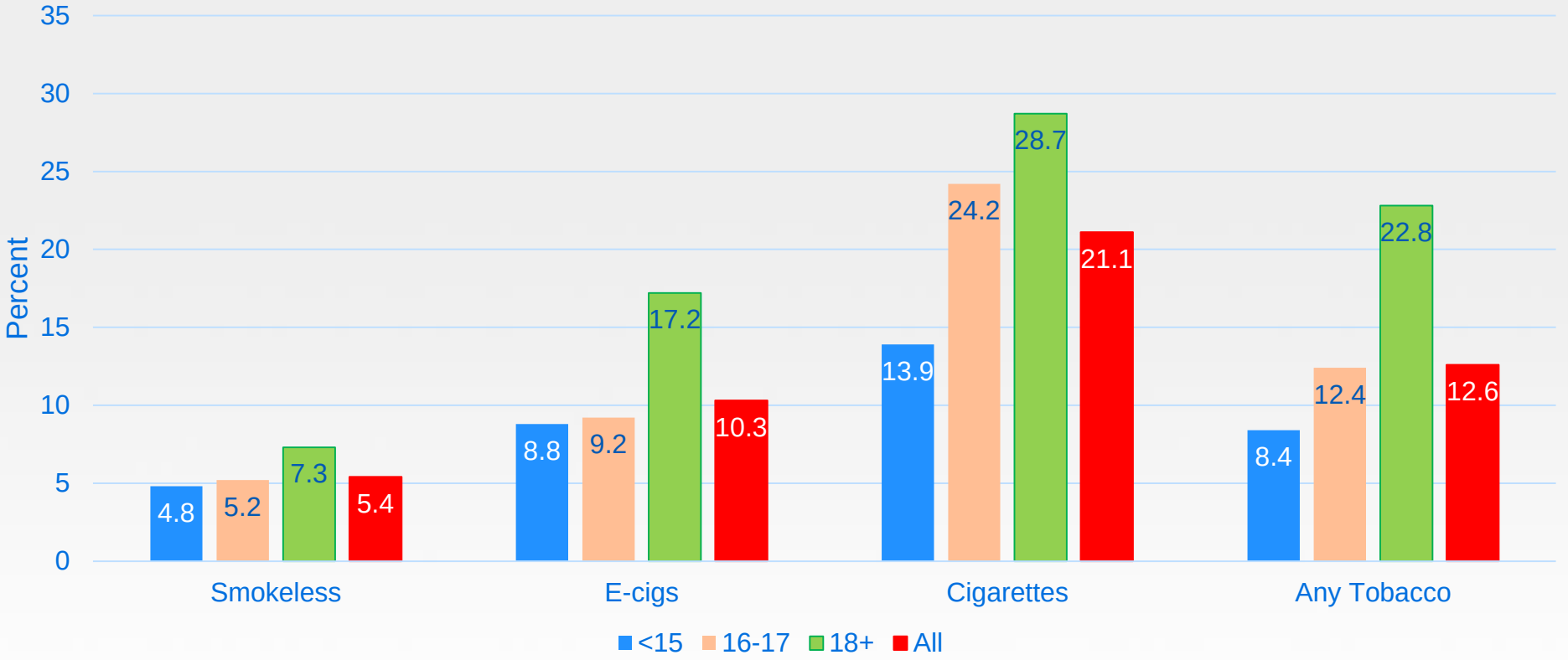
Highest (78)
78216

Surveys of Youth Tobacco Use

- YRBS data from 2001-2017 did not include students from Bexar County
- Texas School Survey
  - 2018 included 1700 Bexar County students
- We'll look at trends among:
  - Students in Texas 2001-2017
  - Students in Region 8 (which includes Bexar County) in 2018

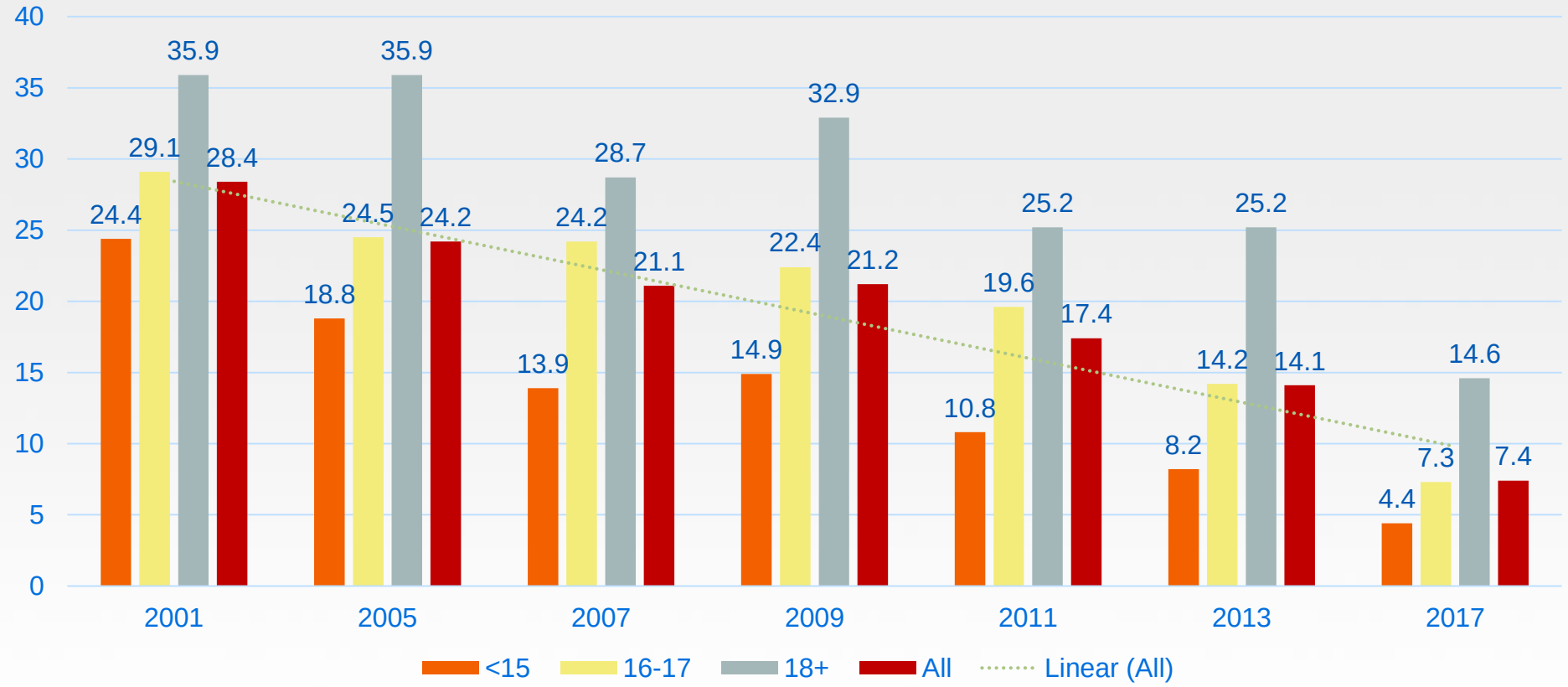


2017 Percentage of Texas Students (9th-12th) Who Tried Selected Nicotine or Tobacco products on One or More Days of the Past 30 Days



Texas health Data, Texas YRBSS, http://healthdata.dshs.texas.gov/Home

Percentage of Texas Students (9th-12th) Who Smoked Cigarettes on One or More Days of the Past 30 Days (Current Smoker)



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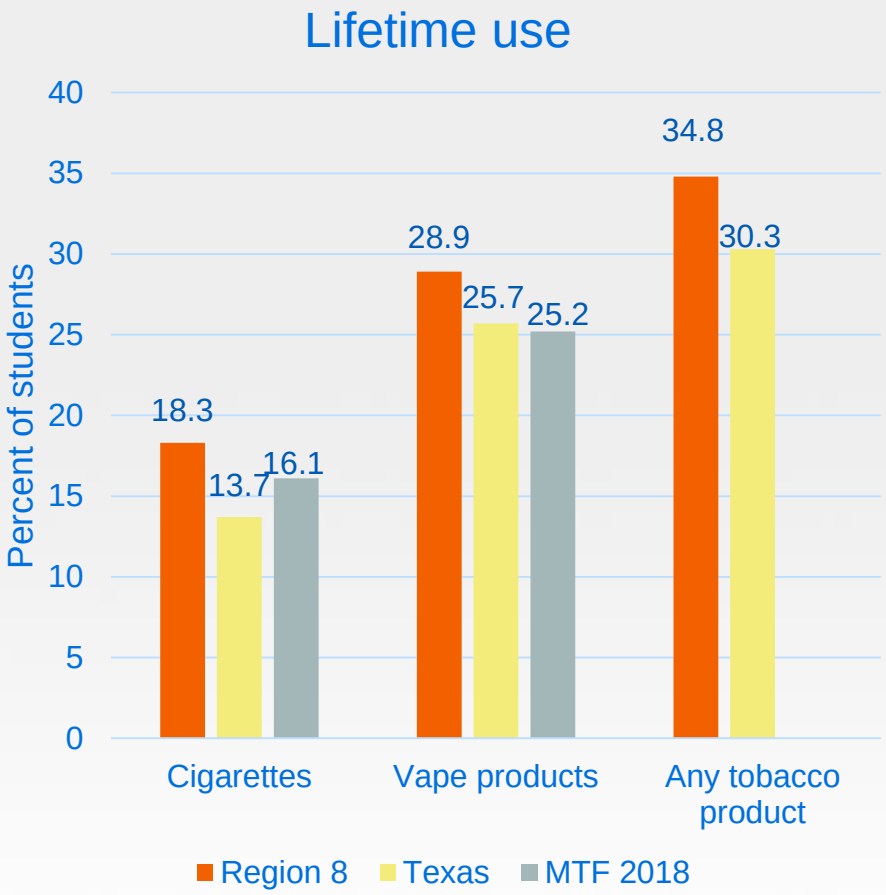
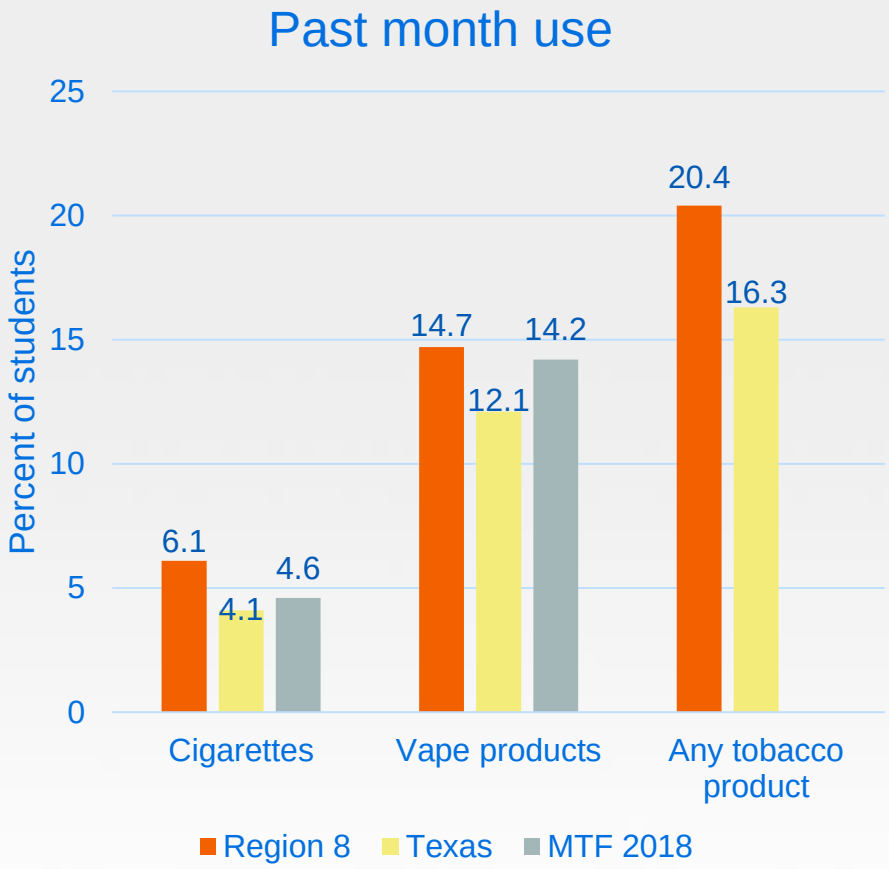
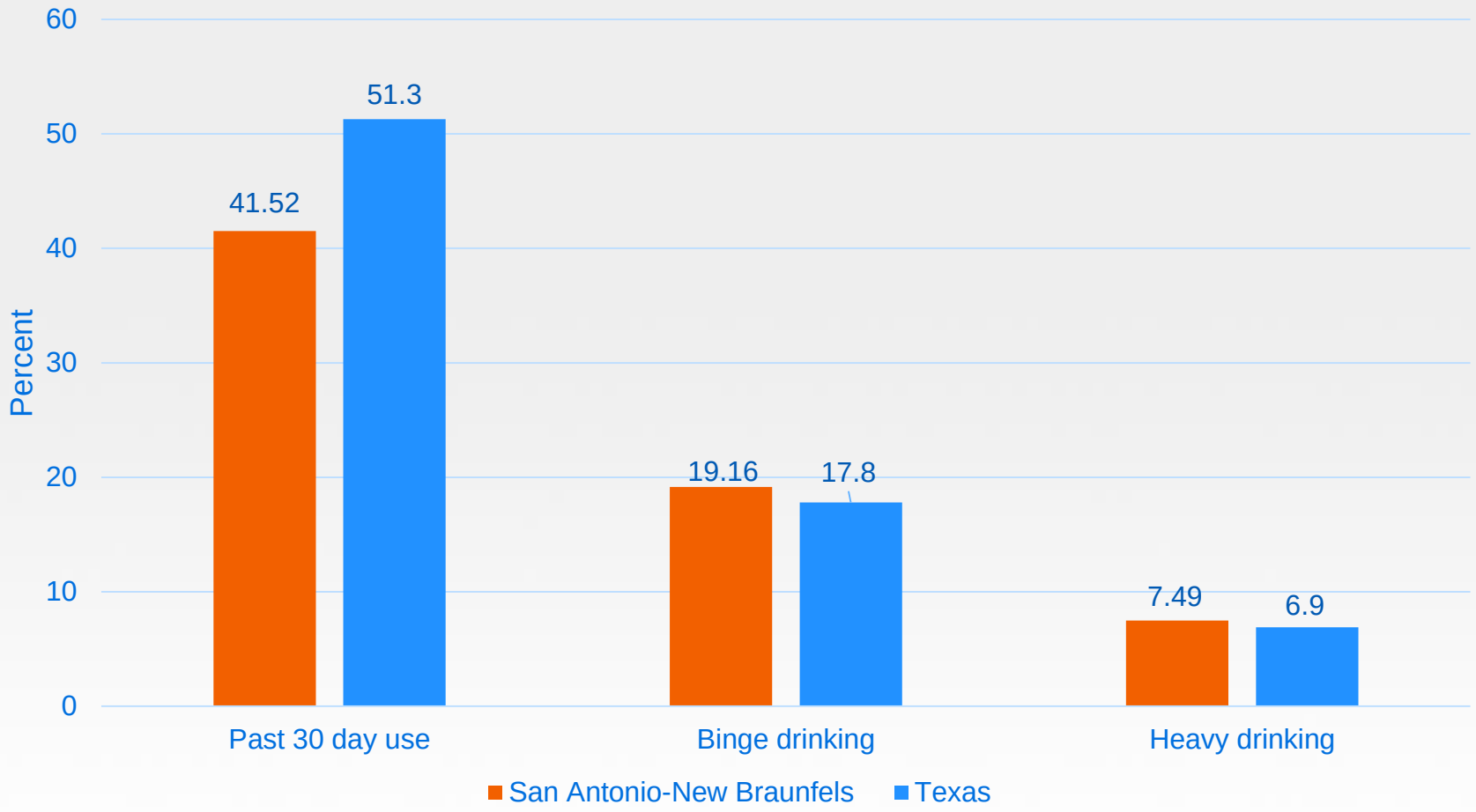
Tobacco use in Region 8 (2018)





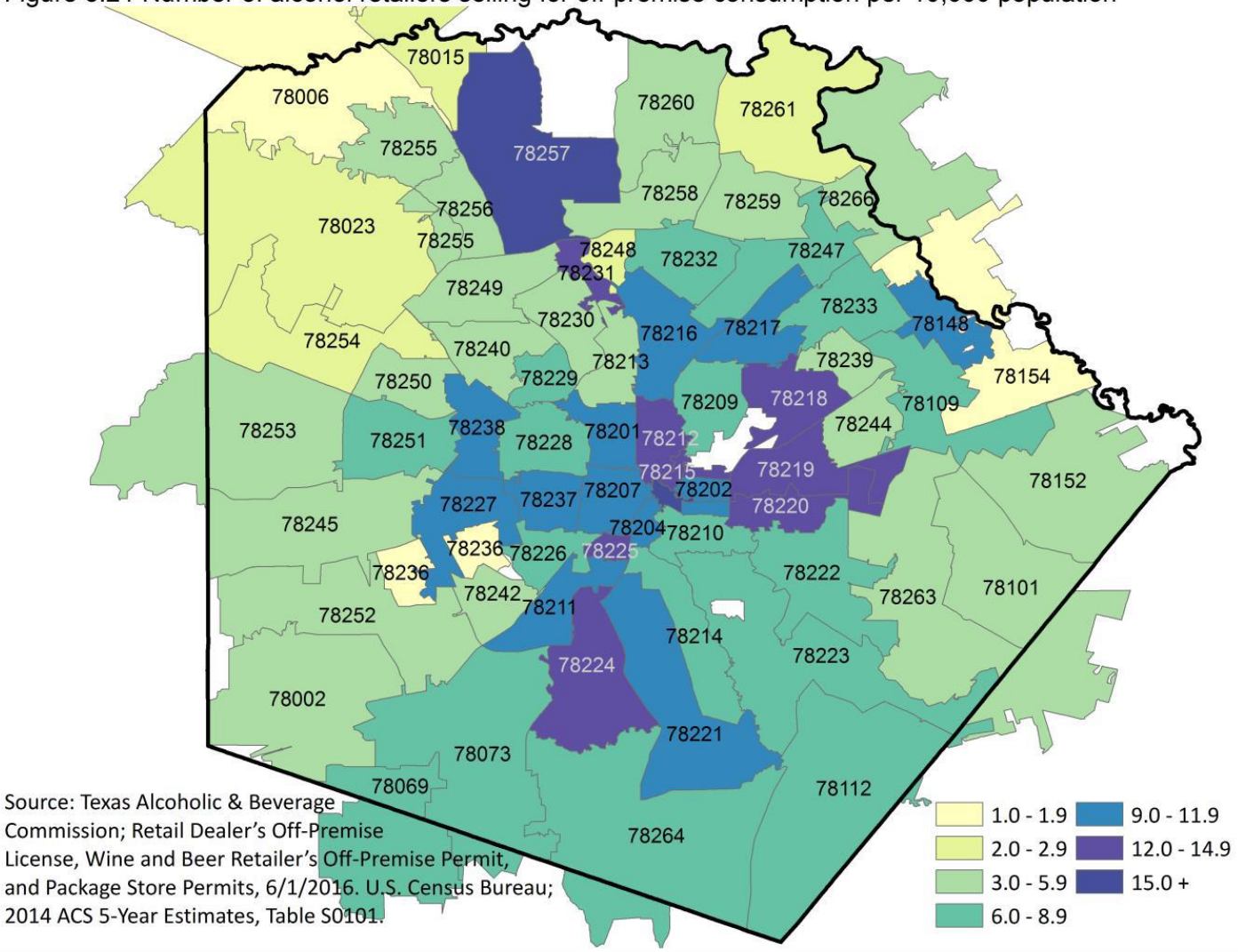
Adult alcohol use indicators (2017)



Source: CDC BRFSS

Alcohol Retailer Density by Zip Code

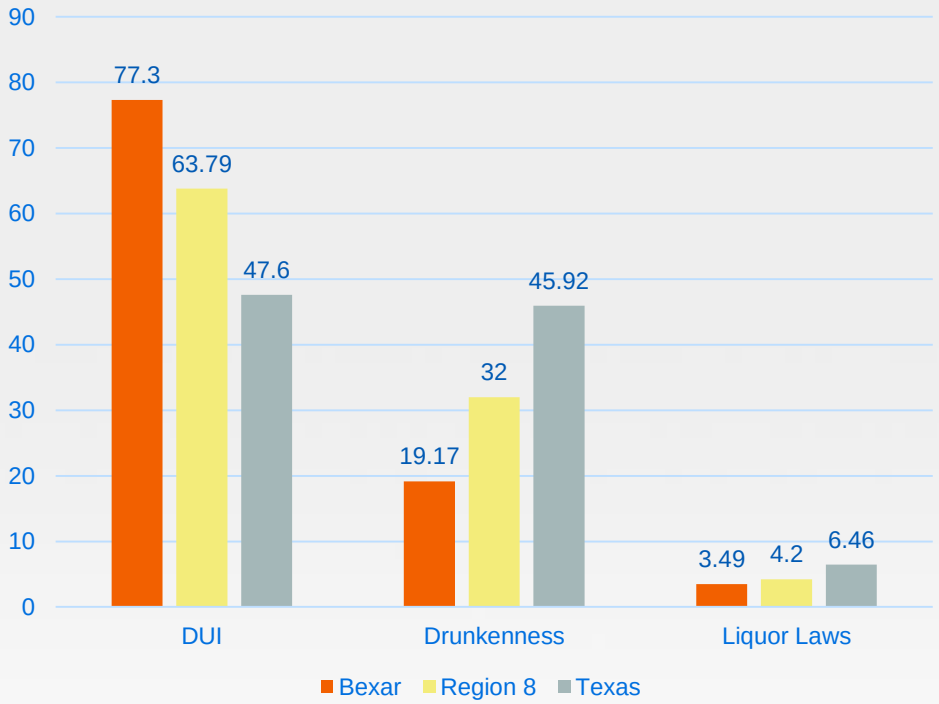
Figure 3.21 Number of alcohol retailers selling for off-premise consumption per 10,000 population



Source: Texas Alcoholic & Beverage Commission; Retail Dealer's Off-Premise License, Wine and Beer Retailer's Off-Premise Permit, and Package Store Permits, 6/1/2016. U.S. Census Bureau; 2014 ACS 5-Year Estimates, Table S0101.

Alcohol related arrests in 2017

2017 Alcohol Related Arrests					
2017	Juvenile	Adult	Total	% Juvenile	% Adult
Texas Alcohol Related Arrests	912	146,548	147,460	0.6	99.4
Texas DUI	**136**	**70,066**	**70,202**	**0.2**	**99.8**
Texas Drunkenness	201	67,521	67,722	0.3	99.7
Texas Liquor Laws	575	8,961	9,536	6.0	94.0
	Juvenile	Adult	Total	% Juvenile	% Adult
Region 8 Alcohol Related Arrests	36	15,272	15,308	0.2	99.8
Region 8 DUI	**3**	**9,762**	**9,765**	**0.03**	**99.96**
Region Drunkenness	7	4,893	4,900	0.1	99.9
Region 8 Liquor Laws	26	617	643	4.0	96.0
	Juvenile	Adult	Total	% Juvenile	% Adult
Bexar Alcohol Related Arrests	5	9573	9578	0.1	99.9
Bexar DUI	**1**	**7405**	**7406**	**0.013**	**100.0**
Bexar Drunkenness	0	1837	1837	0.0	100.0
Bexar Liquor Laws	4	331	335	1.2	98.8
Source: Texas Department of Public Safety, 2017, updated 10/8/2018					



Nearly 8 in 10 alcohol related arrests involve a DUI in Bexar County compared to nearly 5 in 10 in Texas

2017 Bexar County DUI Crashes and Fatalities

Area	DUI Crashes	Crashes No Alcohol	% Crashes DUI	Total Crashes	DUI Fatalities	No Alcohol Fatalities	Total Fatalities	Percent DUI Fatalities
Texas	23,760	514,210	4.4%	537,970	1,024	1,361	3,721	27.5%
Bexar	2,016	48,520	4.0%	50,536	53	111	164	32.3%

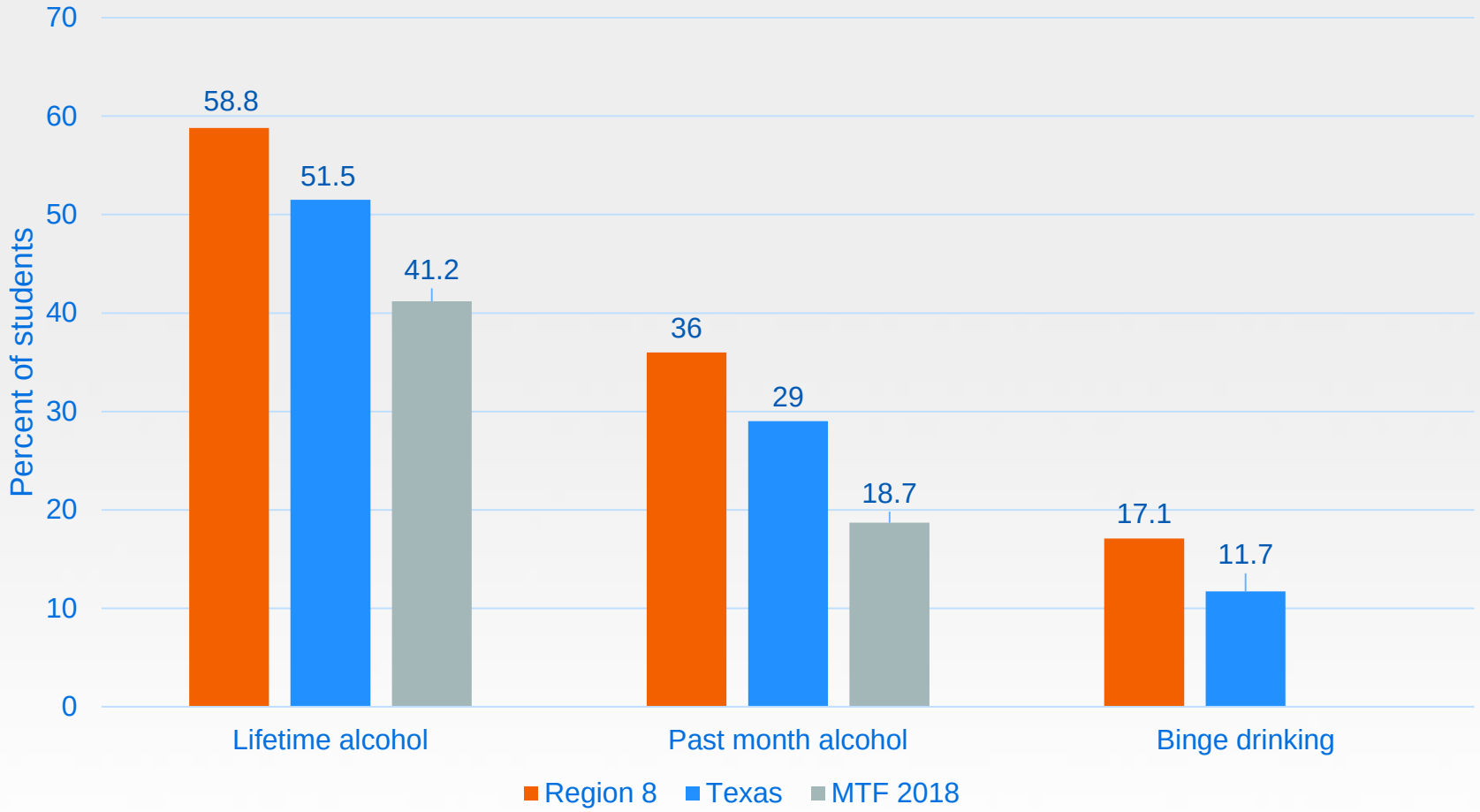
Source: Texas Department of Transportation, Texas Peace Officer's Crash Report (CR-3)

In 2017, 27.5% of Texas's fatalities involved someone Driving Under the Influence.
In 2017, 32.3% of Bexar County fatalities involved someone Driving Under the Influence.
From 2016 to 2017, Bexar County DUI Fatalities decreased by 17.2 percent.

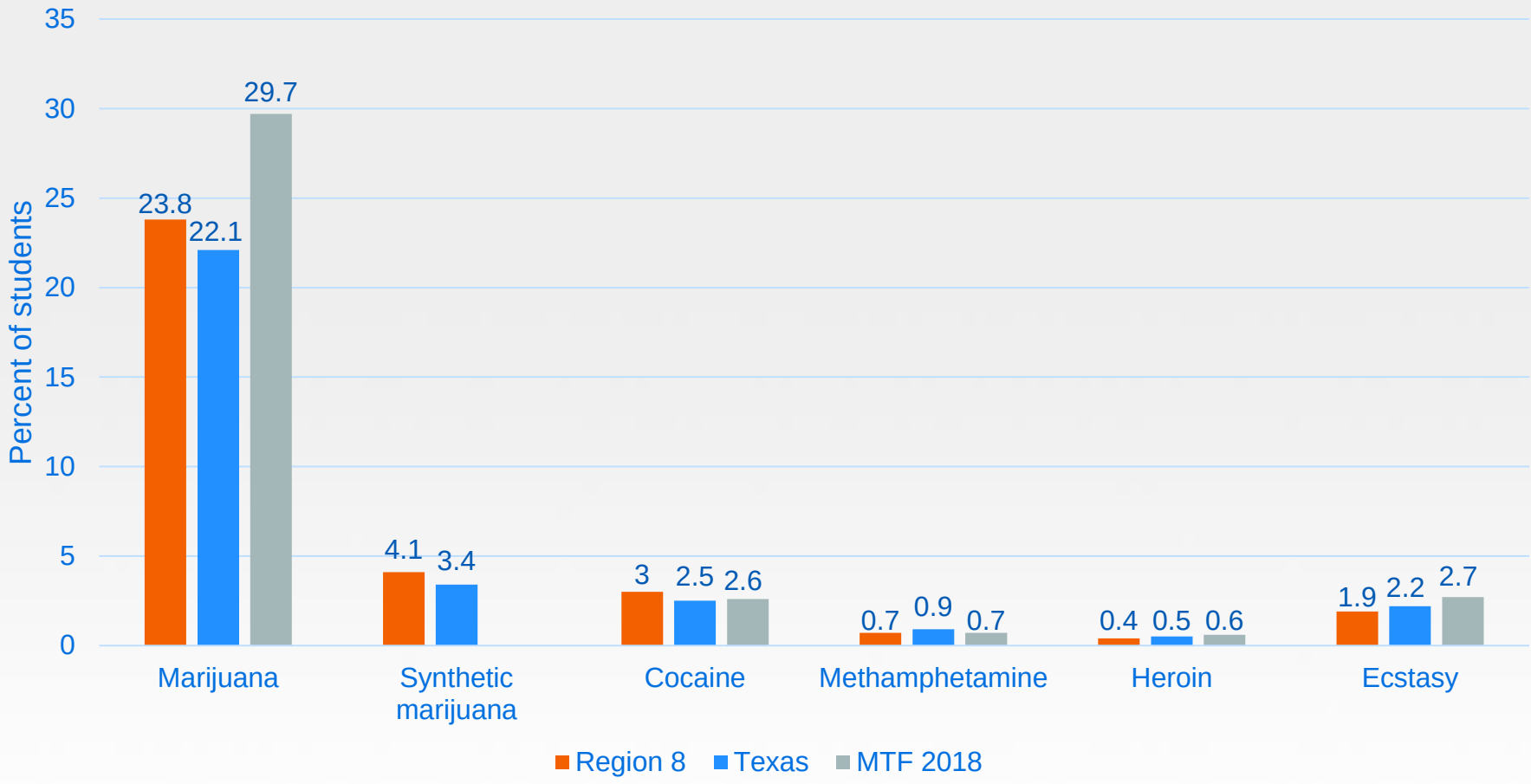
Area	2016 DUI Fatalities	2017 DUI Fatalities	Number Change	Percent Change 2016 to 2017
Texas	1,018	1,024	6	0.6%
Bexar	64	53	-11	-17.2%

Bexar County accounts for **6.3%** of all DUI fatalities in Texas

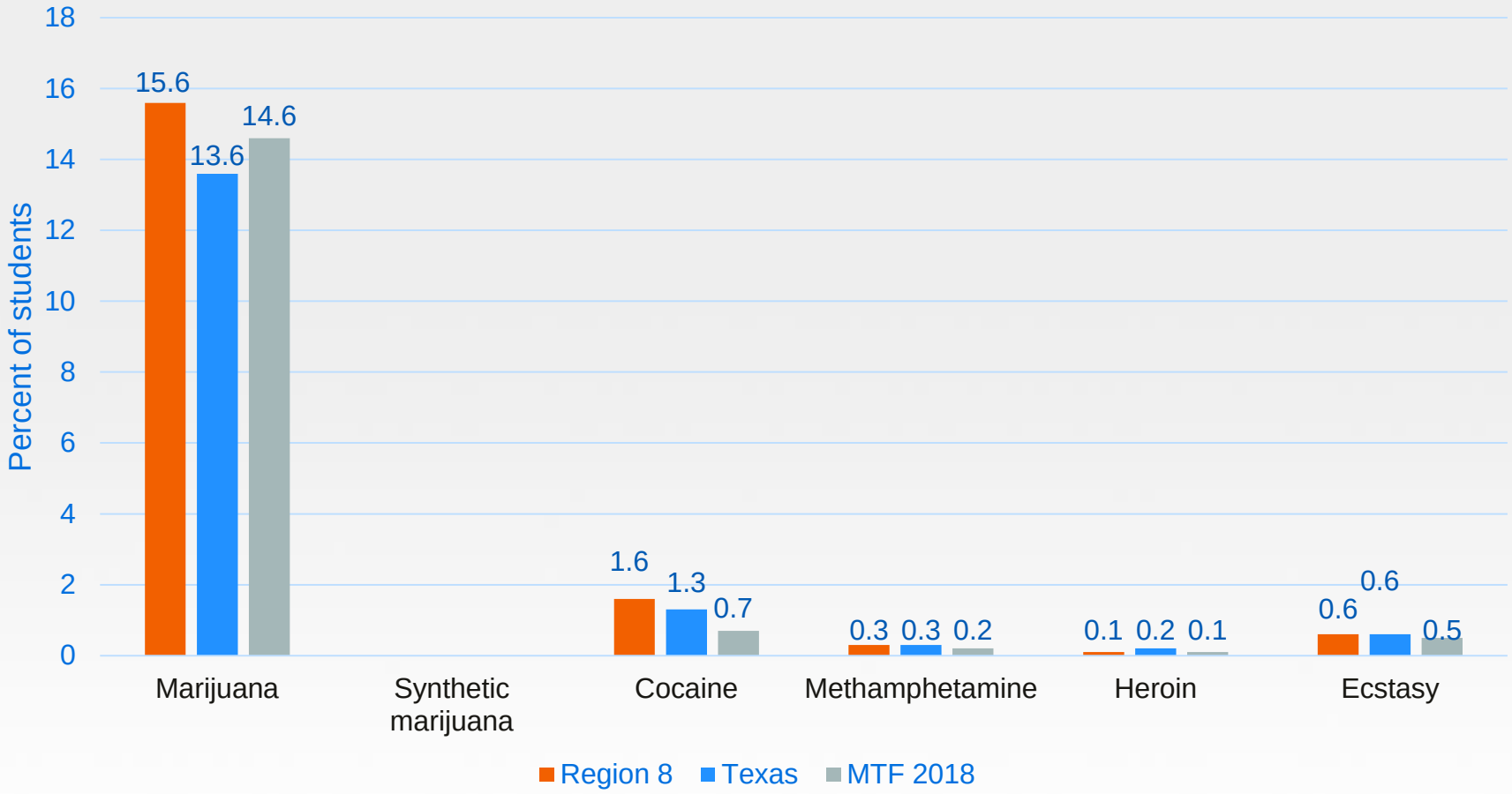
Alcohol use behaviors among youth (2018)



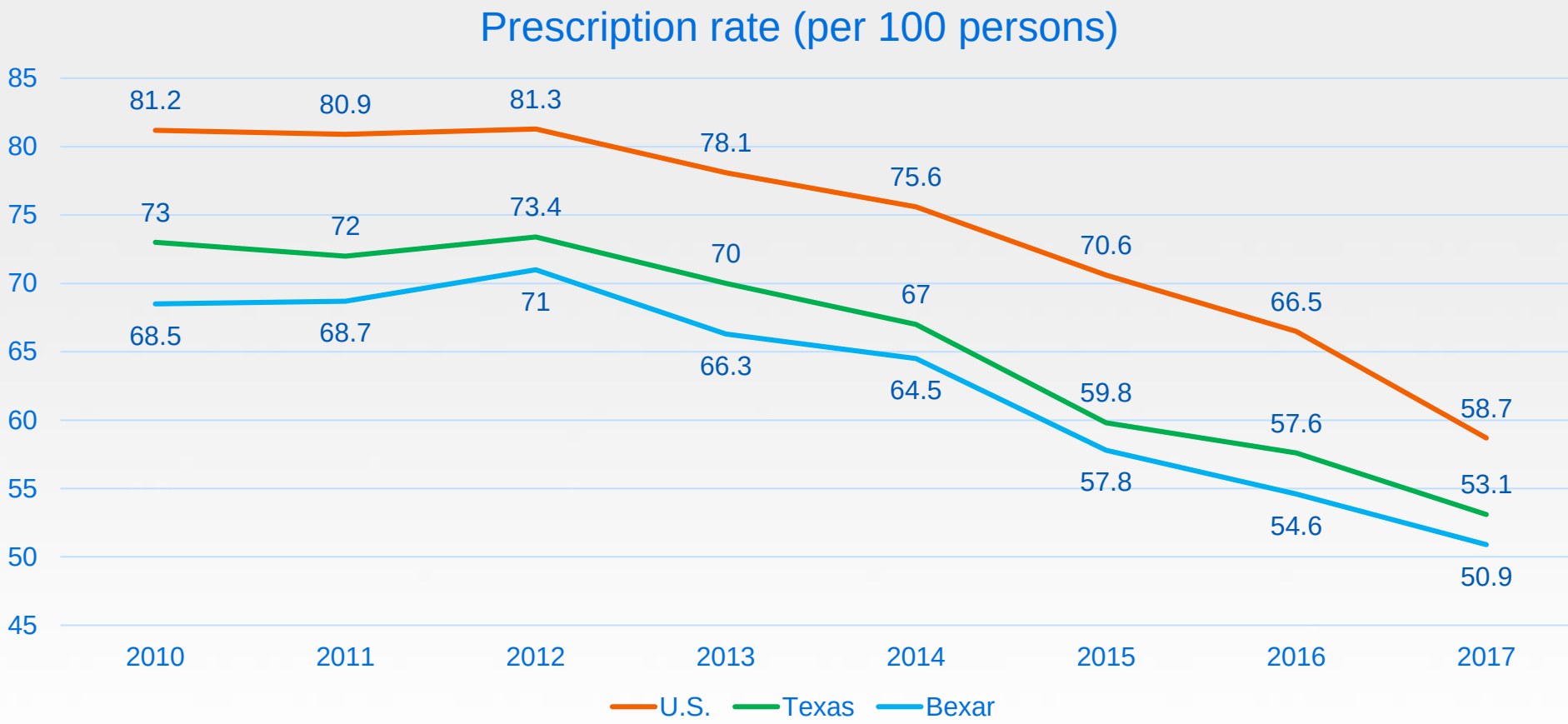
Select *lifetime* youth marijuana and other drug use



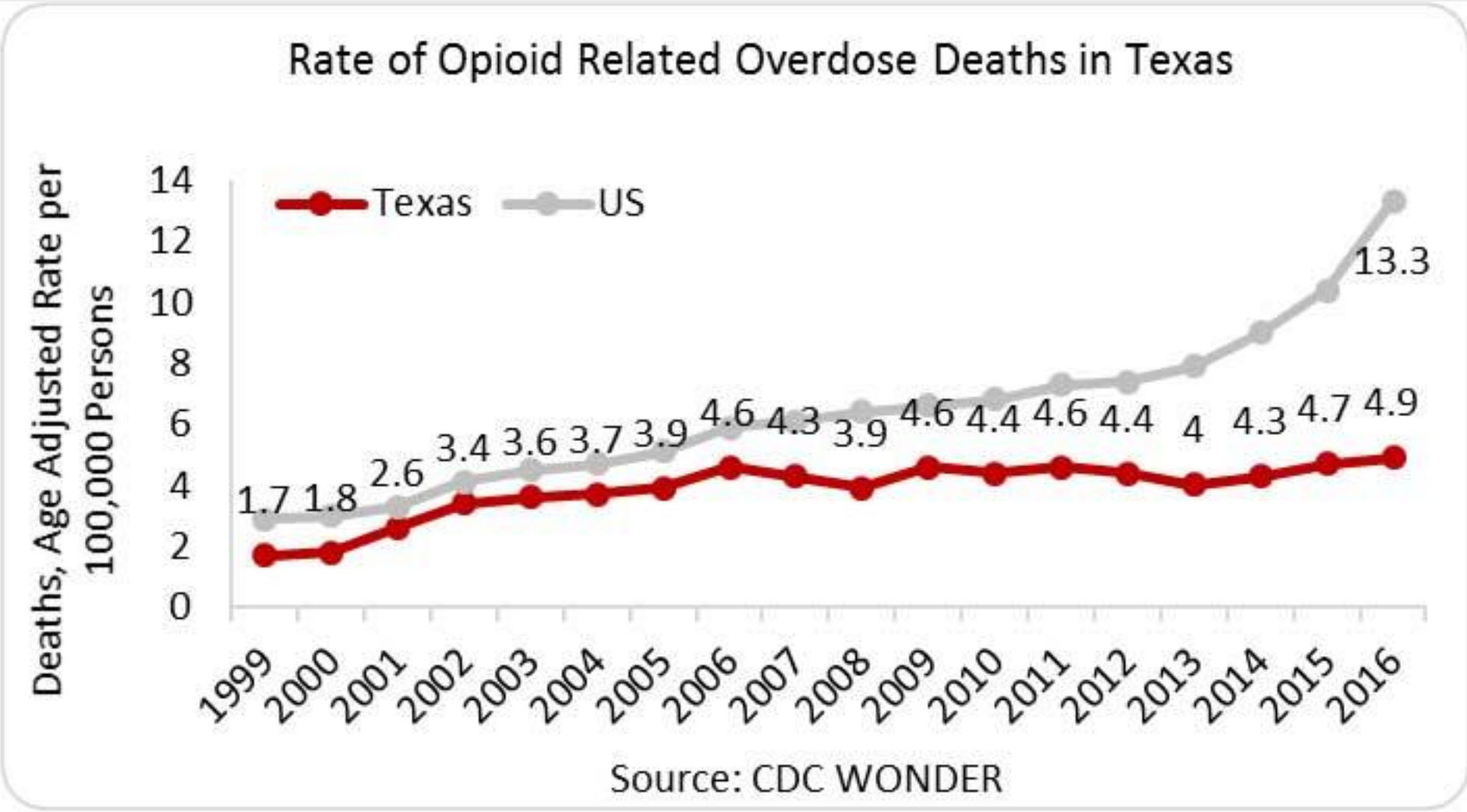
Select *past month* youth marijuana & other drug use

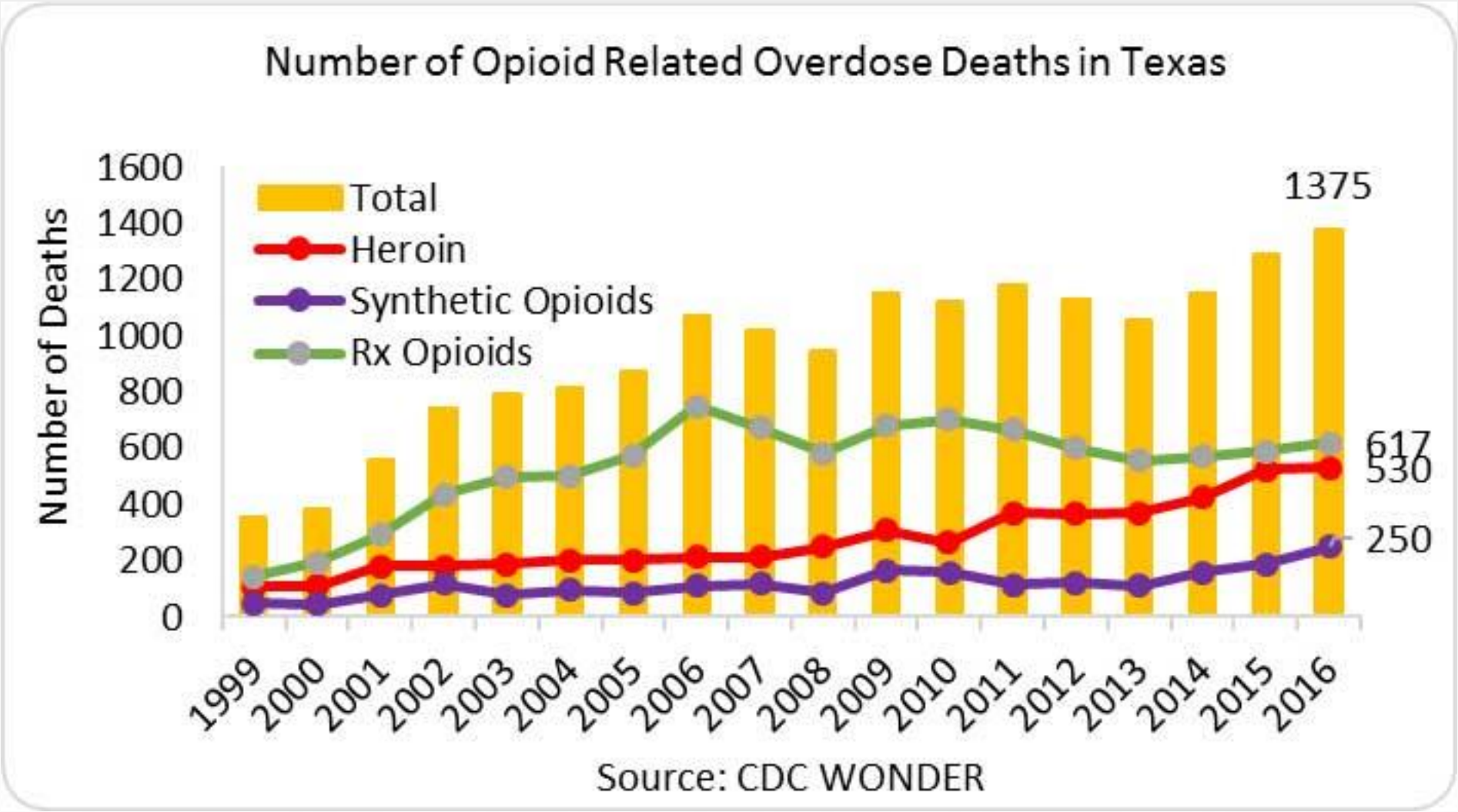


Opioid prescription rates (national, state, county)

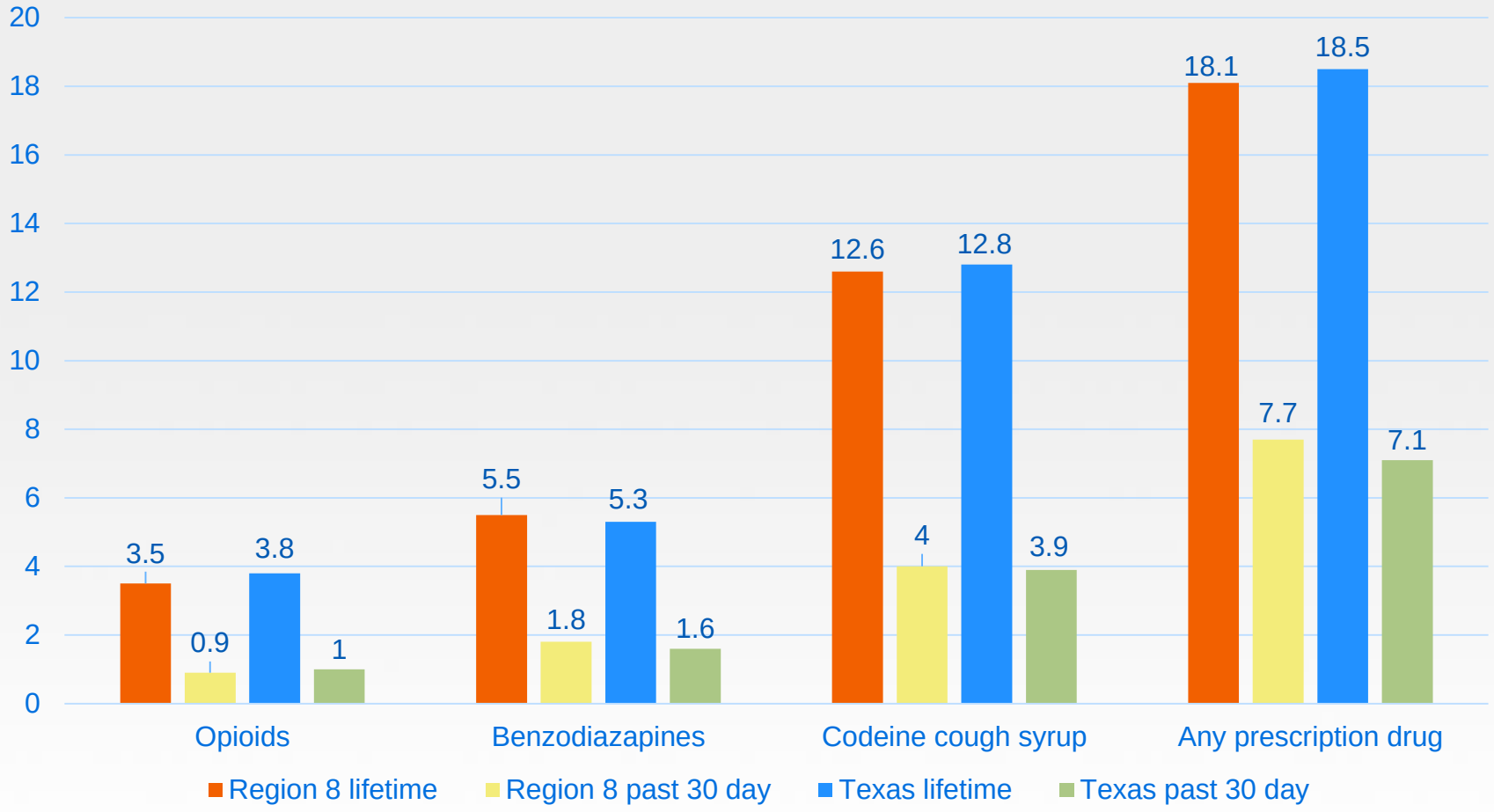


Source: CDC.gov


Rate of Opioid Related Overdose Deaths in Texas
Deaths, Age Adjusted Rate per 100,000 Persons
14
12
10
8
6
4
2
0
Texas
US
1.7 1.8 2.6 3.4 3.6 3.7 3.9 4.6 4.3 3.9 4.6 4.4 4.6 4.4 4 4.3 4.7 4.9
13.3
1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016
Source: CDC WONDER


Number of Opioid Related Overdose Deaths in Texas
Number of Deaths
1600
1400
1200
1000
800
600
400
200
0
Total
Heroin
Synthetic Opioids
Rx Opioids
1375
617
530
250
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
Source: CDC WONDER

Prescription drug misuse among teens (2018)



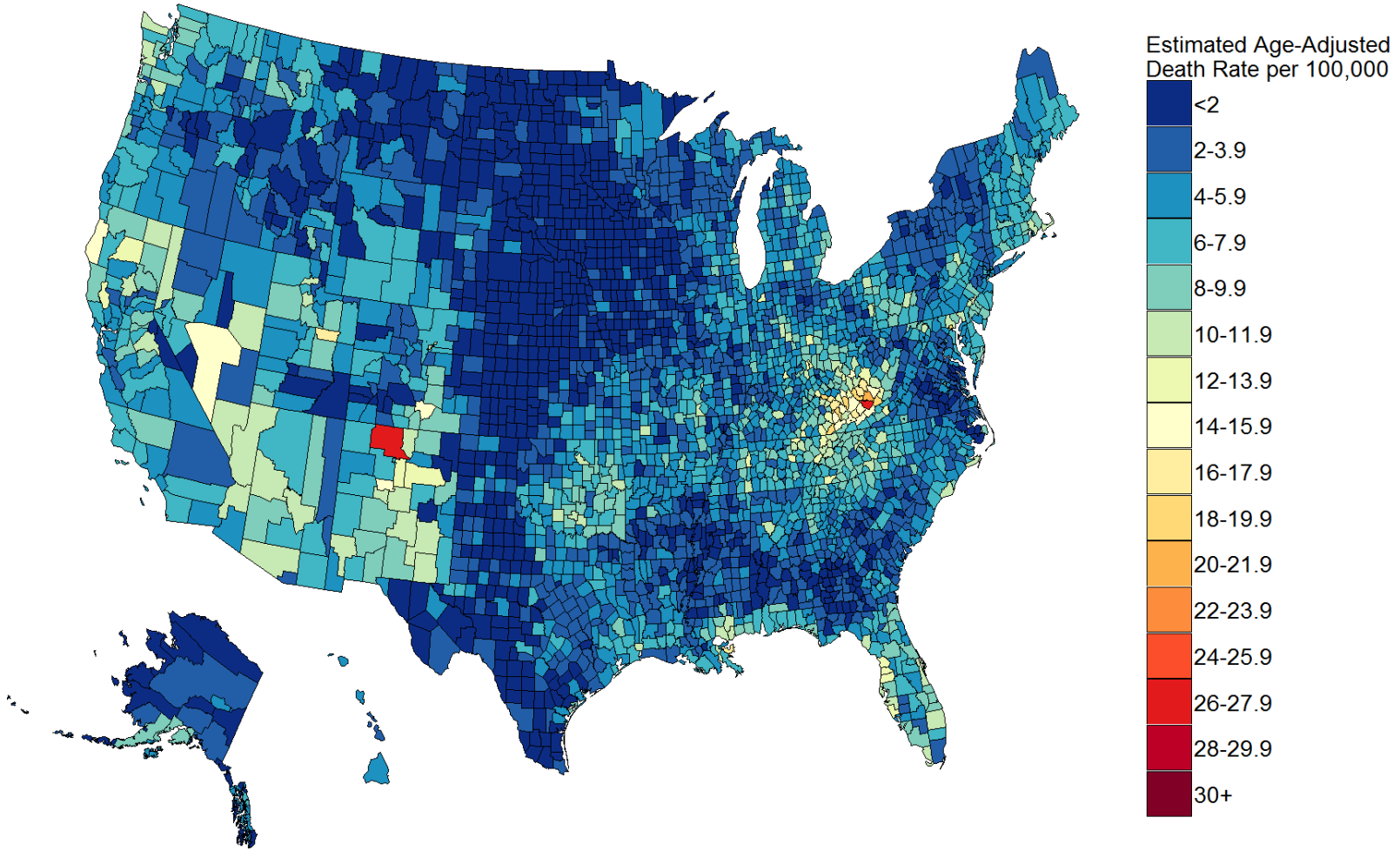
1999 – 2016 Drug Poisoning Mortality

Estimated Age-Adjusted Death Rate per 100,000

SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data (http://www.cdc.gov/nchs/deaths.htm).

Rossen LM, Bastian B, Warner M, Khan D, Chong Y. Drug poisoning mortality: United States, 1999 (Available from: https://www.cdc.gov/nchs/data-visualization/drug-poisoning-mortality/).

1999


Estimated Age-Adjusted
Death Rate per 100,000
<2
2-3.9
4-5.9
6-7.9
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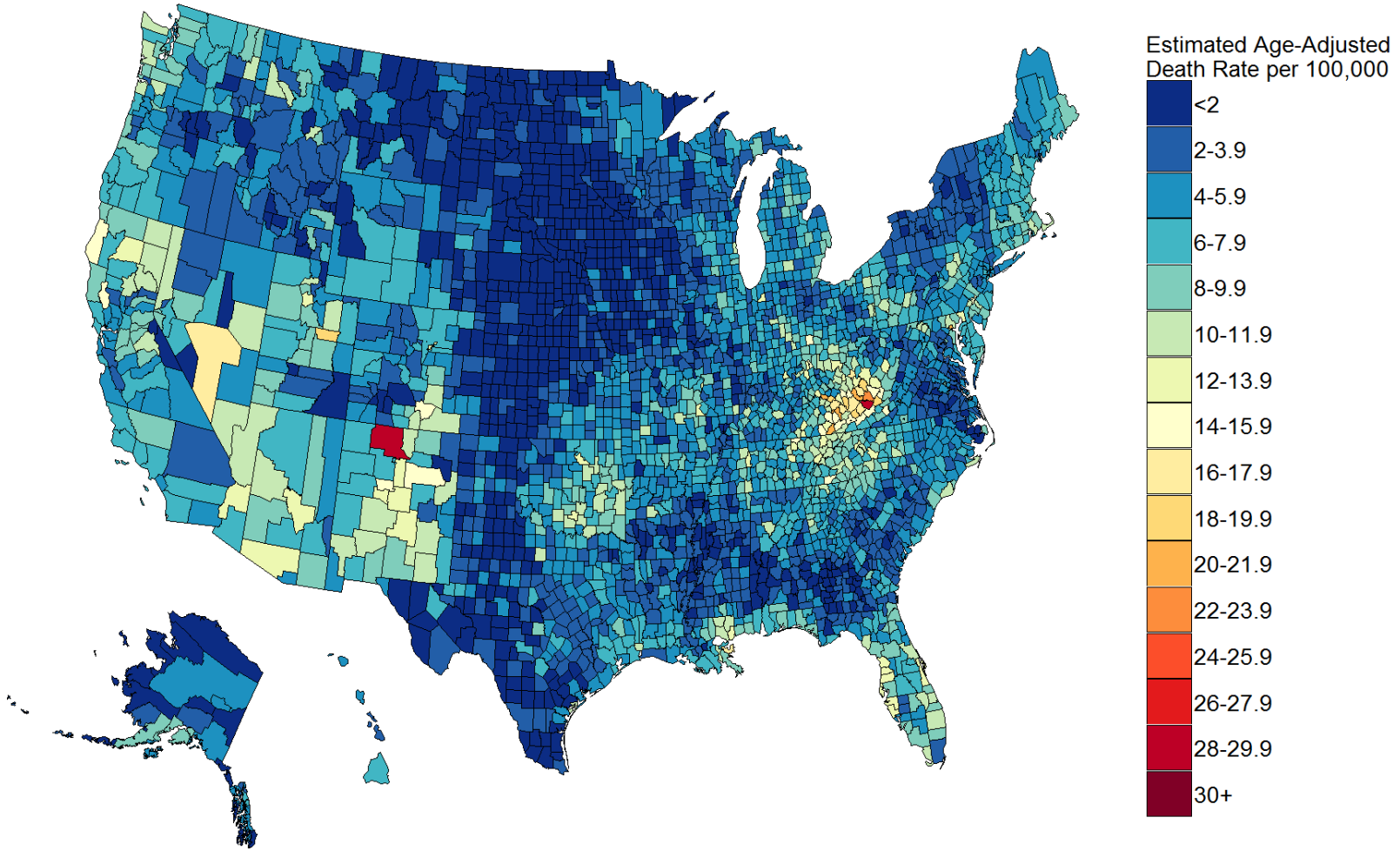
10-11.9
12-13.9
14-15.9
16-17.9
18-19.9
20-21.9
22-23.9
24-25.9
26-27.9
28-29.9
30+

2000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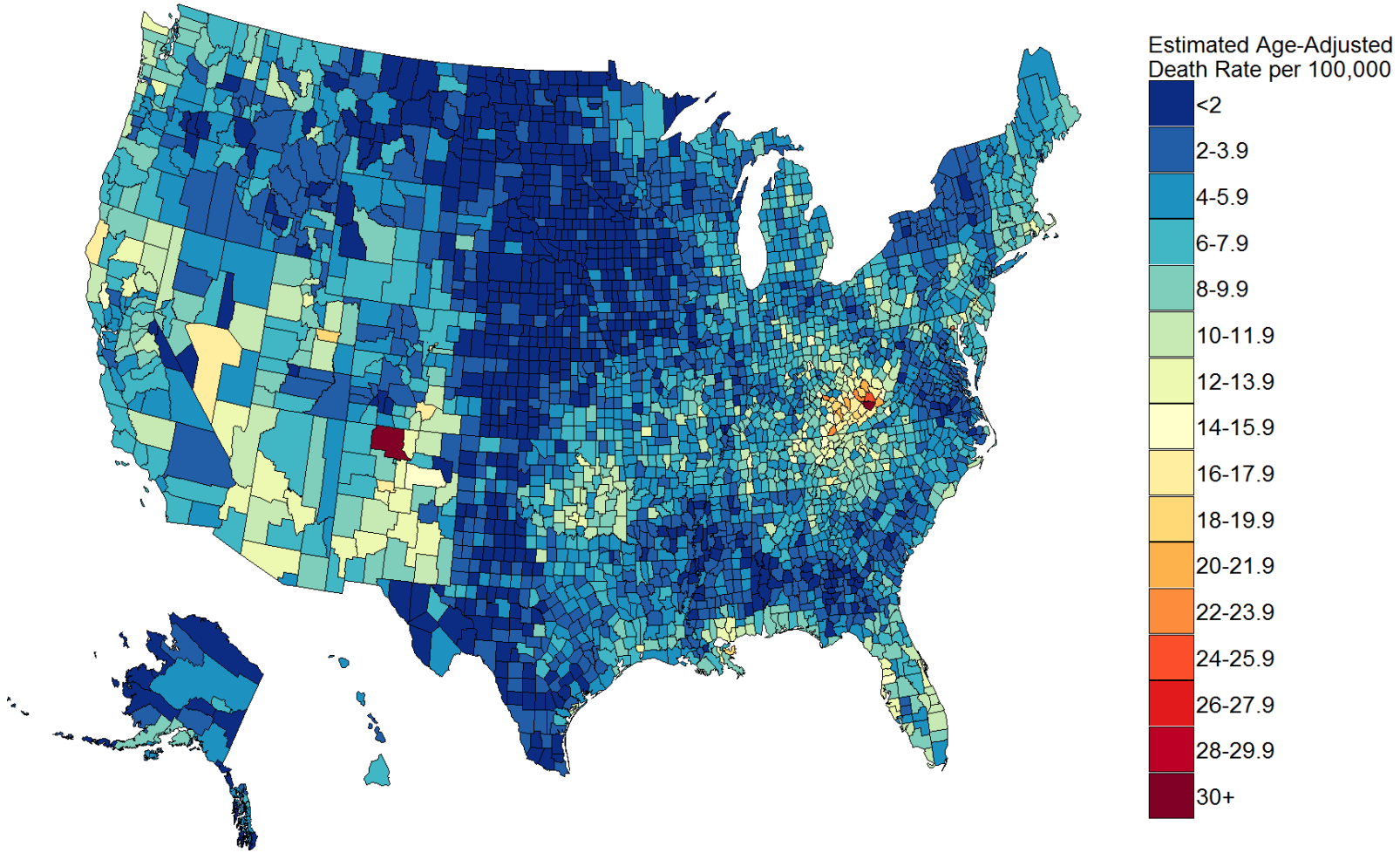
2001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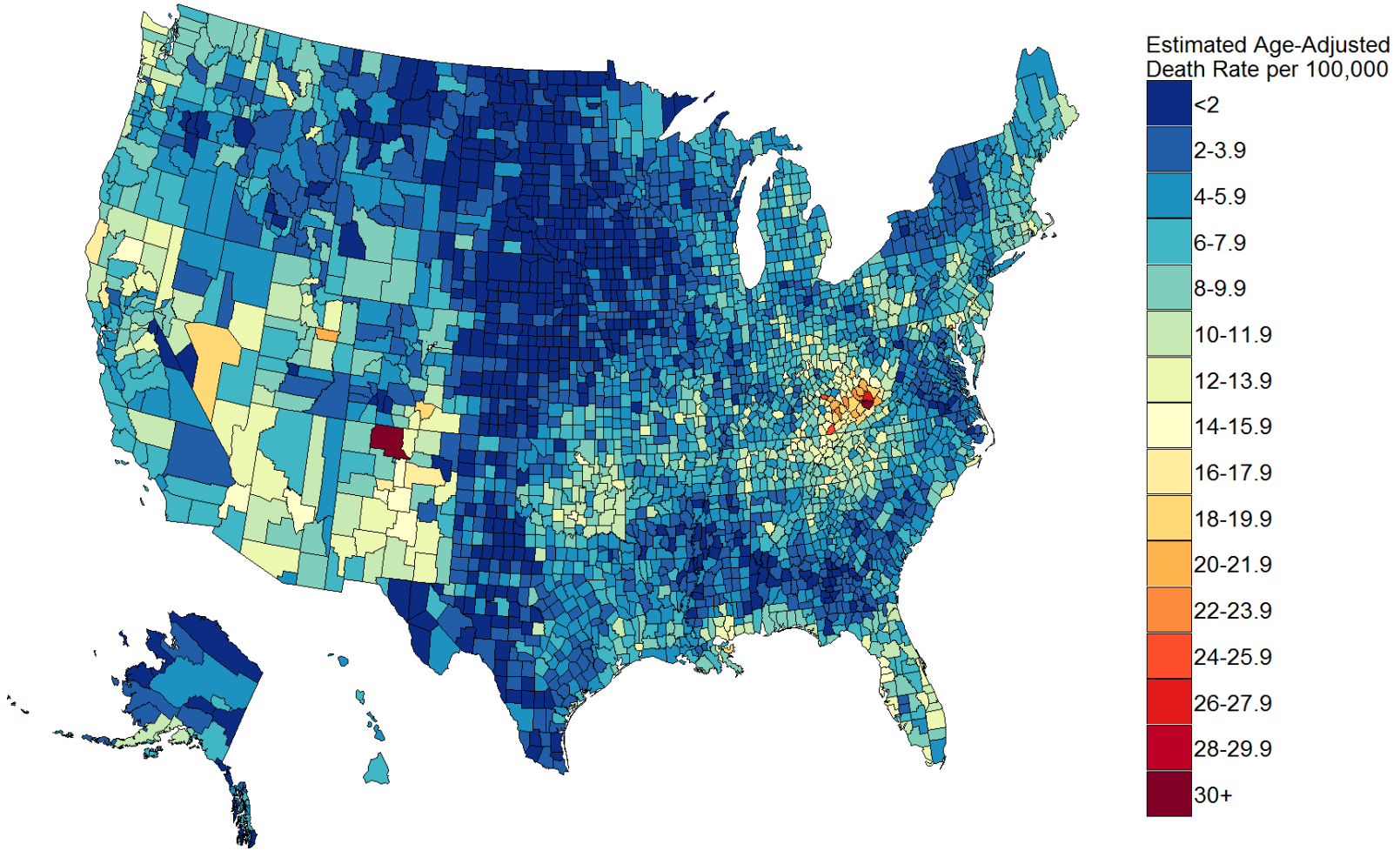
2002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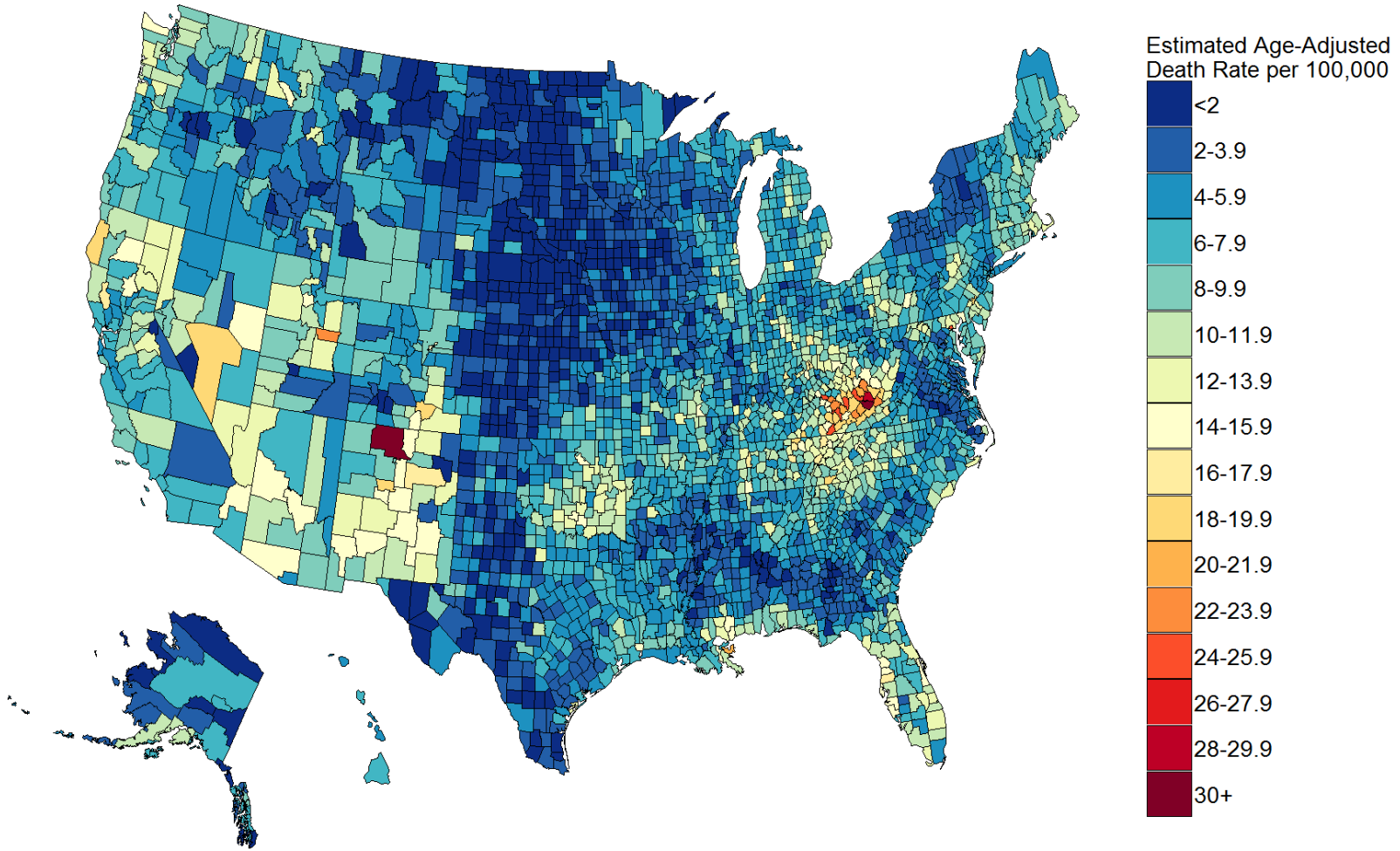
2003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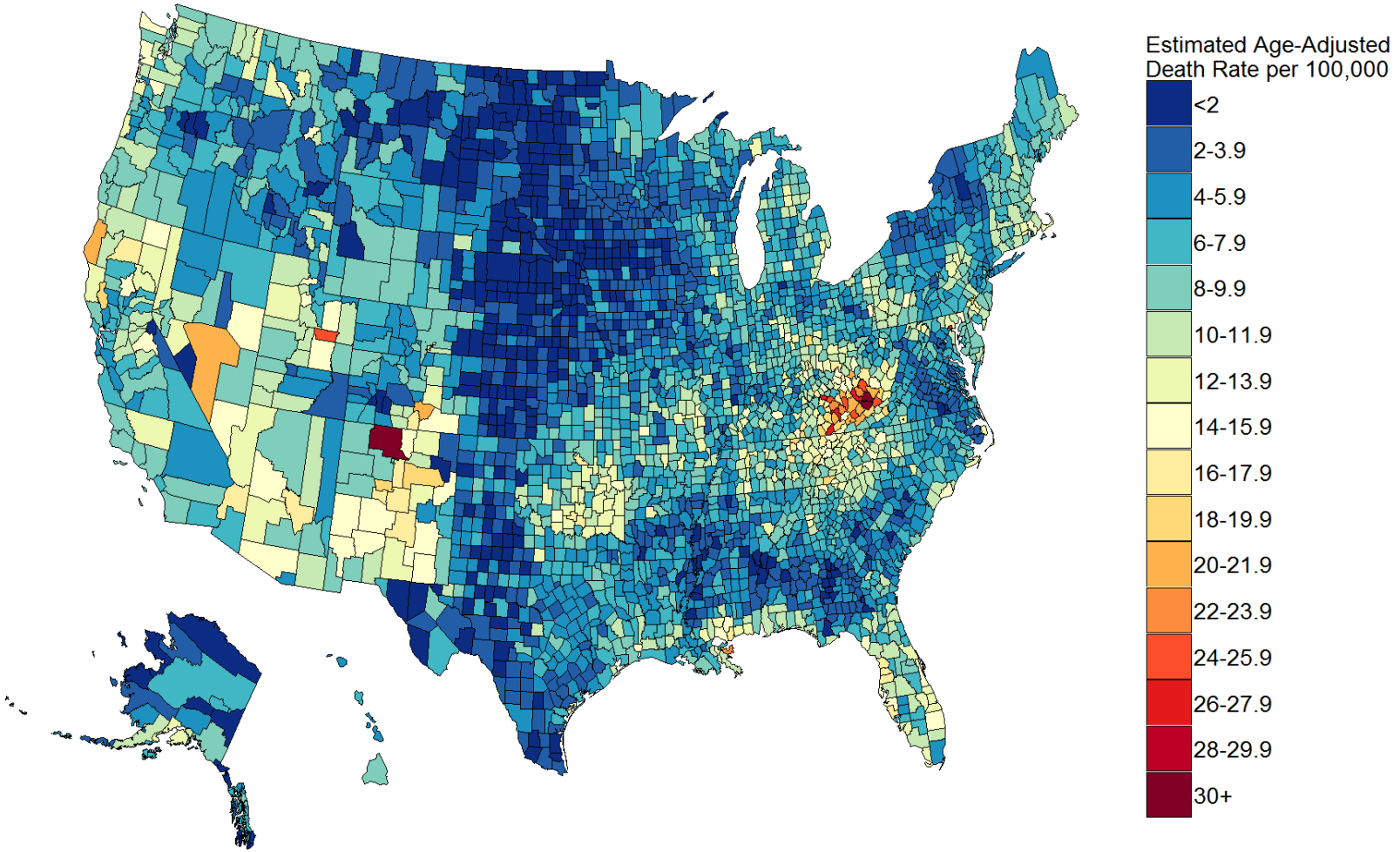
2004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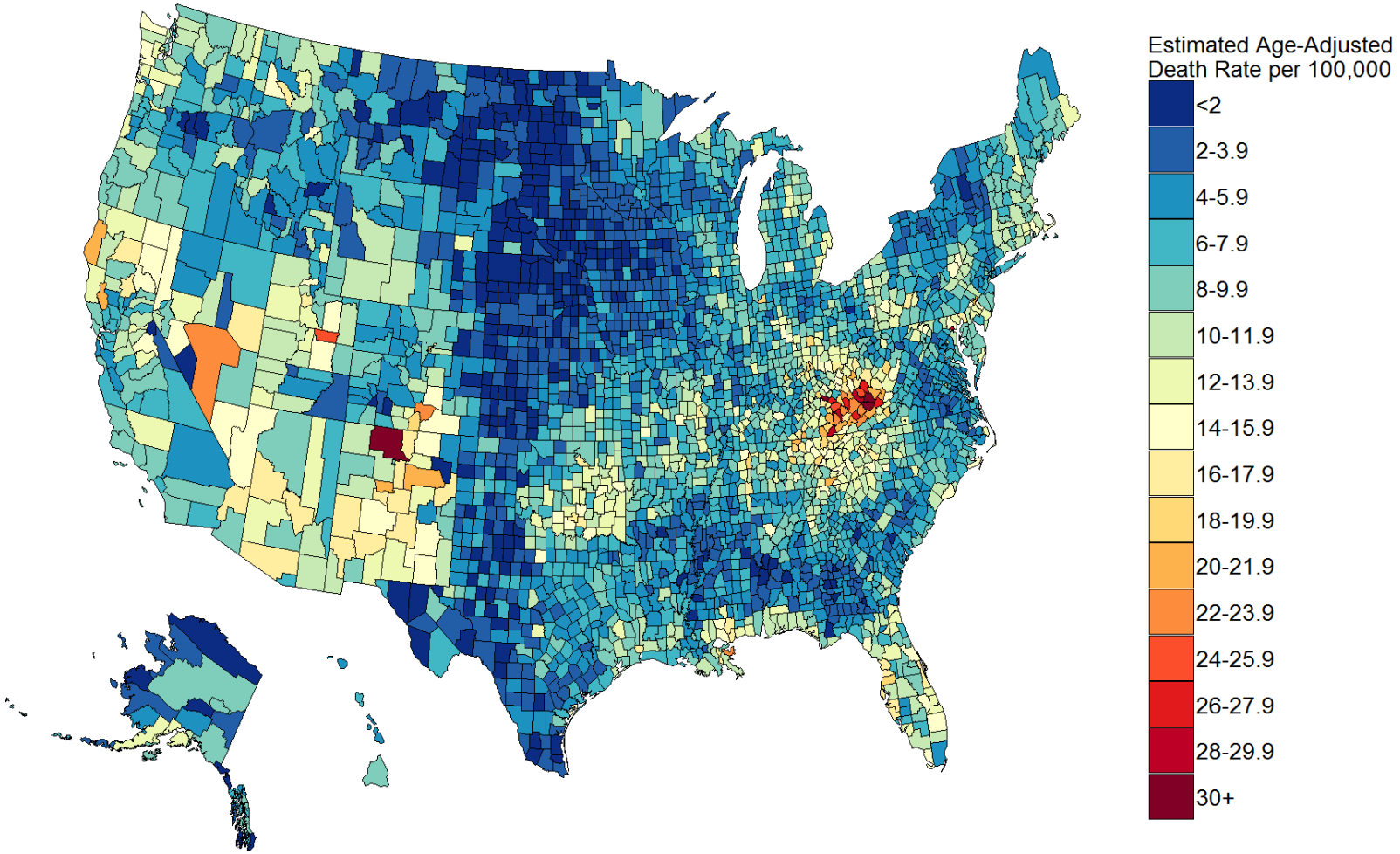
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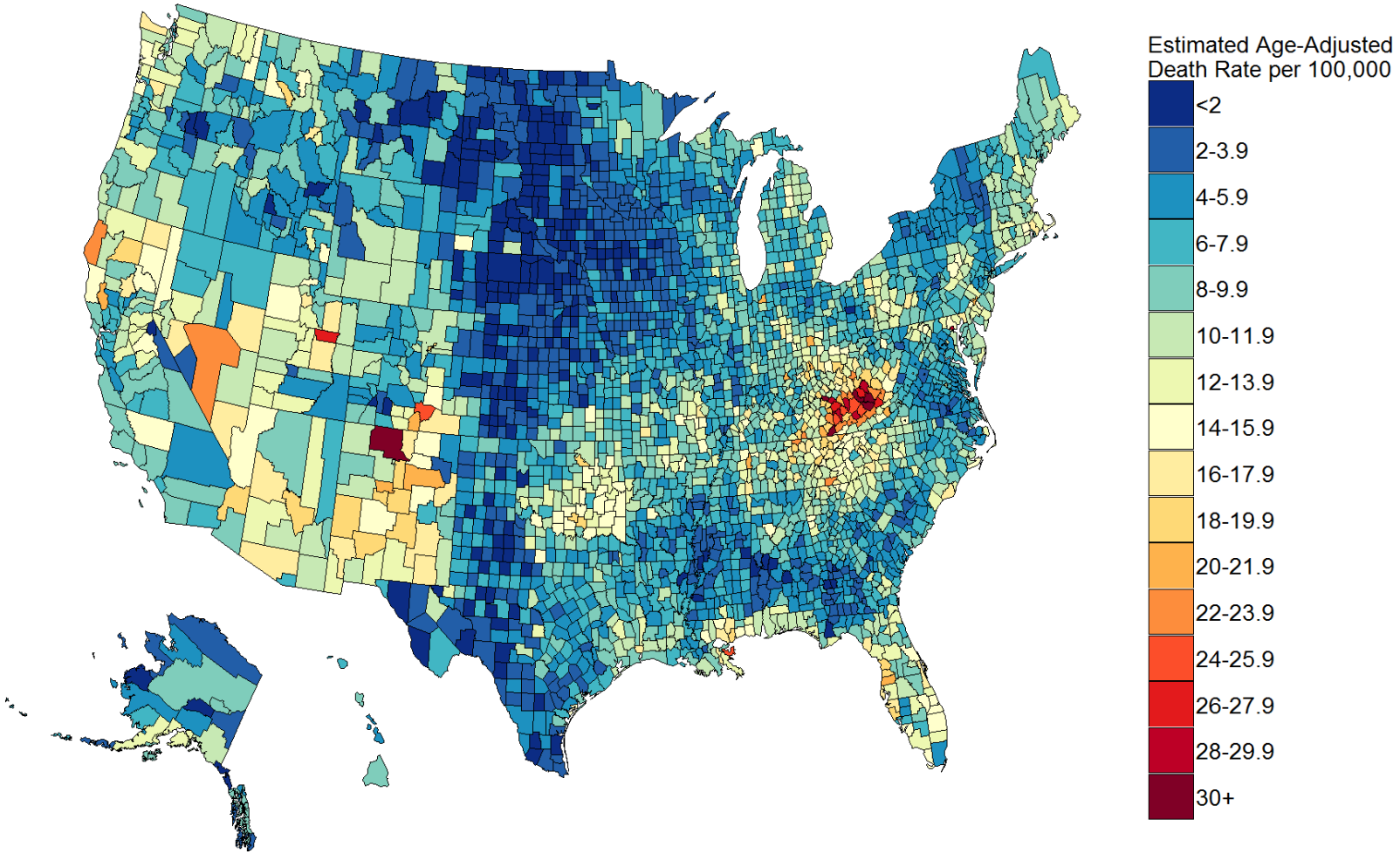
2006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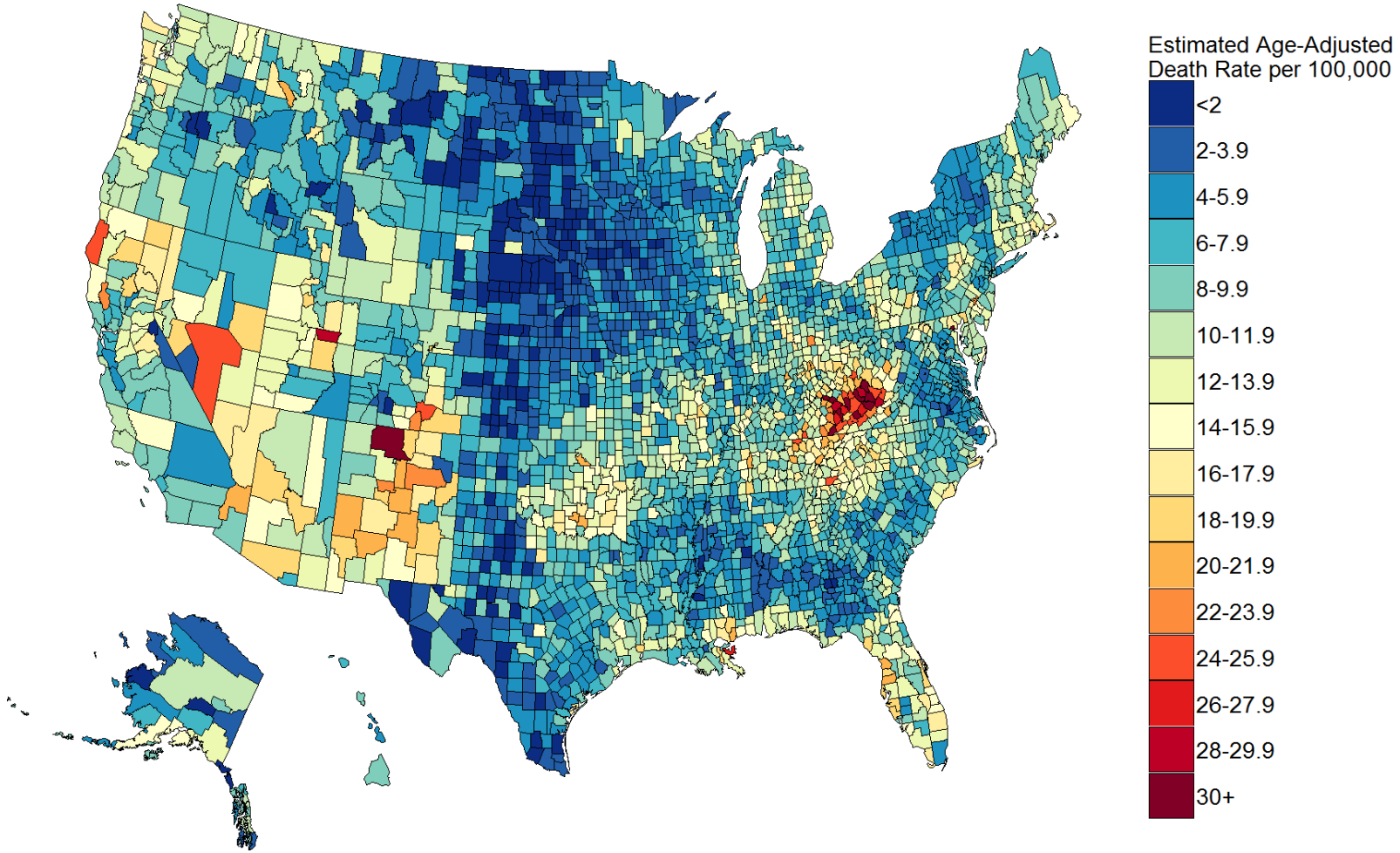
2007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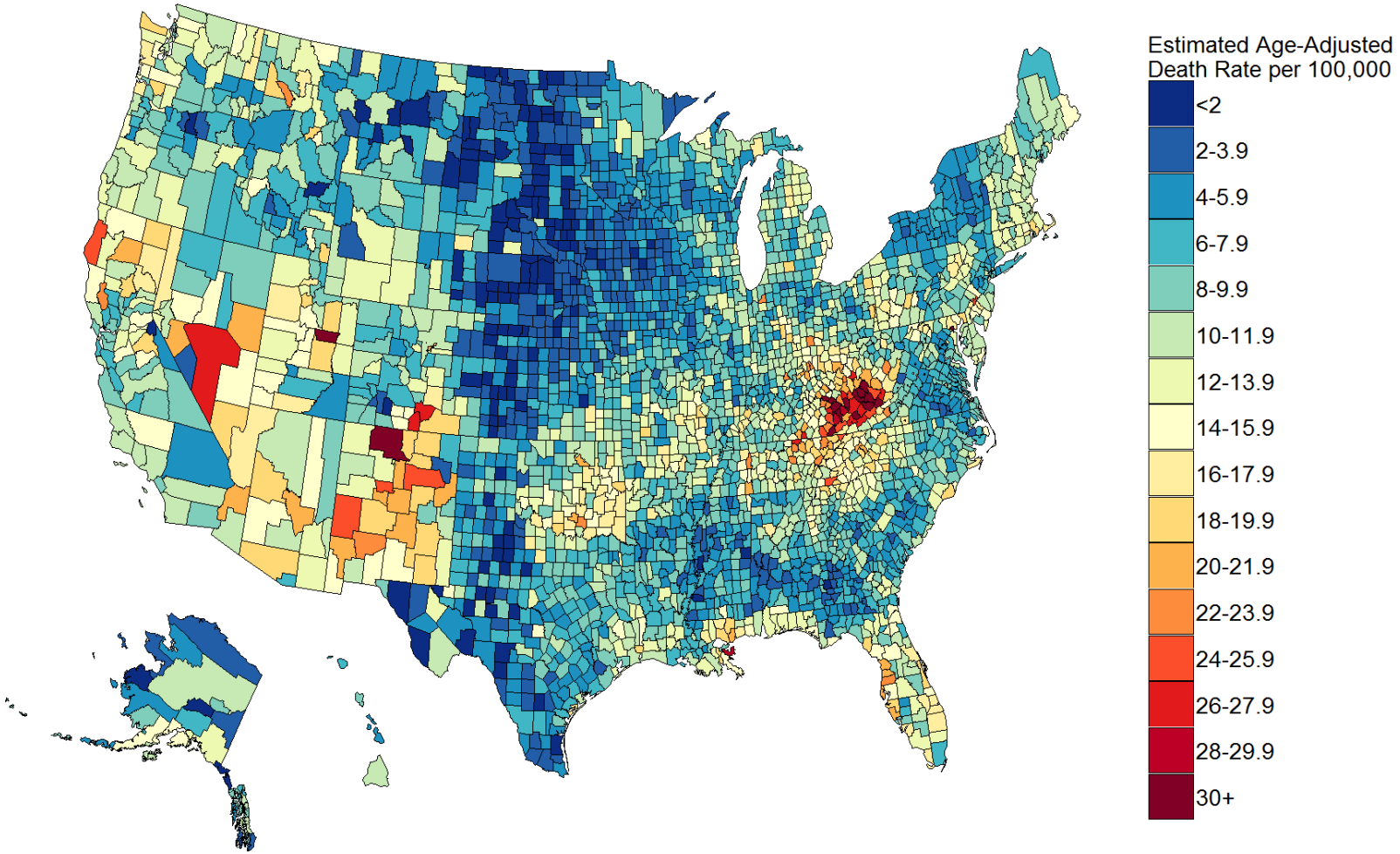
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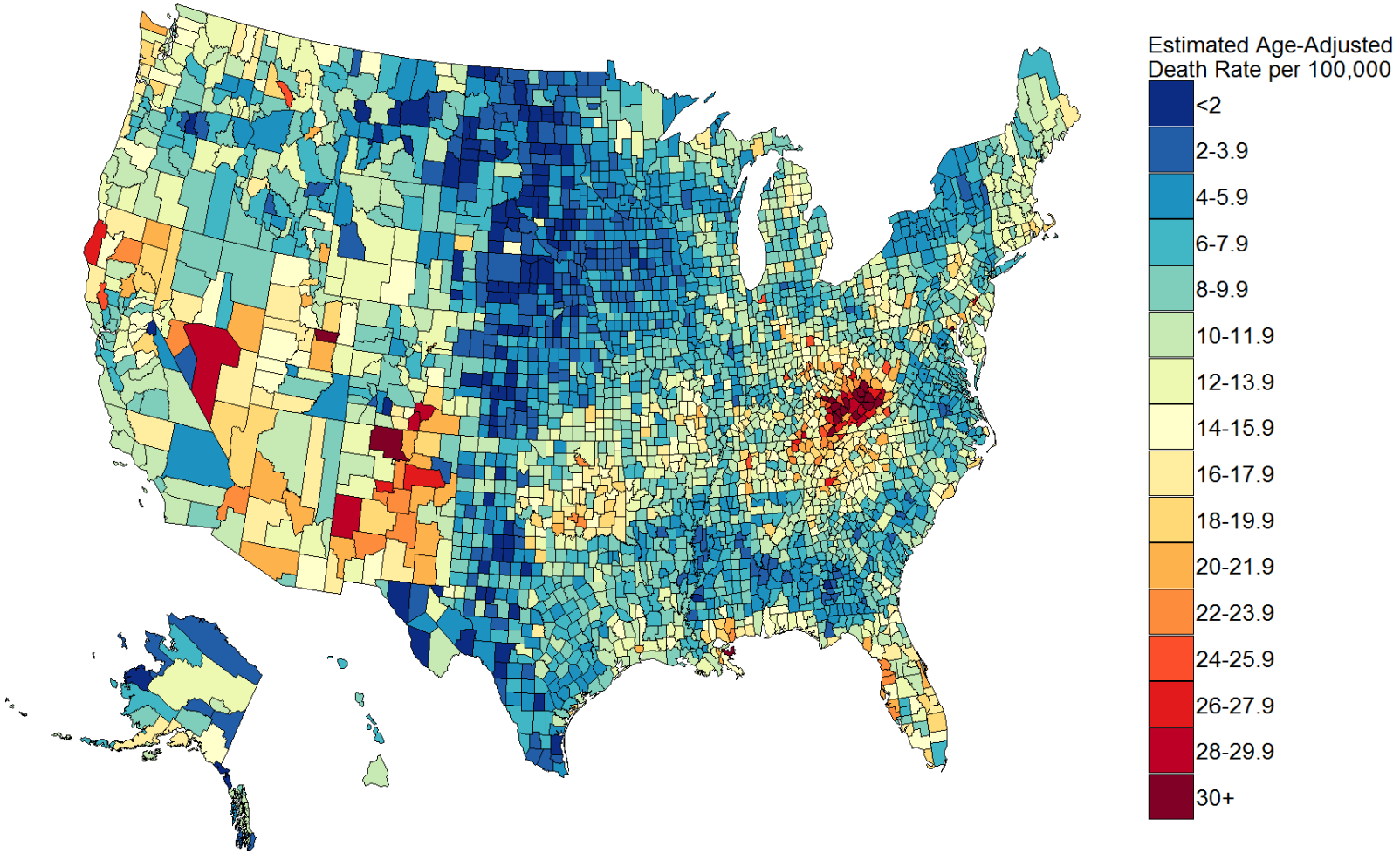
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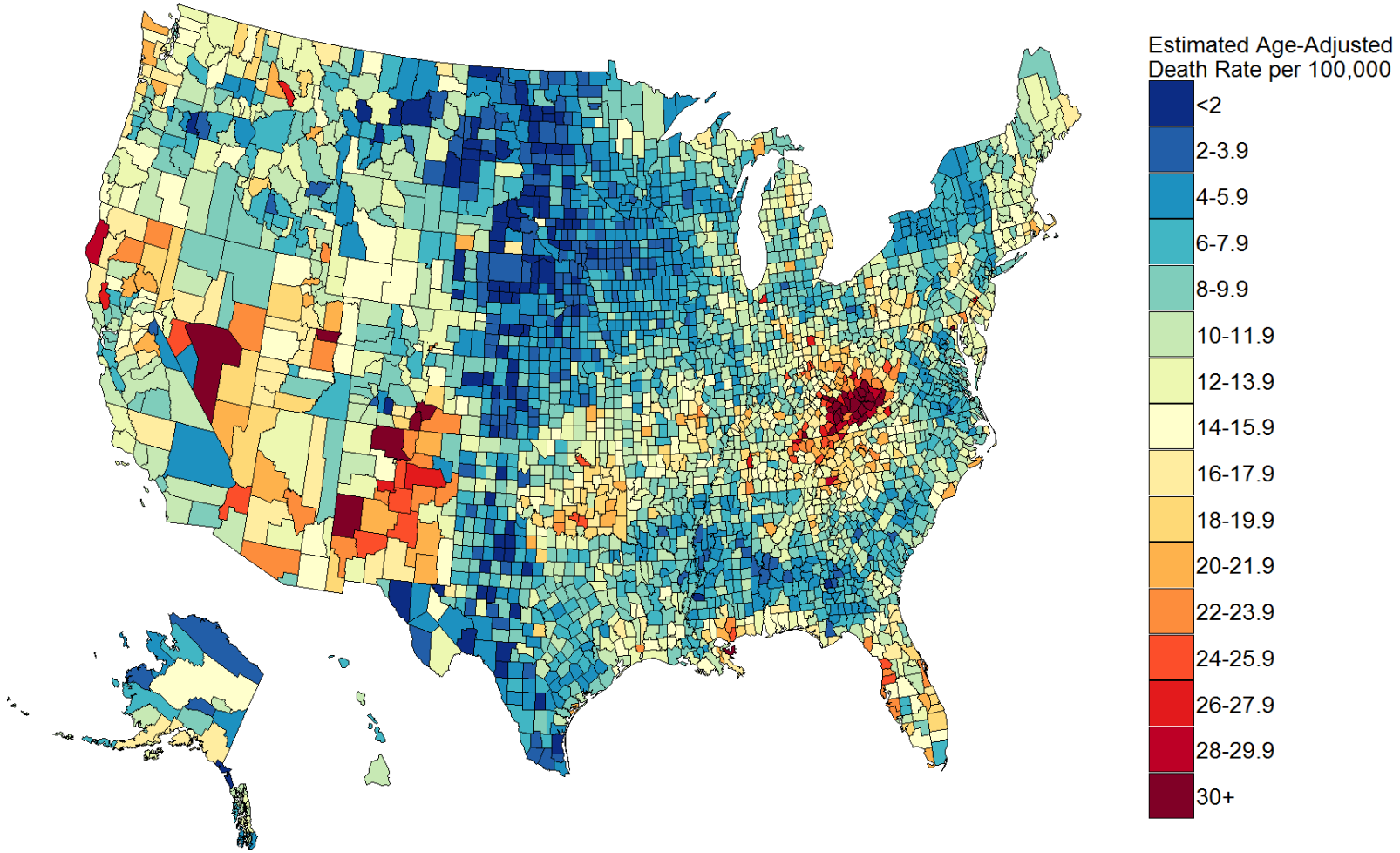
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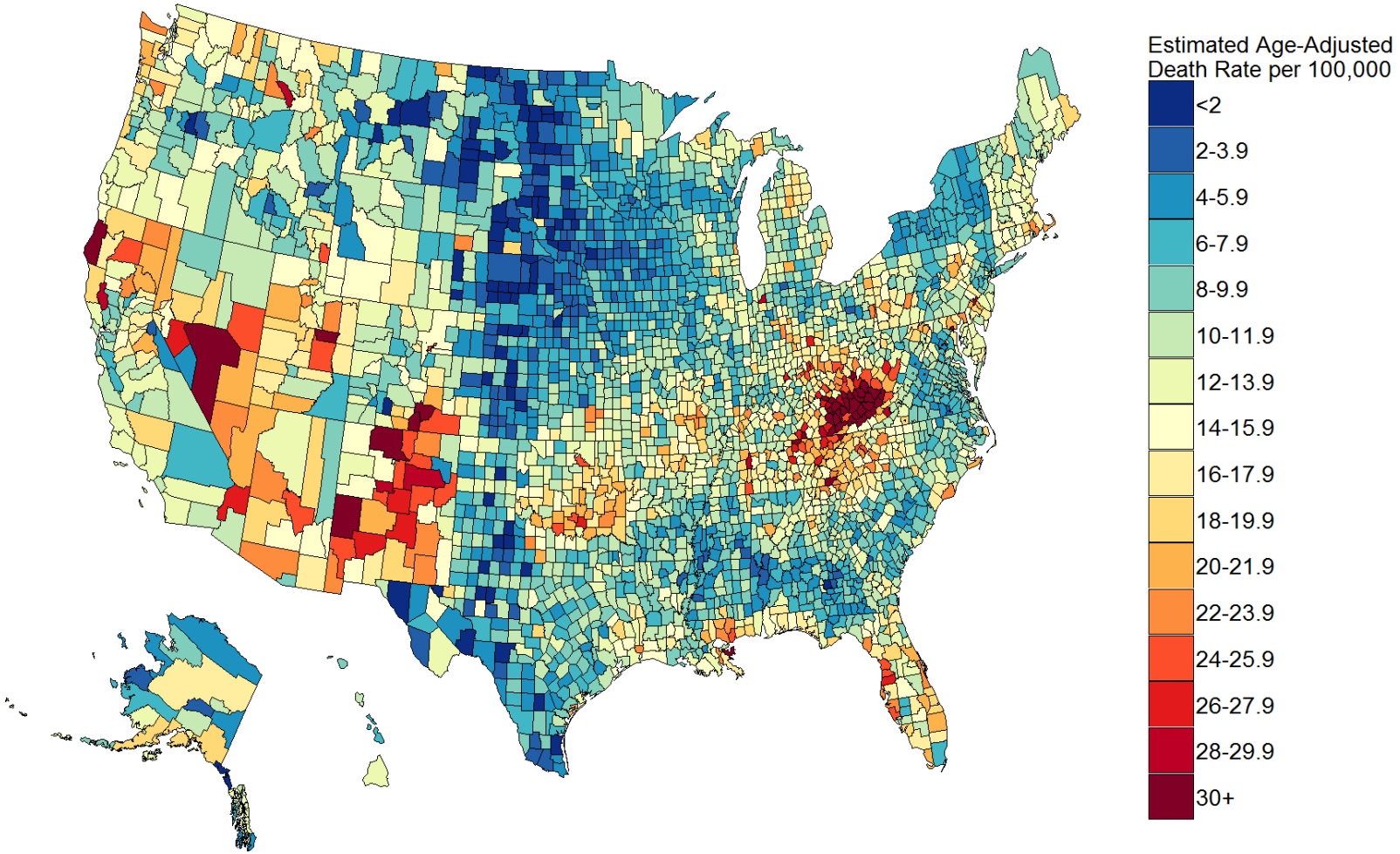
2011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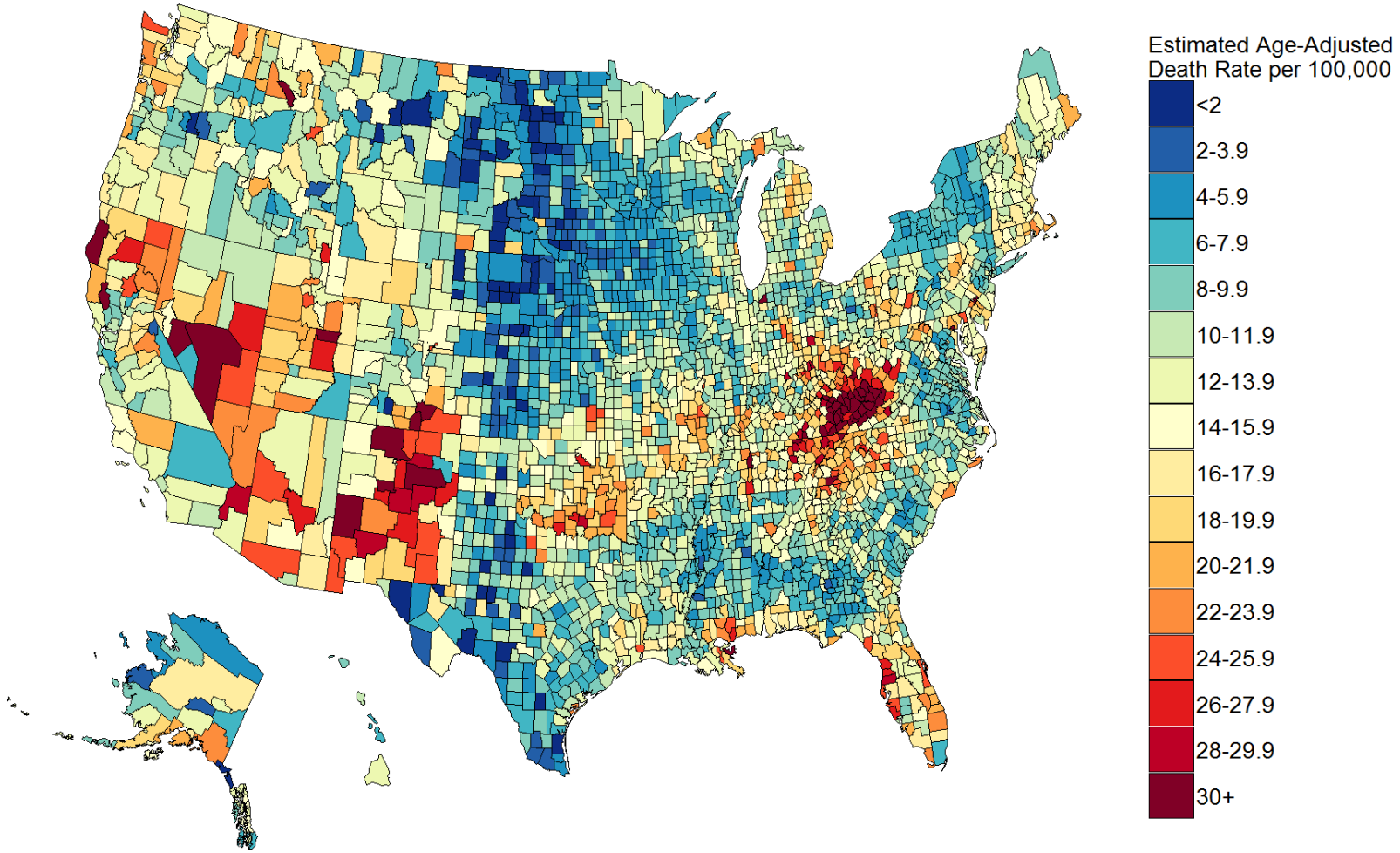
30+

2012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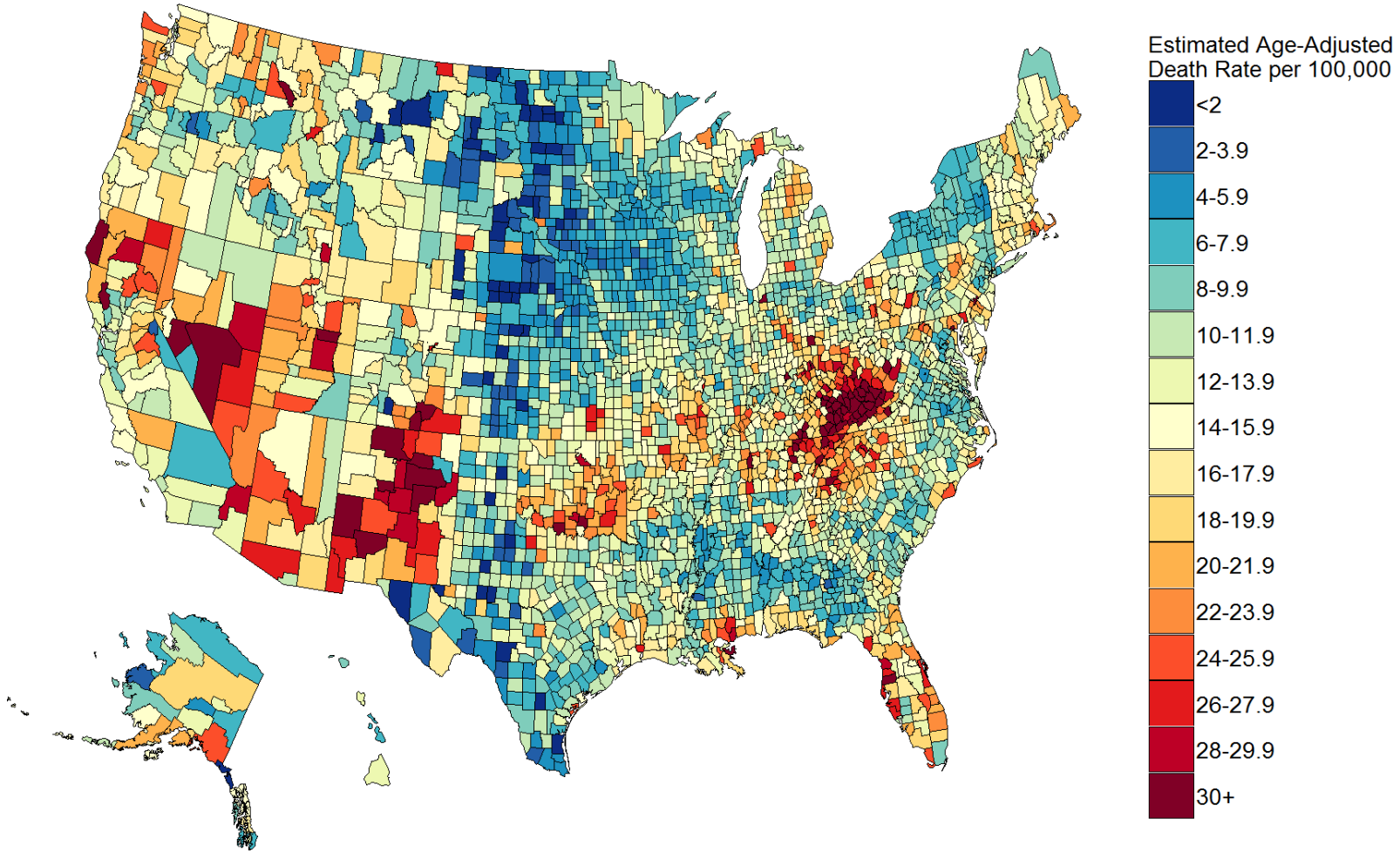
30+

2013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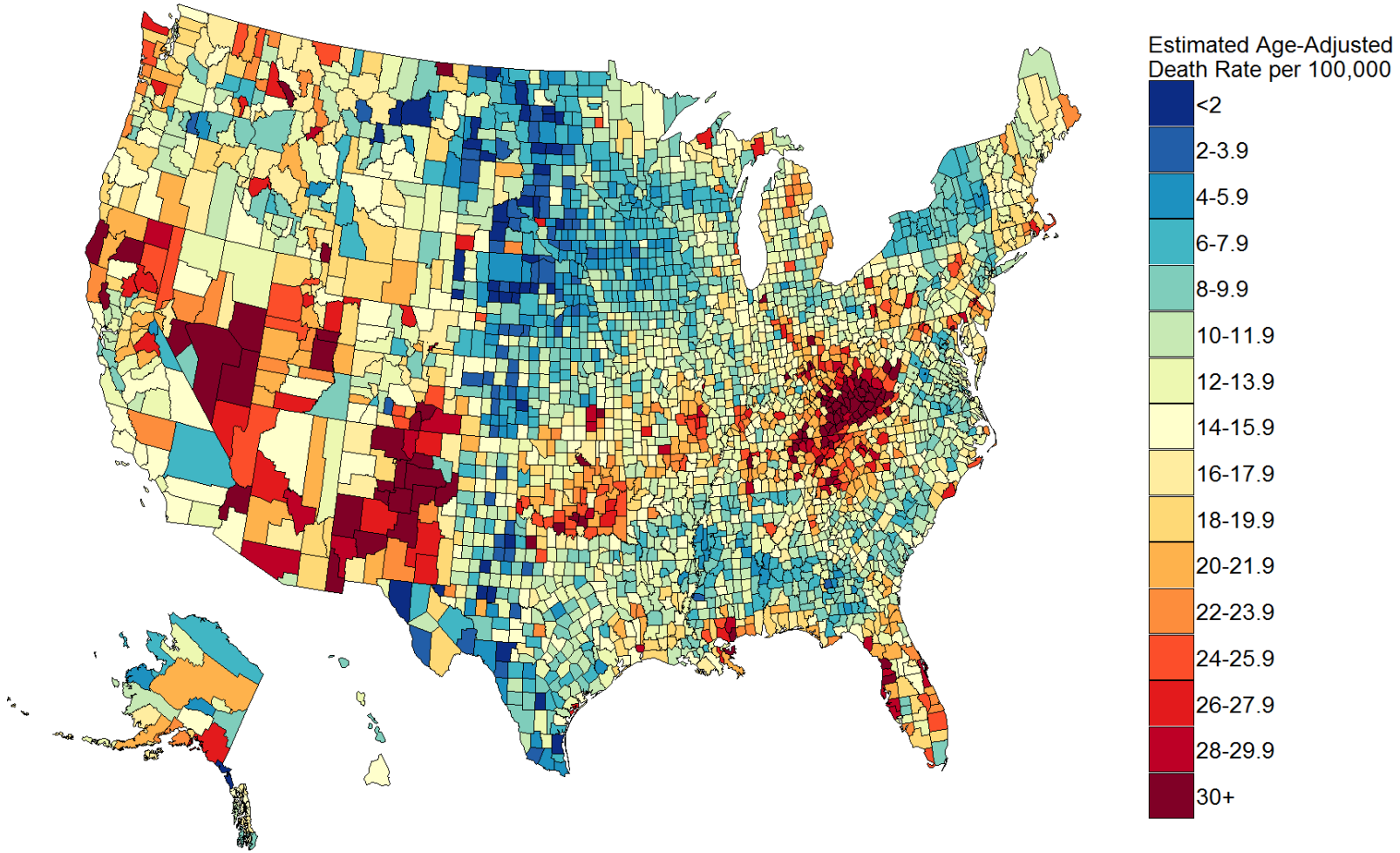
2014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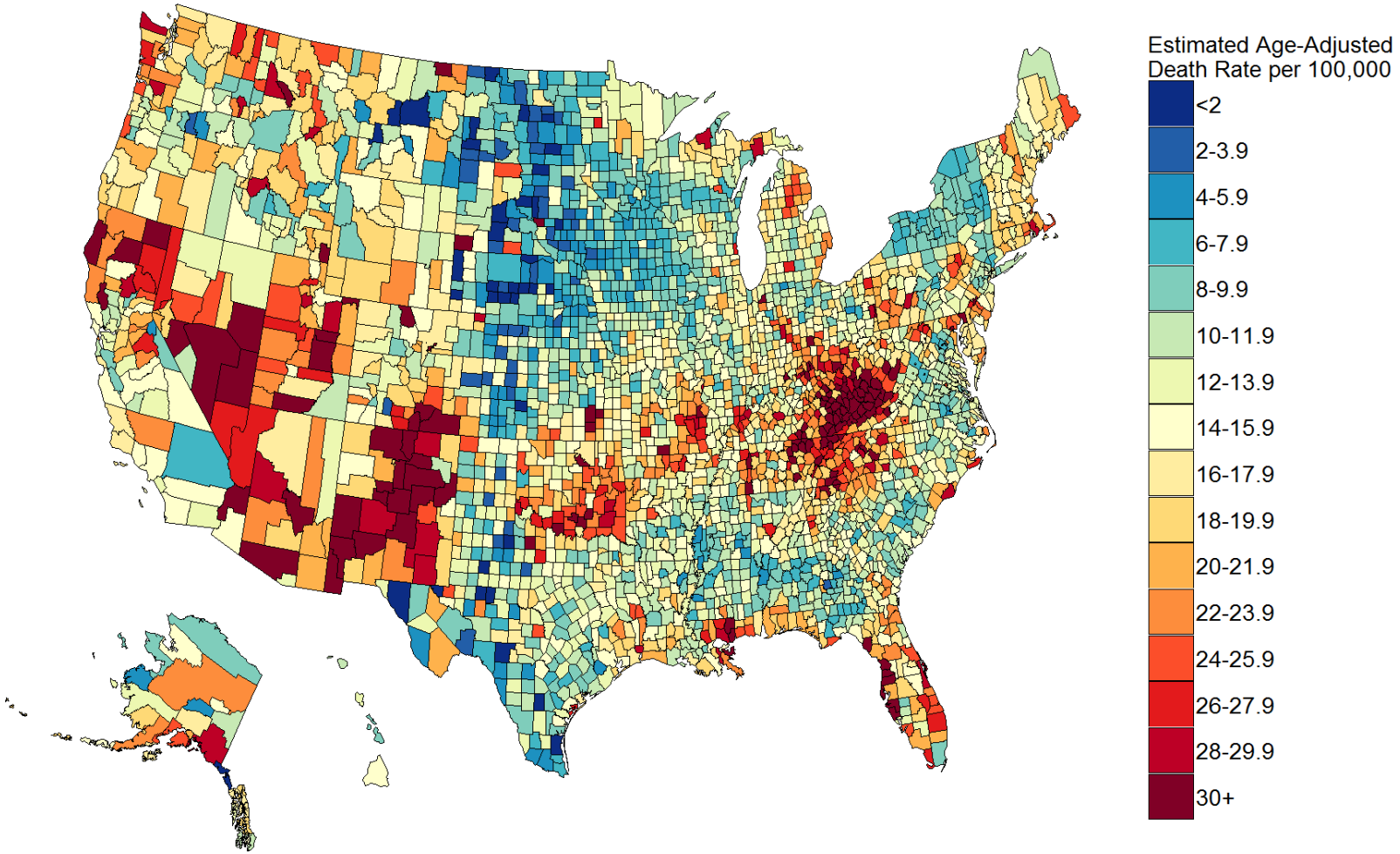
30+

2015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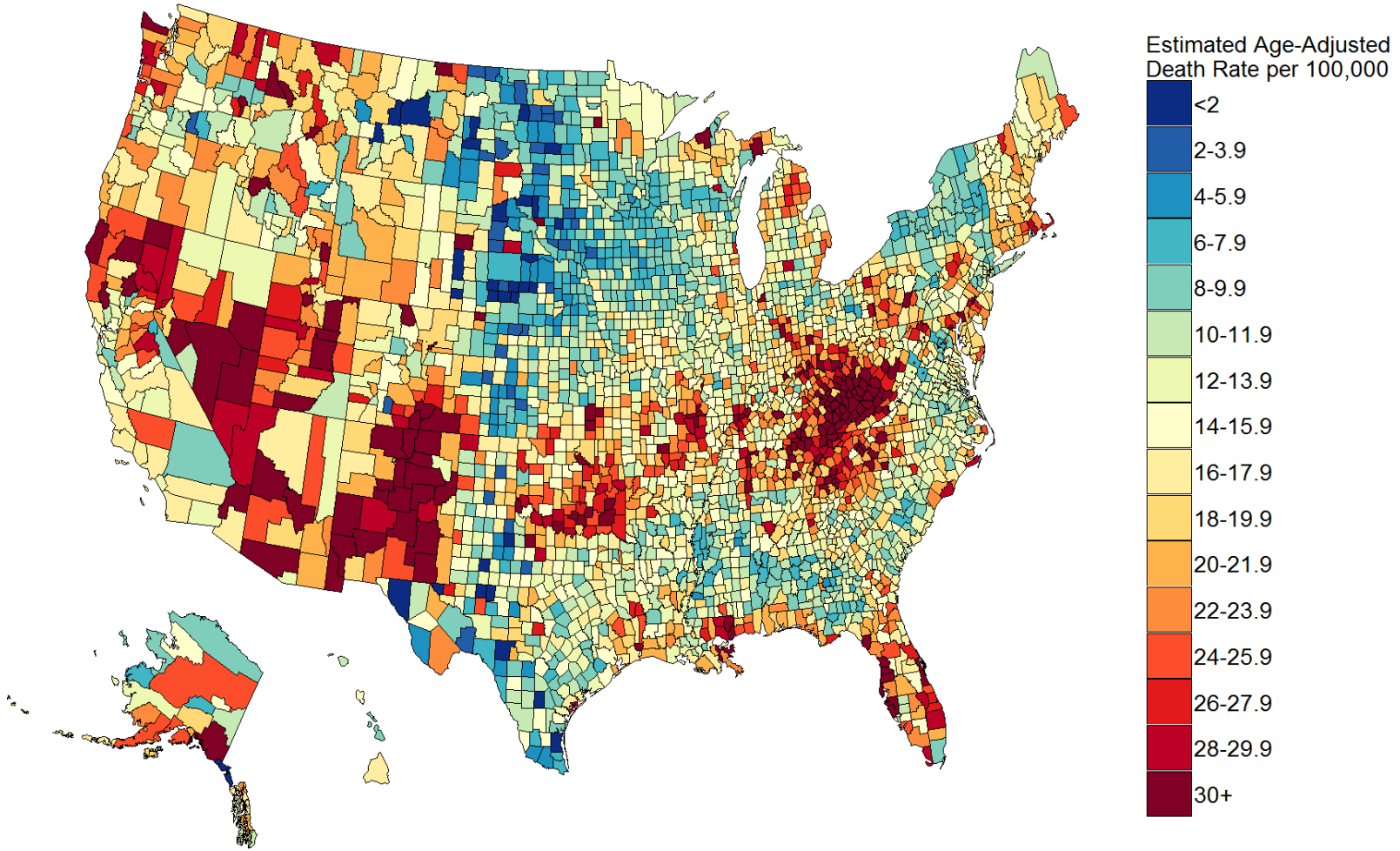
30+

2016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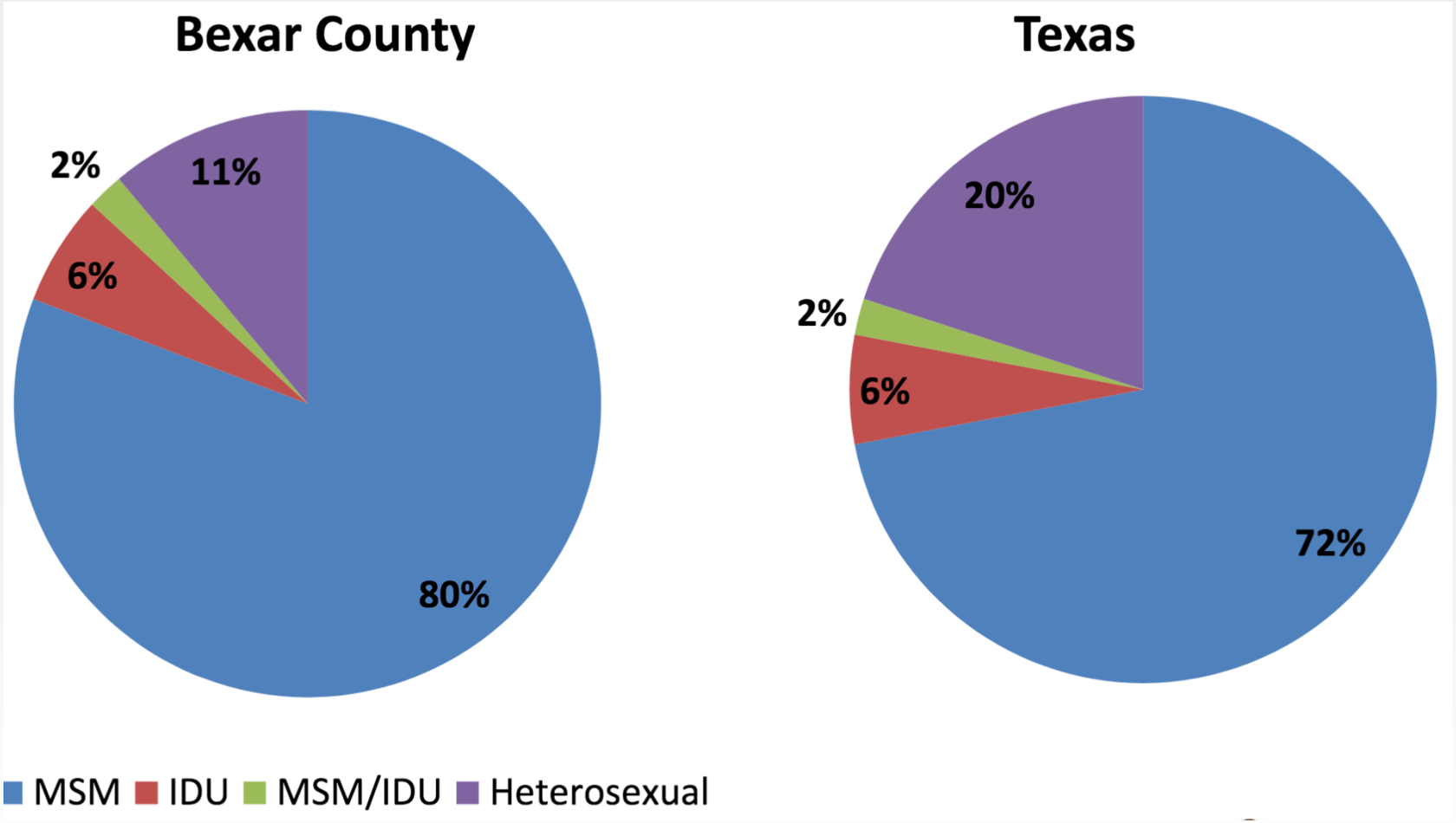
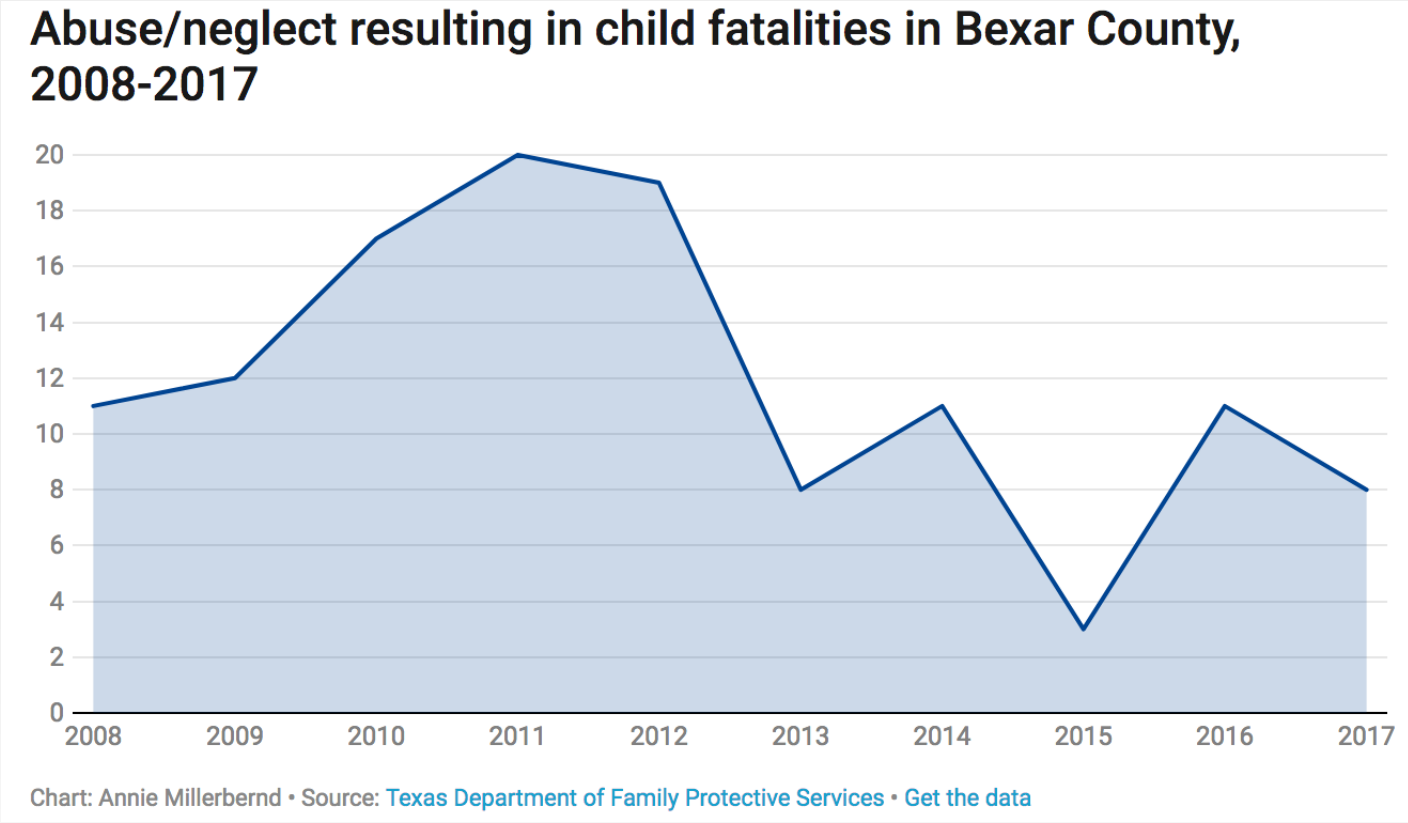
HIV



Texas HARS database, 2016

Statewide, about **52%** of child fatalities resulting from neglect involved caregivers actively using a substance



Of the ***eight*** deaths in 2017 that were related to child abuse or neglect, **five** involved caregivers who either admitted to or tested positive for alcohol, marijuana, cocaine or heroin, and sometimes a combination of all of them.

Takeaways

- Generally, substance use and related outcomes have been decreasing over the last decade.
- Some noteworthy trends warrant future research attention
  - Local cigarette vs. e-cig use compared to national trends
  - “Opioid crisis” has not hit San Antonio in the same way it has affected other communities

A lesson learned

- There is a lot of rich data on substance use in San Antonio, but it is fragmented

- CDC
  - YRBS & BRFSS
- Texas DSHS
- San Antonio Metro Health
- Bexar County Sheriff's Department
- SAPD
- SA Express News
- TXDoT
- Texas School Survey
- Health Collaborative
- TABC
- HARS
- Prevention Resource Center

What can we do to help the everyday consumer?

Region 8 Prevention Resource Center Epidemiology workgroup

- Our group has a common interest to assess the drug abuse patterns, trends and emerging problems to provide the foundation for a public health response.

- Our goal is to eliminate or reduce substance abuse and its related consequences in our communities.

- We are charged with 4 core tasks:
  - Identify drug abuse patterns.
  - Identify changes over time.
  - Detect emerging substances.
  - Communicate and disseminate our findings.

Interested in joining?

Please contact:

Teresa Stewart
Region 8 Prevention Resource Center
tstewart@sacada.org

Buprenorphine, Methadone, or Naltrexone: History, Rationale, and Effectiveness in Opioid Use Disorder

Van L. King, MD
Professor, Department of Psychiatry
UT San Antonio School of Medicine
SASUS March 1, 2019

Dr. King has no conflicts of interest in this presentation

Learning Objectives

1. Brief history of opioid regulation and maintenance in the US.
2. Rationale for opioid maintenance treatment and effectiveness.
3. Comparison of the three major choices for opioid maintenance medication.
4. Integrating medication and psychosocial care is important.

1850 - 1914

- Between 1840 – 1890 there was a 400% increase in crude opium imports into US.
- Availability of more potent opium derivatives and hypodermic syringes.
- High rates of opiate prescribing by some general physicians.

1850 - 1914

- Widely available “patent” medicines were largely unregulated and often did not list contents of the preparation or were untruthful.
- Significant concern by public health advocates for dangerous and not uncommonly deadly consequences of use.

Dr King's New Discovery

For Consumption, Coughs and Colds:

H E Bucklen & Co

Chicago, Ill.

Souvenir of the

World's Columbian Exposition

Chicago, 1893.

Price, 50 Cents.

1850 - 1914

- Increasing political and public health concern about opiate and cocaine addiction, but conversely
- In the wake of the Civil War, much wariness about excessive federal government regulation on the practice of medicine and also a strong patent medicine lobby.

Harrison Narcotic Act 1914

- Dr. Hamilton Wright became crusader for restrictions on opiate prescribing around 1900.
- Led the initiative to ratify the Harrison Narcotic Act 1914. Much political wrangling with physician and pharmacist groups and patent medicine manufacturers.

Hamilton Wright, MD

US Opium Commissioner
Diplomatic hopeful

Harrison Narcotic Act 1914

- AMA: prevent unconstitutional federal restrictions on practice.
- Physicians and pharmacists competed for dispensing.
- Patent medicine manufacturers against limiting narcotics in their products.

Harrison Narcotic Act 1914

- No explicit law enforcement provisions.
- Maintenance defined as not treating an acute issue or not “curing” addiction in a limited time period.
- US Treasury intimidated physicians that were prescribing “maintenance.”
- Cast a wide net for crooked physicians and illicit taffficking.

Harrison Narcotic Act 1914

- District courts not in favor of the federal position. States and local municipalities were divided.
- Temperance movement and increasing conservative mood during WWI.
- Supreme Court opinion 1919 supported no maintenance position.

Repercussions of the Harrison Act

- What to do with all these opioid dependent people?
- Is this a disease or a moral failing?
- Though many “cures” offered, most fraudulent. Maintenance is pragmatic.
- Well-known reciprocal relationship between physician opiate prescribing and illegal “dope peddlers” dealing.

“Treatment” and Politics

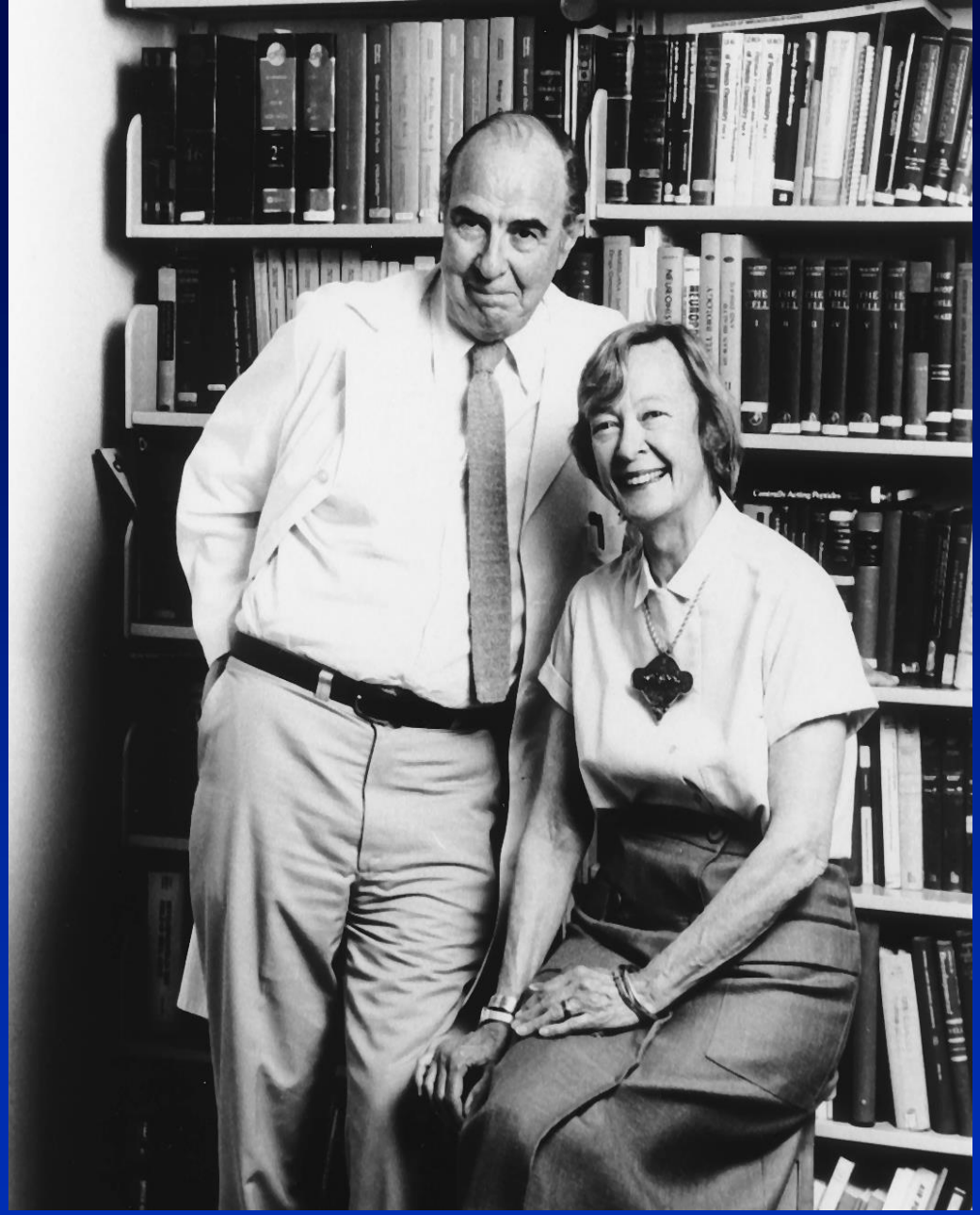
- Local Public Health Clinics vs. private clinics.
- Jacksonville, FL 1911-1915 and Shreveport, LA 1919-1925.
- New York State run by political appointees, NYC more criminals.
- Treasury decided that legal sanctions more effective than public health approach.

“Treatment” and Politics

- Public Health Hospitals in Houston and Lexington (1929) due to unmanageable numbers of opiate addicted federal prisoners.
- No better for rehabilitation.
- Scientists trained there became leaders in NIMH and NIDA.

“Treatment” and Politics

- Zeitgeist of the time would not allow maintenance in the midst of Prohibition and strong conservative social movement.
- Increasing criminal justice approach to addiction over the following decades.
- Upsurge in opiate use after WWII; harsh though ineffective legal penalties in 1950s.

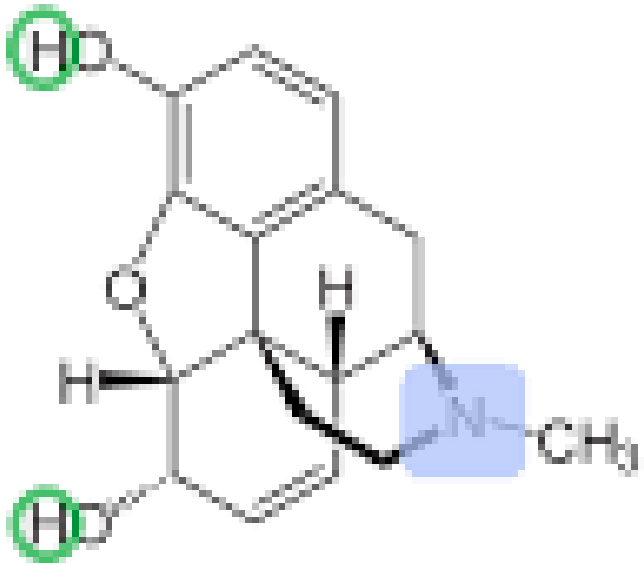


Marie Nyswander, M.D. a psychiatrist and psychoanalyst, and her husband, Vincent P. Dole, M.D., both of The Rockefeller University.

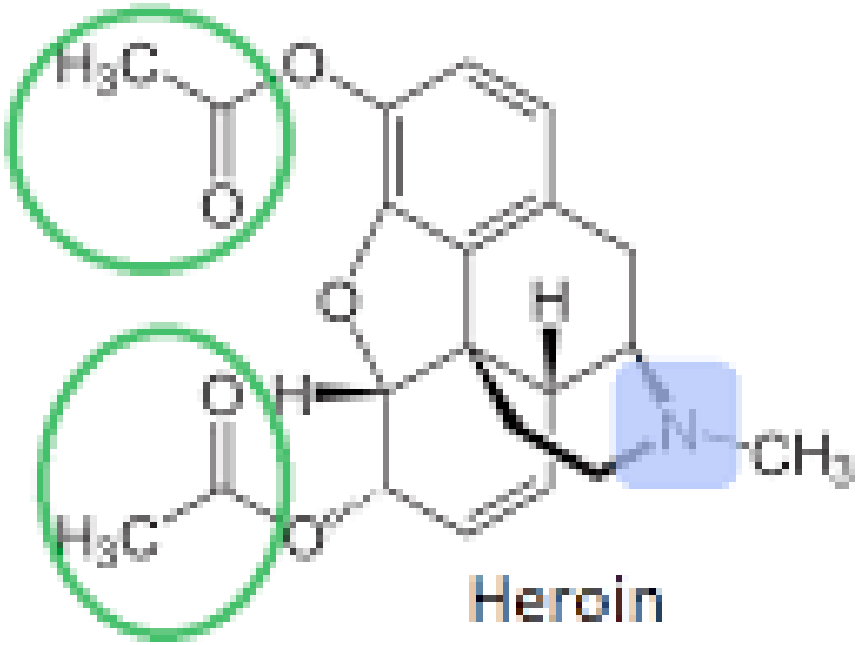
American Journal of Psychiatry, 155:12, 1766, 1998

Dole and Nyswander

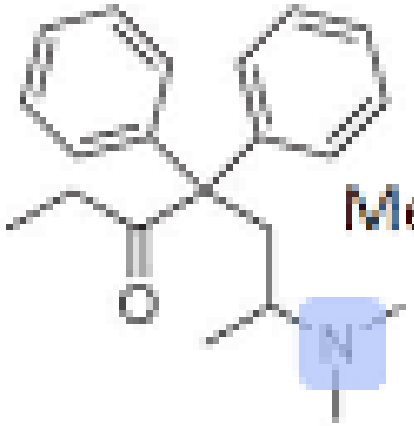
- Frustrated by poor treatment outcomes.
- JAMA 1965, Arch Intern Med 1966, JAMA 1968.
- Empiric trial of opioid maintenance.
- Narcotic blockade.
- Importance of psychosocial treatment.



Morphine



Heroin



Methadone

Dole and Nyswander

- Dole and Nyswander, A Medical Treatment for Diacetylmorphine (Heroin) Addiction.
- JAMA, 193:80-84, 1965.
- Range 10 -180 mg methadone daily.
- Remarkable improvements in majority of patients. “Relieves drug hunger.” Only significant problem constipation.

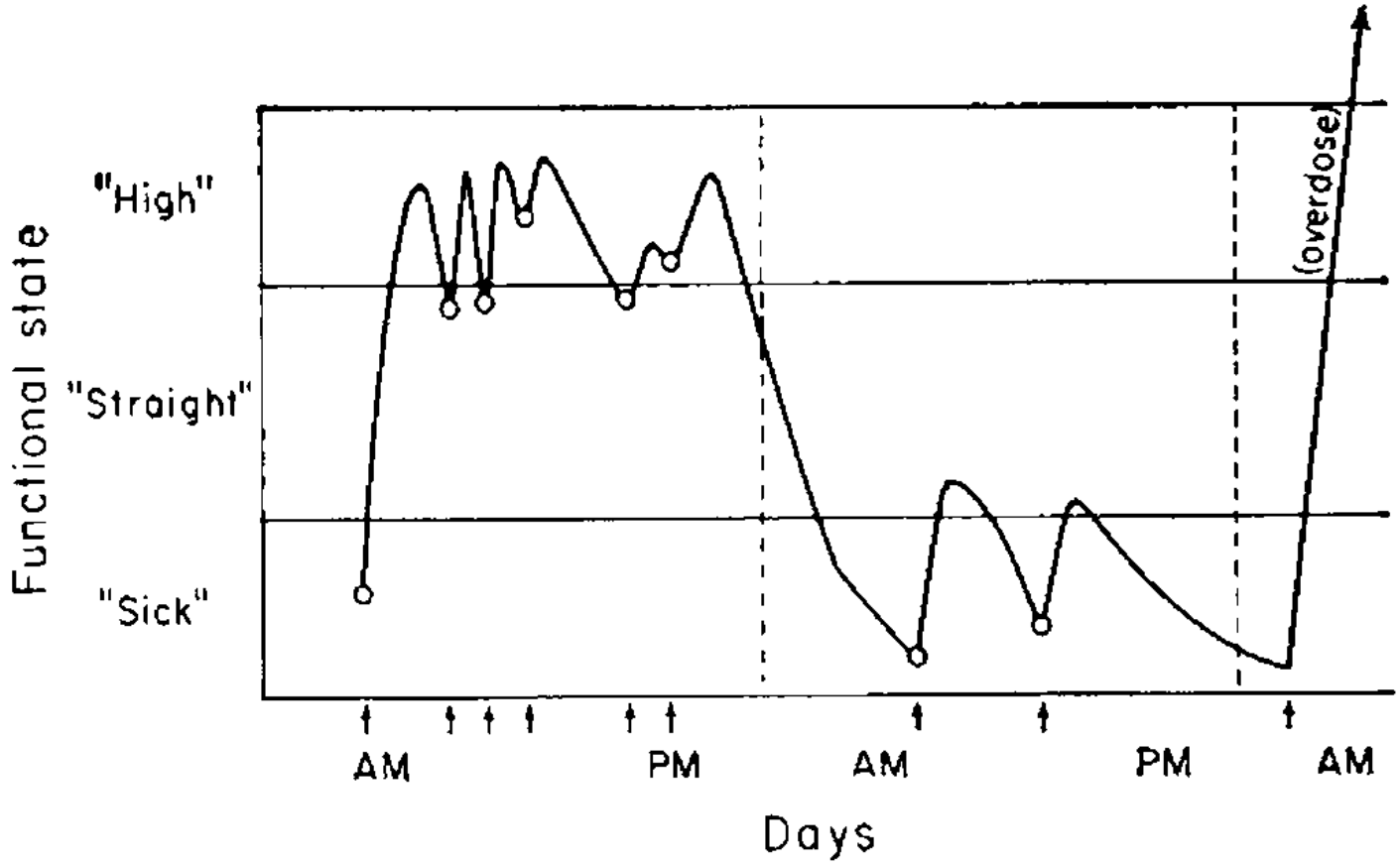


Fig 1.—Diagrammatic summary of functional state of typical "mainline" heroin user. *Arrows* show the repetitive injection of heroin in uncertain dose, usually 10 to 30 mg but sometimes much more. Note that addict is hardly ever in a state of normal function ("straight").

Dole, Nyswander, Kreek. Narcotic Blockade. Arch Intern Med 118: 304-310, 1966

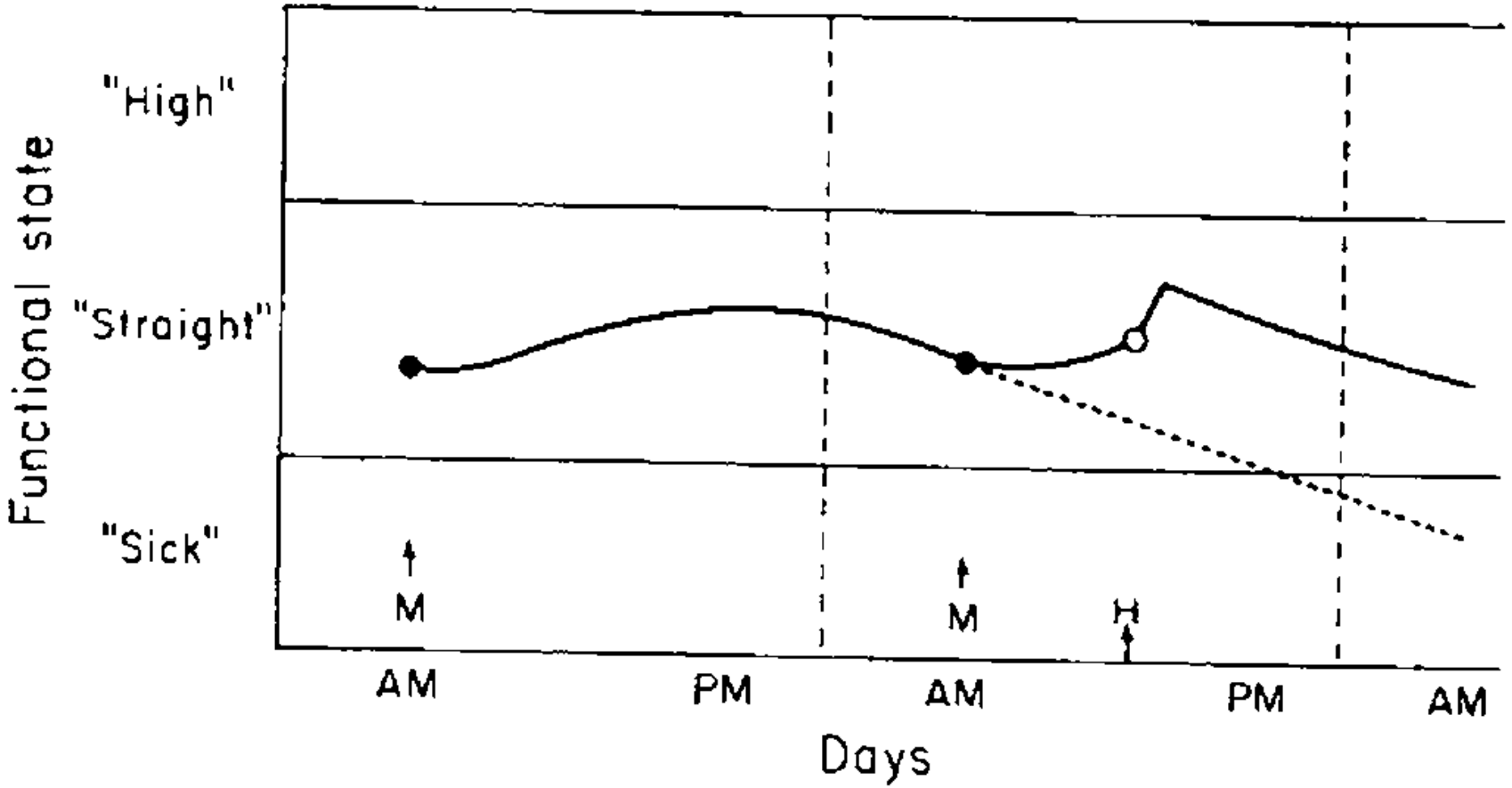


Fig 2.—Stabilization of patient in state of normal function by blockade treatment. A single, daily, oral dose of methadone prevents him from feeling symptoms of abstinence ("sick") or euphoria ("high"), even if he takes a shot of heroin. *Dotted line* indicates course if methadone is omitted.

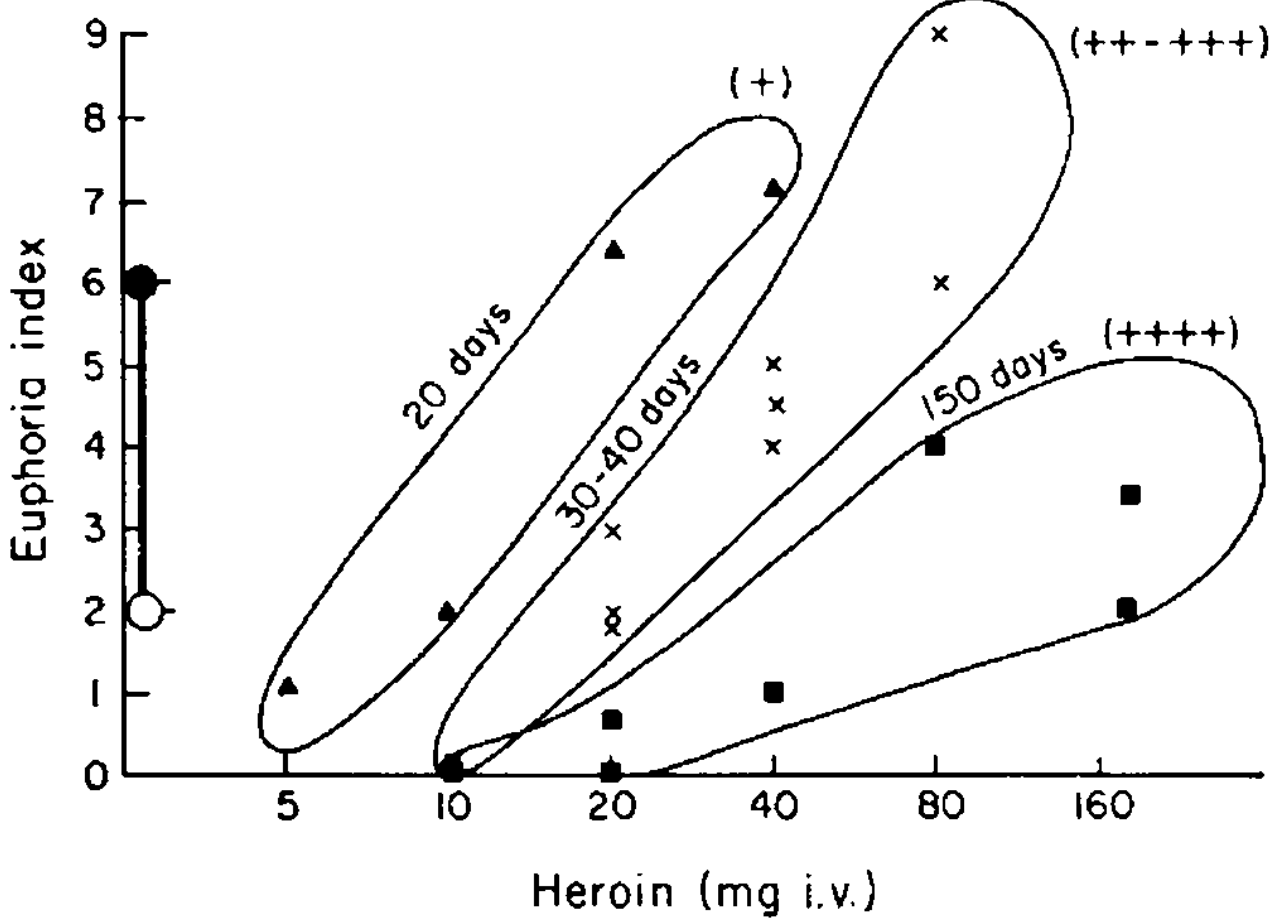
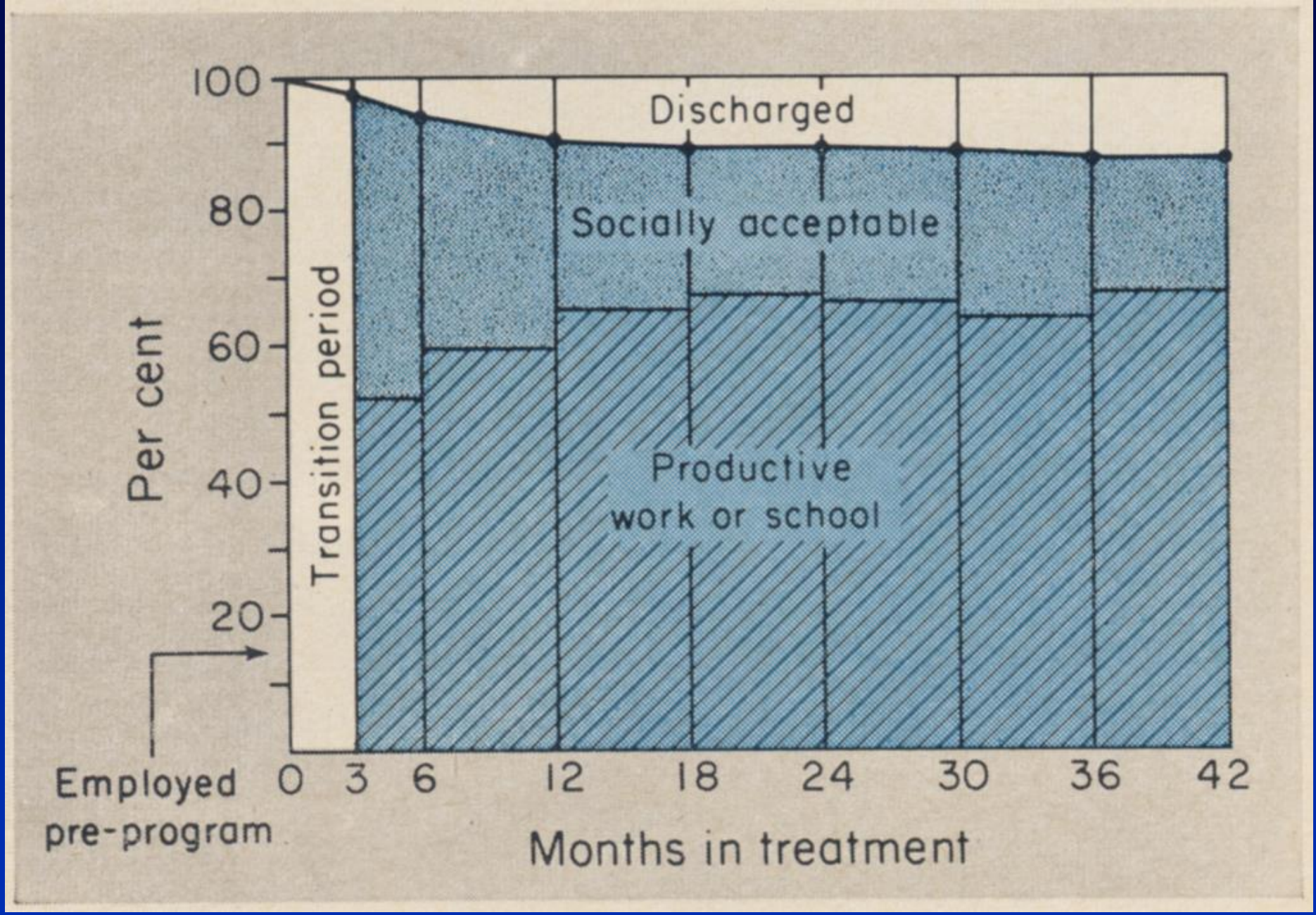


Fig 5.—Blockade of heroin euphoria with methadone maintenance. Clusters of points indicate response of patients with various degrees of narcotic blockade (indicated as +, ++, +++, ++++, +++++). Below a euphoria index of about 2 (shown by *open circle* on ordinate), there is no significant euphoria; above 6 (*solid circle*) the drug has marked euphoric appeal.



Dole, et al. Successful treatment of 750 criminal addicts. JAMA 206:2708-12, 1968

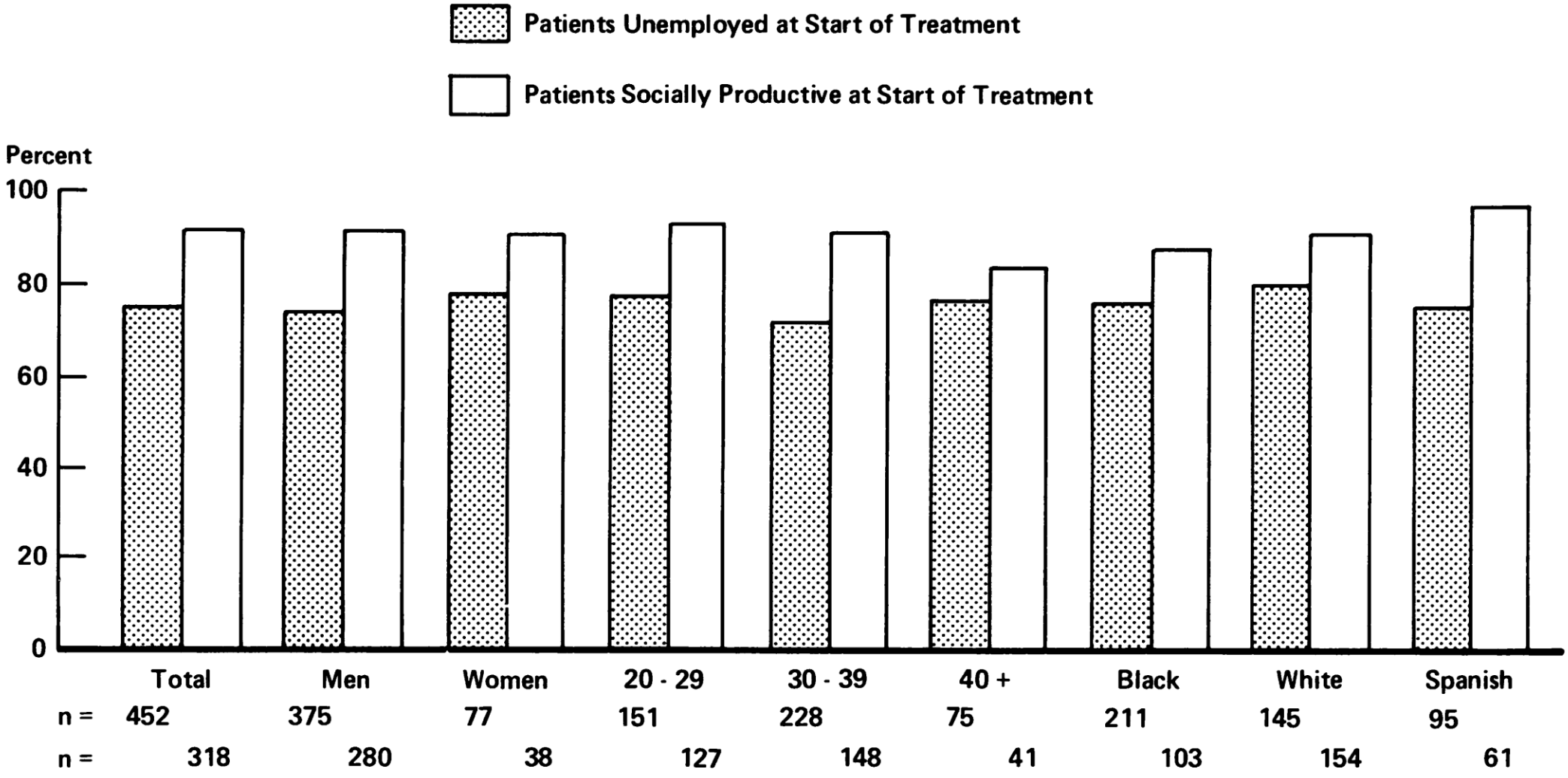
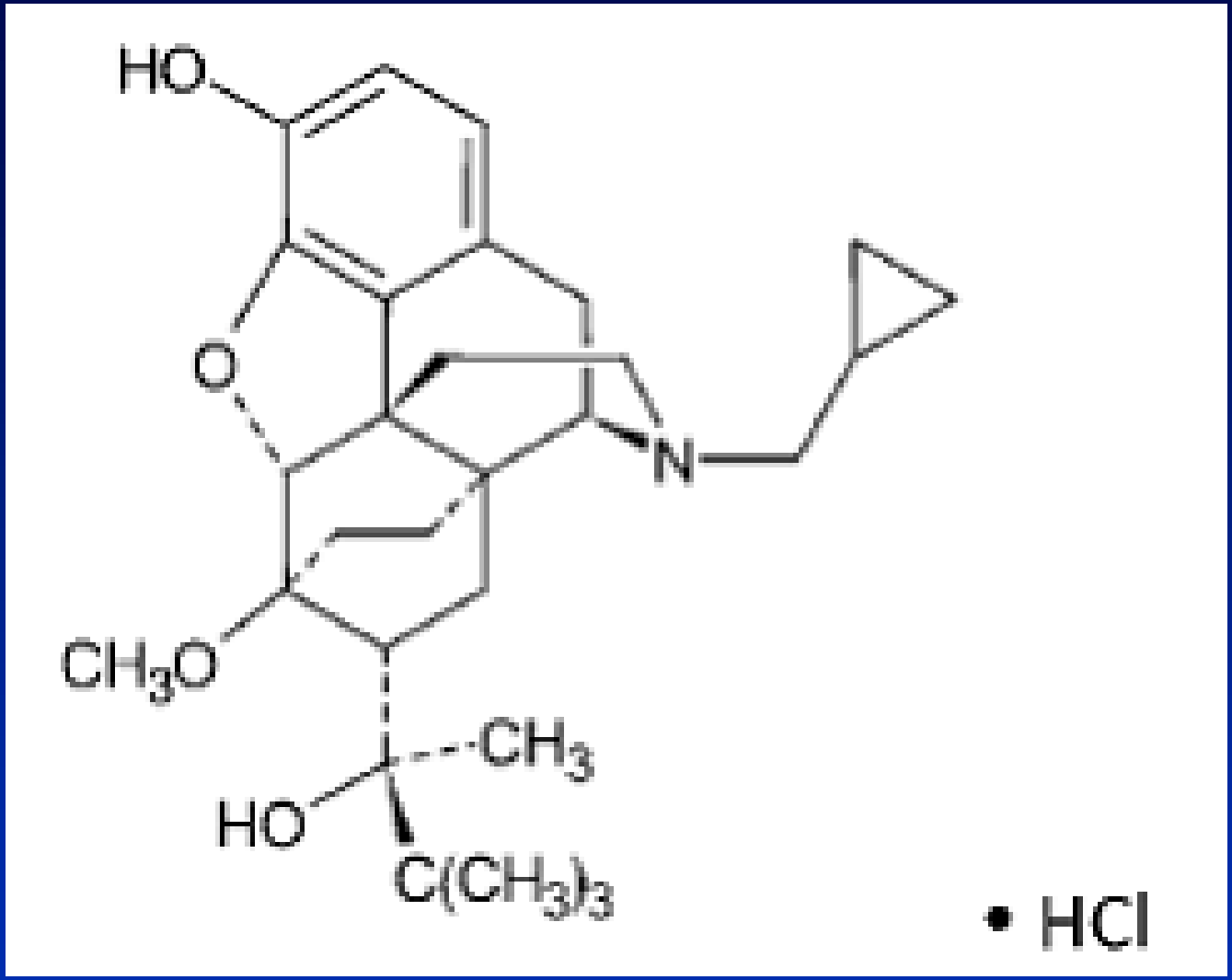


FIGURE 3—Social Productivity* After Five or More Years Participation (as of December 31, 1973)
***Included Employed, In Training, Homemaker.**

Gearing. Methadone maintenance treatment five years later- where are they now? AJPH Supp. 64:44-50, 1974

Narcotic Treatment Programs

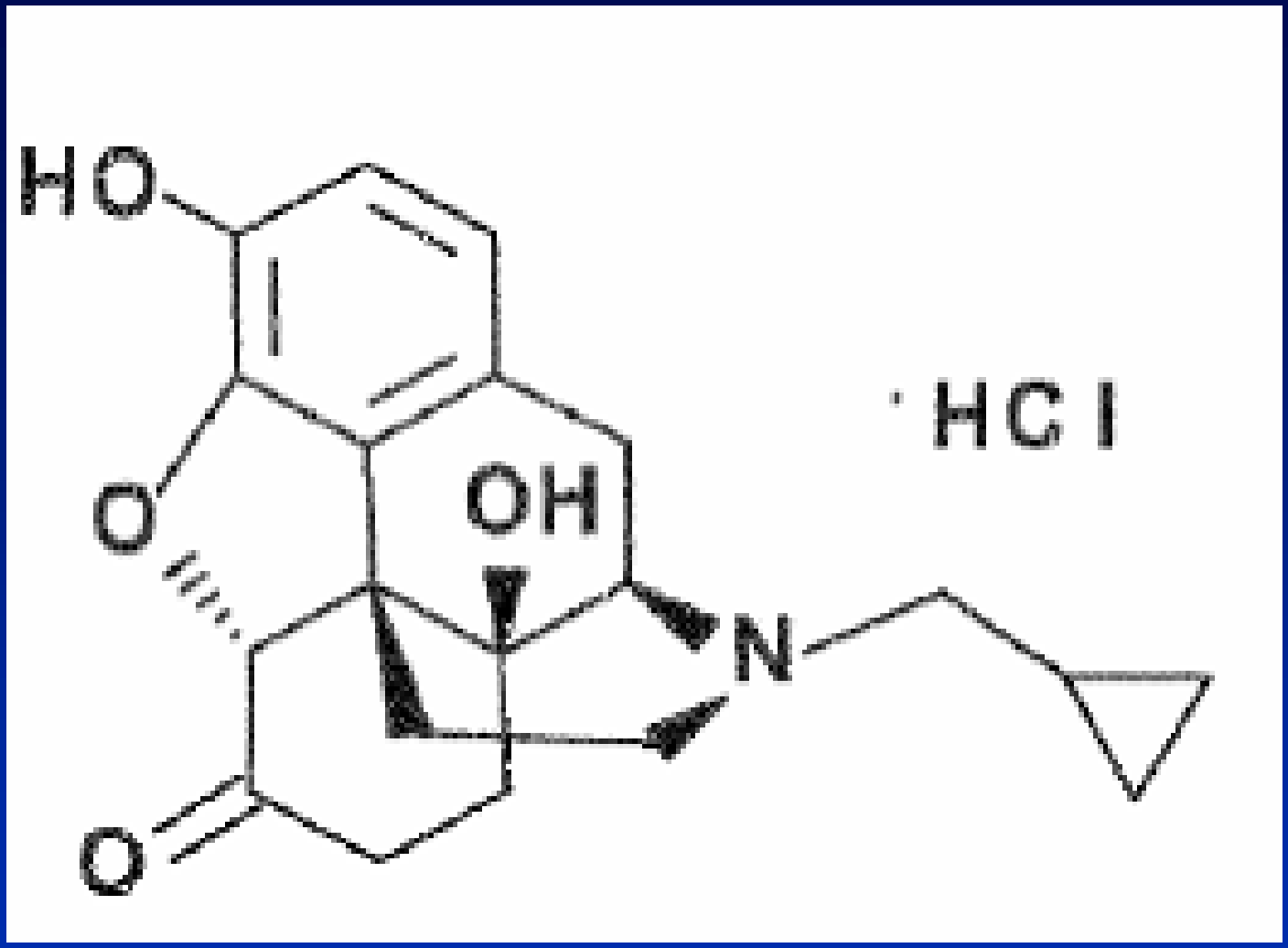
- 1972 FDA regulations for control of methadone maintenance treatment.
- Much improved outcomes with maintenance versus other treatments.
- Increased retention, decreased opioid use, reduced mortality and overdose, improved employment and reduced crime.
- Still largely stigmatized.



Buprenorphine

Buprenorphine

- Buprenorphine approved 2000. Partial mu receptor agonist.
- Less potent/ toxic than methadone.
- Fewer restrictions on prescribing (NIMBY) potentially more available.
- Generally as effective as methadone, but lower retention (less reinforcing) and more diversion.



Naltrexone

Naltrexone

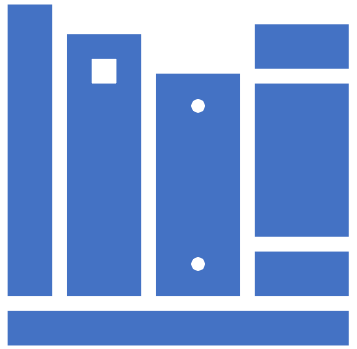
- Naltrexone development funded almost entirely by US government in 1970s. FDA approved in 1984.
- Very effective oral opioid blockade and often extinguishes opioid use.
- Difficult induction hurdle for patients actively using opioids.

Naltrexone

- Much higher rates of adherence with monthly depot injectable compared to tablet.
- Head-to-head studies with buprenorphine show equivalent outcomes over several months if successfully start depot naltrexone.

Summary

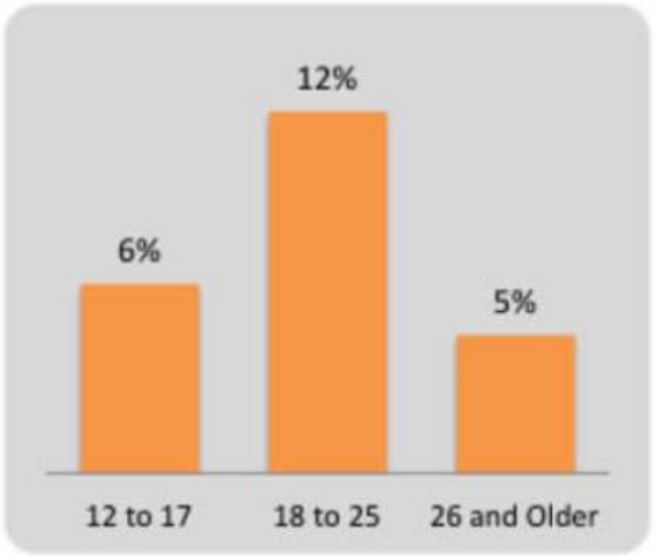
- The more things change the more they stay the same.
- Increased opioid prescribing leads to increased opioid use problems.
- Still no “cure” for opioid addiction. Much better management. Diversion problematic.
- Lack adequate psychosocial emphasis.
- Stigma lessened but remains.



Recovery High Schools

“Safe, Sober, Scholastic”*

*University High School, Austin, TX



In 2014, the nonmedical use of prescription drugs was highest among young adults.[2]

Adolescents and Addiction

- The earlier the drug use, the higher the risk for addiction
- By the time they are seniors…
  - Almost 70% of HS students will have tried alcohol
  - Half will have taken an illegal drug
  - 20% will have used a prescription drug for nonmedical purposes
- 25% of those who begin abusing prescription drugs at age 13 or younger develop a substance use disorder at some time in their lives
- 9% of marijuana users become addicted. Starting young **doubles** your risk. Daily use **triples** it.

Adolescents in San Antonio

- According to SACADA, Average age of first use in Bexar County is **11.5 years old**
- Most common drugs teens use, as observed by local professionals, in order*:
    1. Marijuana
    2. Amphetamines (Ritalin)
    3. Methamphetamines
    4. Benzodiazepines (Xanax)
    5. Polysubstances (a mixture)

*Synthetic marijuana cannot be tested

*Opiates is 4th nationally for teens, but San Antonio has less teen opiate use among those drug tested

Adolescents and Recovery: Most Effective Community Response

- Early intervention
- Treatment (at least three months)
- Transitional Care
- Assessing and addressing underlying issues
- Family support services

What is a Recovery High School

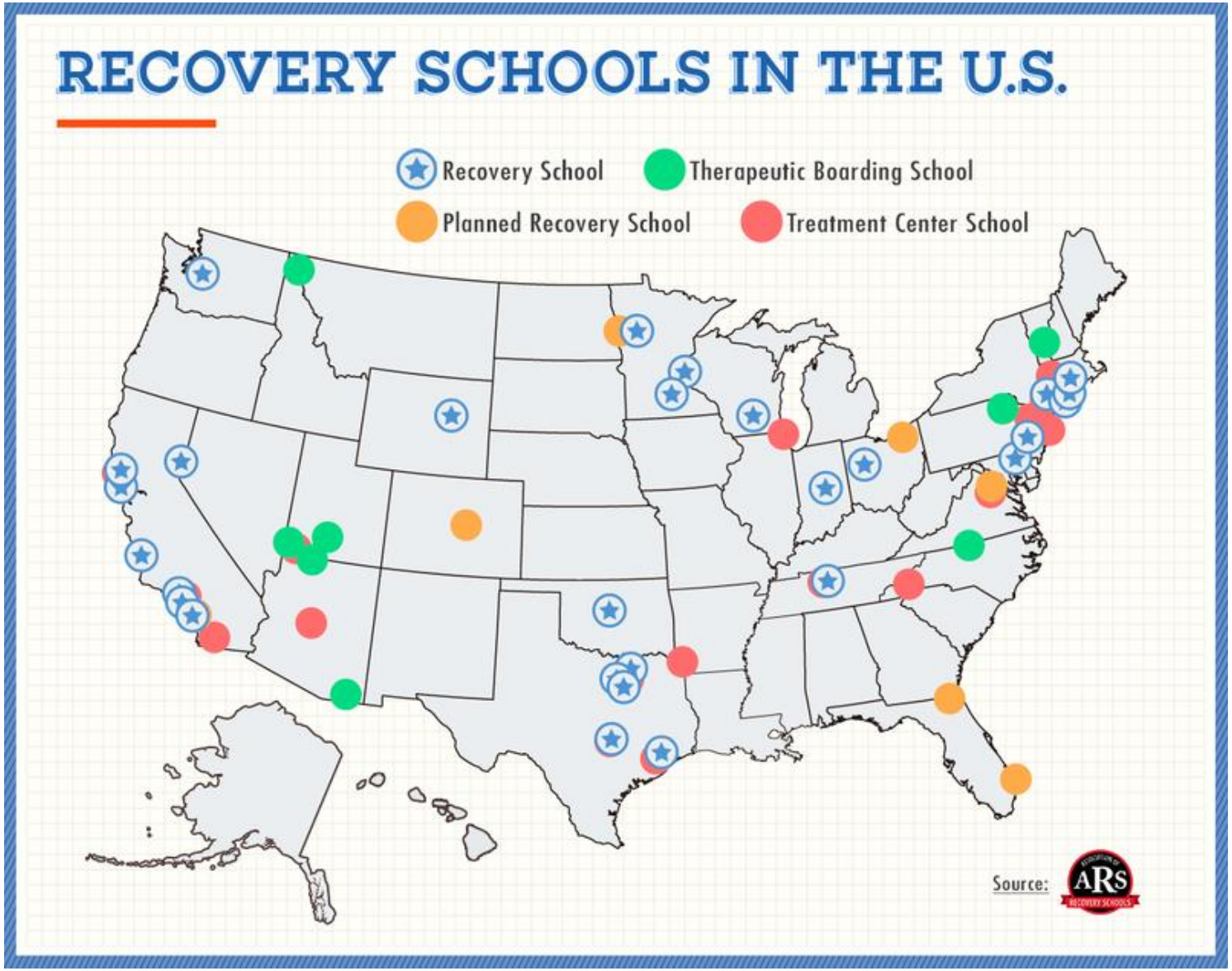
Why do adolescents need one?

"If you talk to kids in recovery, they will tell you the first time they felt truly accepted for who they are and not necessarily singled out for having a substance use disorder is when they arrived at a recovery school. They're surrounded by a bunch of kids who feel similar to them and they feel like they can understand them and they can be themselves." - Teacher

– Teacher

Life or death difference in the lives of our kids.


MACKLEMORE


RECOVERY SCHOOLS IN THE U.S.
Recovery School
Therapeutic Boarding School
Planned Recovery School
Treatment Center School
Source:
ARs

Student Engagement

The semester student enrollment of reporting recovery schools, the gender distribution among that student population, and the activities that contribute to recovery school attendance.

24 Male

19 Female

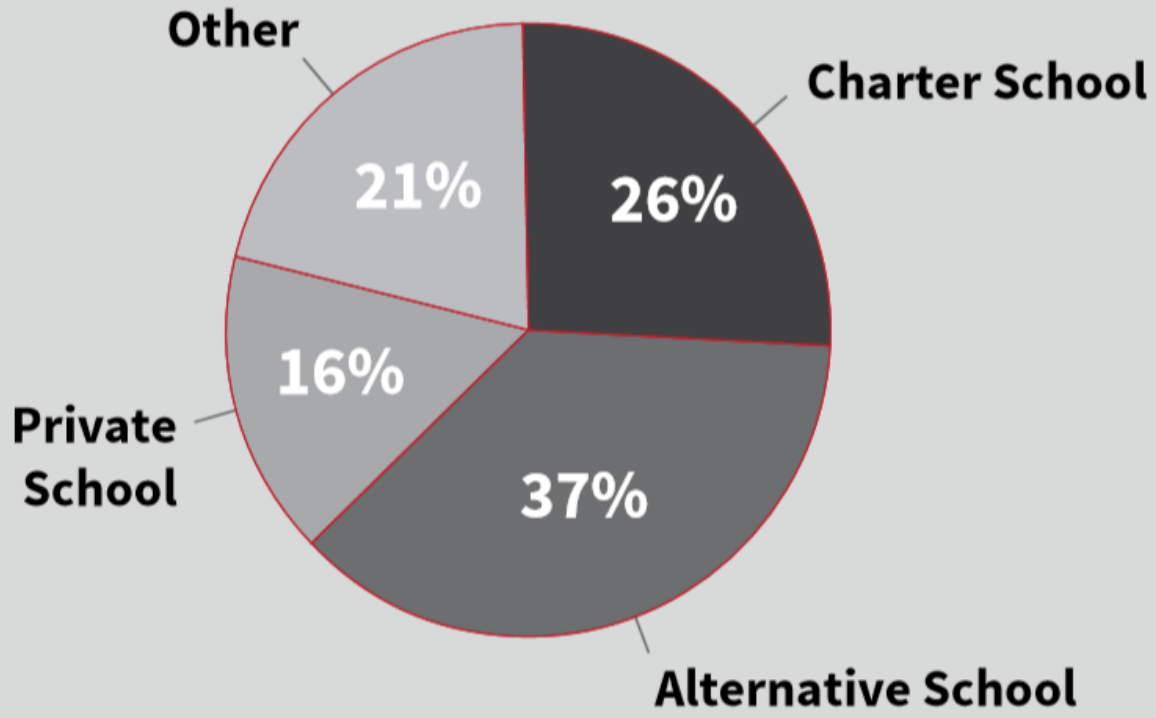
Average Male & Female Student Enrollment at a Recovery High School

2-115 **Range of Students Enrolled in a Recovery High School**

Average Student Enrollment is 32

School Classifications

How reporting recovery schools are classified by local and state school districts across the U.S.



A Sample Recovery School Schedule

Period	Activity	Begin	End
1	English	9:00 AM	9:50 AM
2	Math	9:50 AM	10:40 AM
3	PE / Health	10:50 AM	11:40 AM
4	Lunch	11:40 AM	12:10 PM
5	Group	12:10 PM	1:00 PM
6	Social Studies	1:00 PM	1:50 PM
7	Science	1:50 PM	2:40 PM
8	Tutorial / 1x1	2:50 PM	3:30 PM
9	End of Day Check In	3:30 PM	4:00 PM

Recovery School Students

2.75

Average Recovery School GPA

3.0

National Average High School GPA

Source: U.S. Department of Education

Students Average 2 Treatment Episodes Prior to Recovery School Admittance

Enrollment in Recovery High Schools

2 ------ 115 Range of Students Enrolled in a Recovery High School

Your text here

Average Student Enrollment is 32

"So You Want to Start a Recovery School In Texas?"
www.recoverypeople.org

Average Student Engagement

100%

Peer
Support

89%

Social Activities
& Sober Fun

41%

Counceling or
Clinical Support

28%

Other

Recovery School Model

Next Steps

1. Adolescent Recovery Oriented Systems of Care (AROSC)
   *Wednesday March 20, 2019
2. Recovery School Taskforce
   *Wednesday March 11, 2019
3. Letters of Support/Testimonies

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Rise Recovery

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Recovery School Taskforce Chair

Bexar County Juvenile Probation Department

Coordinator Behavioral Health Services Resource Development

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#SASUS2019

Promoting recovery with every word: Stigma and discrimination

March 1, 2019

USciences
University of the Sciences

Substance Use Disorders Institute
EDUCATION • POLICY • RESEARCH

Robert D. Ashford, MSW
@rdashford

Session Agenda

Promoting recovery with every word: Stigma and discrimination

- Introduction
- What is recovery?
- Recovery across the United States
- History of recovery messaging
- What are stigma and discrimination?
- What does the research say about language?
- Emerging research
- The dialects of recovery: Self-labeling and identification
- The role of imagery in promoting stigma and discrimination
- Media guidelines

A Brief Primer on Recovery

SOURCE	YEAR	DEFINITION
CENTER FOR SUBSTANCE ABUSE TREATMENT (CSAT)	2005	Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.
AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)	2005	A patient is in a "state of recovery" when he or she has reached a state of physical and psychological health such that his/her abstinence from dependency-producing drugs is complete and comfortable.
BETTY FORD INSTITUTE	2006	A voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship.
WILLIAM L. WHITE	2007	Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD- related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life.
UK DRUG POLICY COMMISSION	2008	The process of recovery from problematic substance use is characterised by voluntarilysustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.
SCOTTISH GOVERNMENT	2008	A process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society.
SAMSHA	2011	Recovery from mental disorders and substance use disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)	2013	A process of sustained action that addresses the biological, psychological, social and spiritual disturbances inherent in addiction.
KELLY AND HOEPPNER	2014	Recovery is a dynamic process characterized by increasingly stable remission resulting in and supported by increased recovery capital and enhanced quality of life.
RECOVERY RESEARCH INSTITUTE ADDICTION-ARY	2017	The process of improved physical, psychological, and social well-being and health after having suffered from a substance-related condition.

- The fields of SUD and MH recovery have seen several attempts at defining the word and concept of “recovery.”
- National organizations such as the Substance Abuse and Mental Health Association (SAMHSA), the American Society for Addiction Medicine (ASAM), the Hazelden Betty Ford Foundation (HBFF), and others have developed working definitions of recovery (SAMHSA, 2011; ASAM, 2013; The Betty Ford Institute Consensus Panel, 2007).
- Each of these has its merits, and weaknesses, and we have yet to reach true consensus among the scientific and professional communities, or the lay public.

* This figure documents the most popular definitions of recovery (Kelly & Hoeppner, 2015; *Courtesy of the Recovery Research Institute, 2017*).

A Brief Primer on Recovery

Recovery Science Research Collaborative Consensus Definition of Recovery

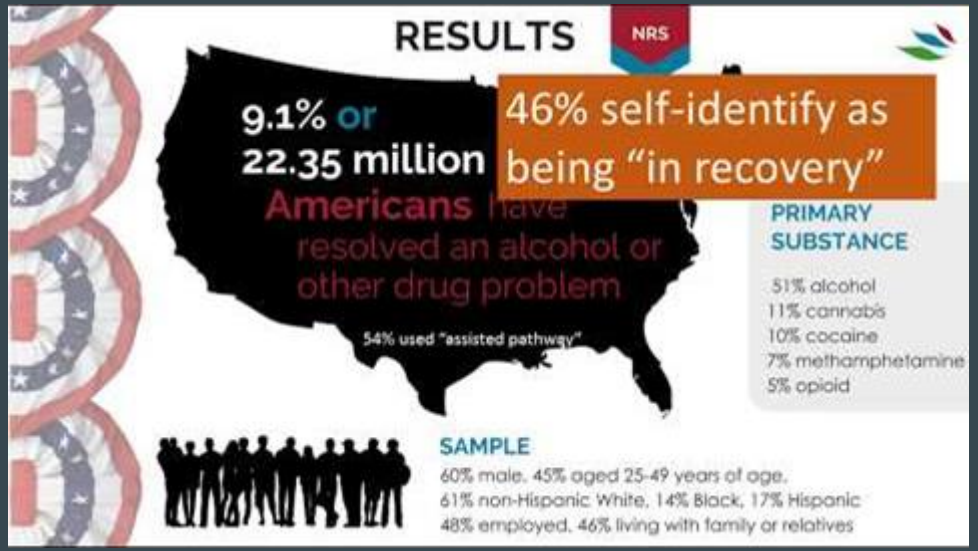
"Recovery is an individualized, intentional, dynamic, and relational process involving sustained efforts to improve wellness."

Ashford, R. D., Brown A., Brown, T., Callis, J., Cleveland, H. H., Eisenhart, E., ... Whitney, J. (2018). Defining and Operationalizing the Phenomena of Recovery: A Working Definition from the Recovery Science Research Collaborative. Addiction Research and Theory.

- The RSRC recently defined recovery in this way (2018)
- The definition is intended to help operationalize future recovery research
- Includes both MH and SUD
- Helps preclude discrimination resulting from individuals using different pathways and programs of recovery

Recovery Prevalence and Outcomes

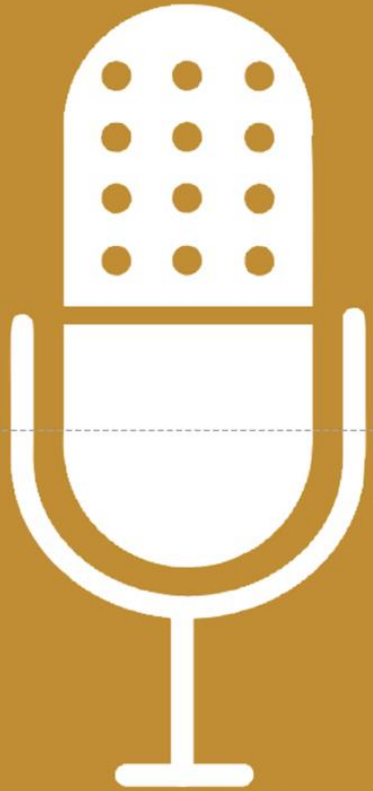
- The 2017 National Recovery Study estimates that 9.1% of the US population (18+ years, non-institutionalized) has resolved an AOD problem. (Kelly et al., 2017)
- About half of these individuals self-identified as a “person in recovery”
- Over half (53.9%) reported resolution via an “assisted pathway” (i.e. lifetime use of a formal support mechanism)
- A few previous studies have also estimated a national recovery prevalence rate between 9-10%



(Courtesy of the Recovery Research Institute, 2017)

History of Recovery Messaging

- In the mid-2000's, Faces and Voices of Recovery (FAVOR), a national addiction recovery advocacy organization, developed the "Our Stories Have Power" recovery community messaging training
    - Training was designed to give individuals in the recovery community (i.e. advocates) the tools to tell their personal stories with positive, person-first language
    - The original training was focused on storytelling in the advocacy space - policy makers and mainstream media



FACES & VOICES OF RECOVERY

Our Stories Have Power

Recovery Community Messaging Training

History of Recovery Messaging

- In 2015, Young People in Recovery (YPR), another national addiction recovery advocacy organization, developed “Recovery Messaging” training
    - Training was based on the original FAVOR training, but expanded on person-first language for personal use in all-settings
    - This training was designed to impact advocacy interactions, but also more day to day interactions in the community and personal spaces

Recovery Messaging Training

Our words are more powerful than we know…

Basics of Recovery Messaging Training

Developing the message

- Solution-focused
- Recovery story, not your addiction story

Know your audience

- Family
- Friends
- Neighbors
- Co-workers
- Media
- Public officials

Use positive language

- “I’m in long-term recovery which means...”
- Long-term recovery has given me new hope and stability

Messaging training has helped.
Between the FAVOR and YPR training, 10s of thousands of people have been trained in recovery messaging.

There has also been positive policy implications...

128th MAINE LEGISLATURE

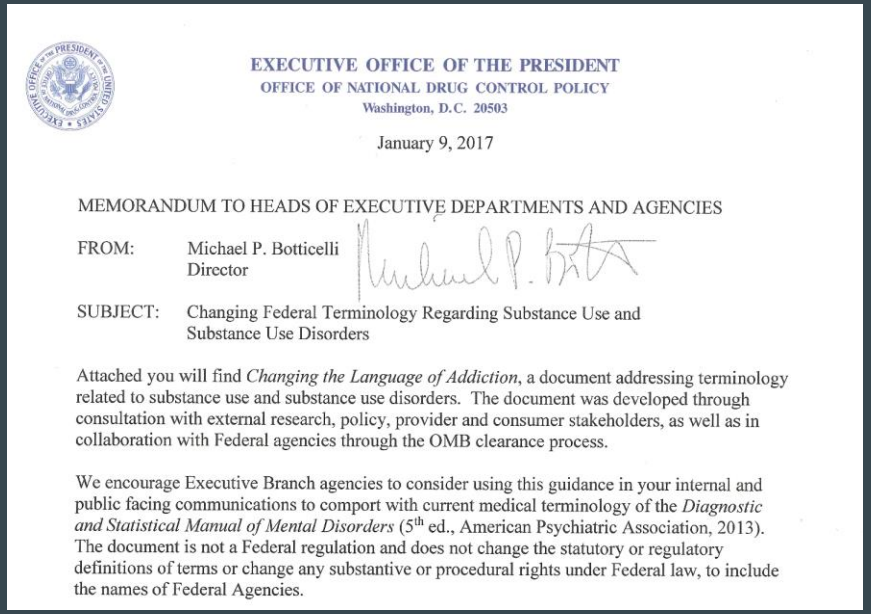
SECOND REGULAR SESSION-2018

Legislative Document **No. 1871**

S.P. 714 In Senate, March 20, 2018

An Act To Implement the Recommendations of the Task Force To Address the Opioid Crisis in the State Regarding Respectful Language

(EMERGENCY)



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

January 9, 2017

MEMORANDUM TO HEADS OF EXECUTIVE DEPARTMENTS AND AGENCIES

FROM: Michael P. Botticelli
Director

SUBJECT: Changing Federal Terminology Regarding Substance Use and Substance Use Disorders

Attached you will find *Changing the Language of Addiction*, a document addressing terminology related to substance use and substance use disorders. The document was developed through consultation with external research, policy, provider and consumer stakeholders, as well as in collaboration with Federal agencies through the OMB clearance process.

We encourage Executive Branch agencies to consider using this guidance in your internal and public facing communications to comport with current medical terminology of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., American Psychiatric Association, 2013). The document is not a Federal regulation and does not change the statutory or regulatory definitions of terms or change any substantive or procedural rights under Federal law, to include the names of Federal Agencies.

But stigma and discrimination still exist...

What are stigma and discrimination?

Stigma

Stigma is a multidimensional construct that can manifest in a variety of ways.

Link and Phelan (2001) define stigma as:

- A label AND a stereotype
- The label (e.g. addict) links the person to a set of undesirable characteristics (i.e. criminal, dirty, untrustworthy) that work to form the stereotype (i.e. beliefs held about a group of people with a substance use disorder).

Discrimination

Discrimination is the actual manifestation of actions that people take when they believe a stereotype and then associate the label with others.

Examples of Discrimination:

- Denial of housing and employment
- Bullying and/or harassment
- A condition, rule, or policy disproportionately impacts only certain individuals

Contributors to stigma

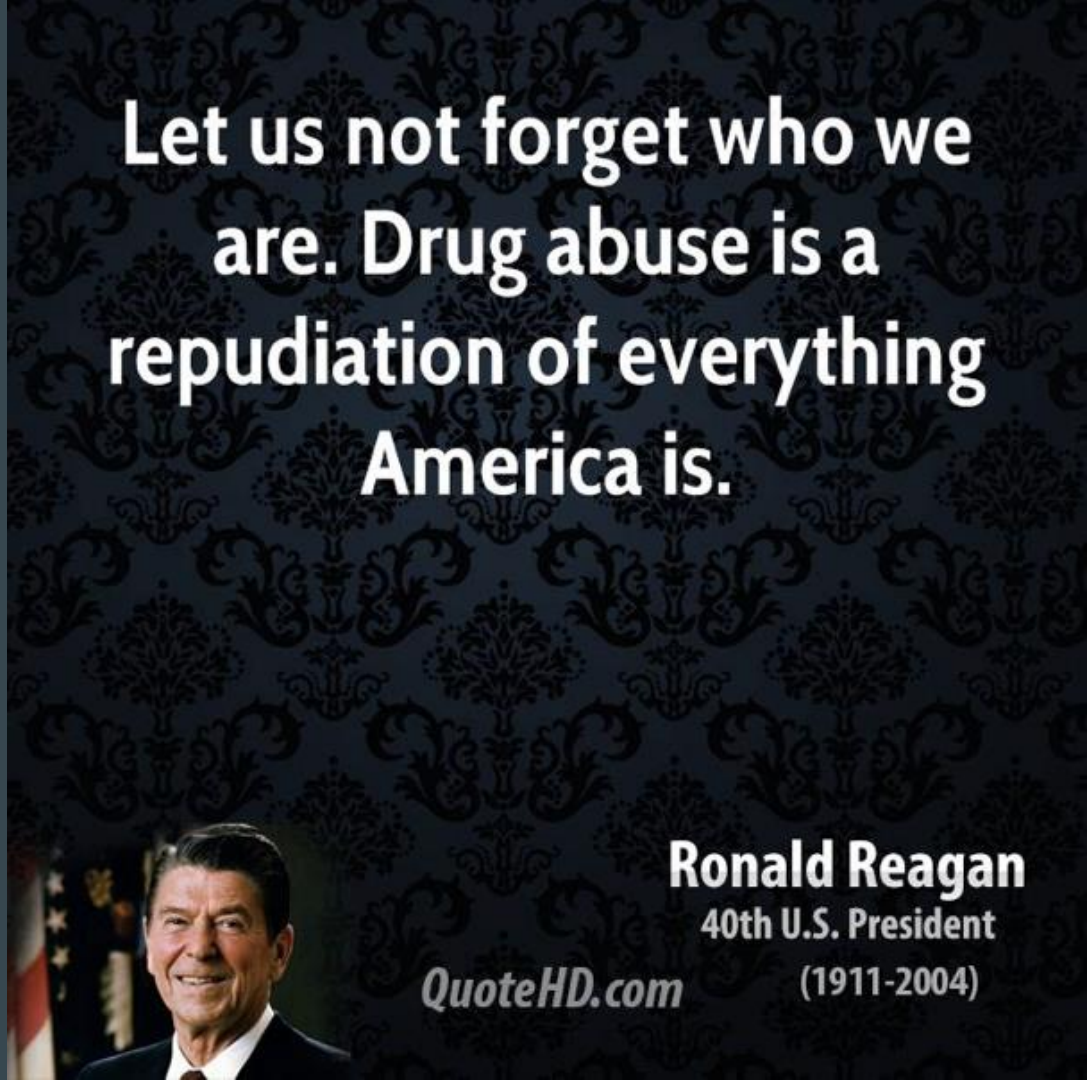
If labels and stereotypes makeup stigma, then what labels exist within the substance use and recovery landscape?

- “Addict”
- “Alcoholic”
- “Junkie”
- “Dope Fiend”
- “Substance Abuse”
- “Clean/Dirty”
- “Relapse”
- “Addiction”

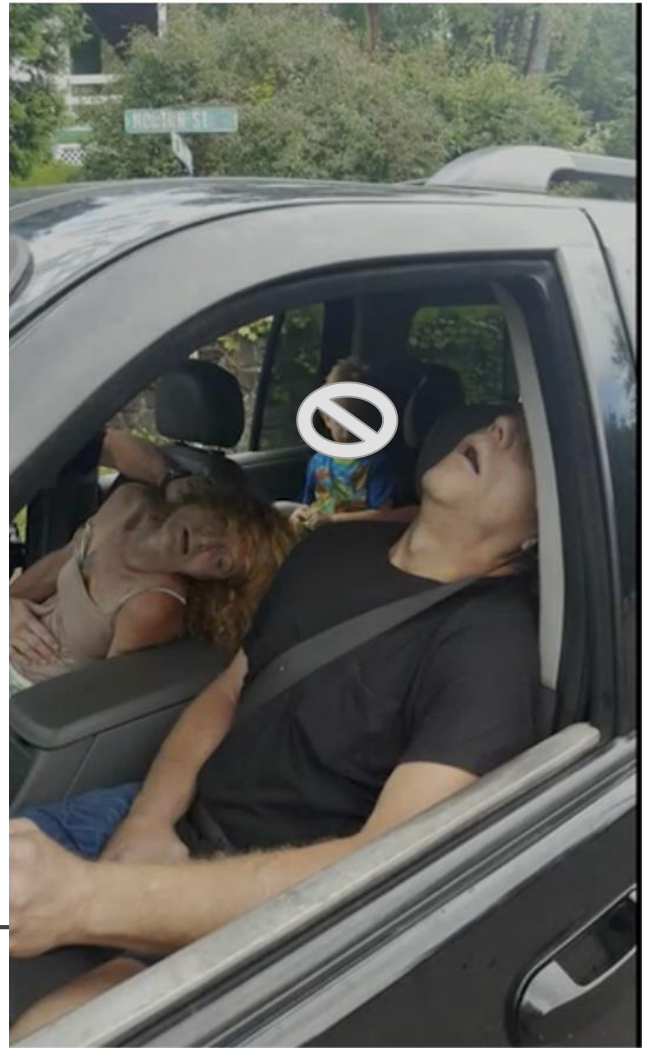
And, what types of stereotypes are tied to these labels?

- Years of campaigns - from the temperance movement of the 1800’s to the war on drugs of the 1980s
- “Addicts” are criminals, homeless, sinners, unworthy and lack self control
- “They choose this”
- “You can’t trust a junkie”
- What stereotypes have you placed on others, or had placed on you?

Stigma


Let us not forget who we are. Drug abuse is a repudiation of everything America is.
Ronald Reagan
40th U.S. President
(1911-2004)
QuoteHD.com

Discrimination



Stigma

COURT

Heroin addict jailed after handbag snatch at Dundalk shopping centre

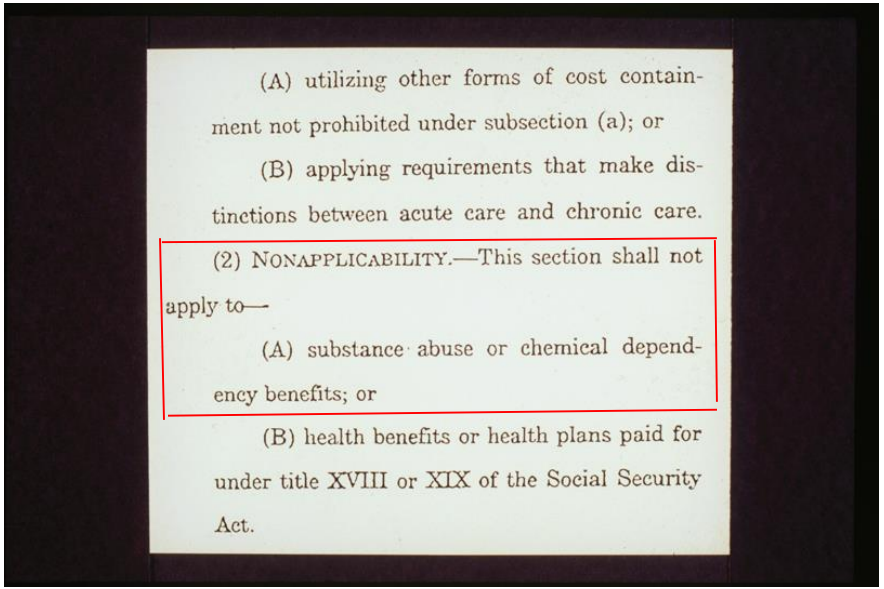
DUNDALK CIRCUIT COURT

by **Court Reporter** 27 May 2018
Email: editor@dundalkdemocrat.ie

Drug addict ‘pulled a knife’ in A&E unit

Posted: 8:11 pm May 23, 2018

Discrimination



(A) utilizing other forms of cost containment not prohibited under subsection (a); or

(B) applying requirements that make distinctions between acute care and chronic care.

(2) NONAPPLICABILITY.—This section shall not apply to—

(A) substance abuse or chemical dependency benefits; or

(B) health benefits or health plans paid for under title XVIII or XIX of the Social Security Act.

Stigma


Recovery Boot Camp
May 12 at 10:32am
A roomful of junkies sitting around shooting heroin. Every time someone dies, another junkie whips out the Narcan. Is this a thing?
"NARCAN PARTIES"
RECOVERYBOOTCAMP.COM
Are Narcan Parties a Thing? | Recovery Boot Camp
Narcan Parties aka Narc-Me Parties aka Lazarus Parties are all t...
1
1 Comment • 1 Share

Discrimination

Stigma

Addicted At Birth: The Babies Hooked On Heroin

Sky News
YouTube - Sep 7, 2015

Disturbing Video of Baby Born Addicted to Heroin

The Doctors
YouTube - Jan 25, 2016

Born Addicted: Treating Drug-Dependent Babies

Wall Street Journal
YouTube - Dec 28, 2012

The Tragedy of Opioid Addicted Babies - Behavioral Health Of The ...
https://www.bhpalmbeach.com/blog/tragedy-opioid-addicted-babies/
May 2, 2018 - Every 19 minutes, an opioid **addicted baby** is born in America. [1] Many of us are well aware of the repercussions of addiction in adults, but very ...

Discrimination

Eric Finkelstein I'm not an addict but have gotten opioids from my vet for my dog that had knee replacement. I have been told that addicts will harm their pets to get these meds. These are not just addicts these are scum of the earth that do this. These people don't need recovery they need to be taken out of society.

Like · Reply · 1d

Over the same stretch of time, Dr. Pollard has grown increasingly disillusioned with hospitals that consider addiction treatment beyond their purview, and haunted by the likelihood that many of his drug-addicted patients will die young whether they get heart surgery or not. He set up a task force in 2016 to address the problem but has faced obstacles, especially concerning cost and, he believes, a societal reluctance to spend money on people who abuse drugs.

"Everybody has sympathy for babies and children," he said. "No one wants to help the adult drug addict because the thought is they did this to themselves."

What does the research say?

Substance Abuse	• Abuse versus SUD invoked greater negative explicit bias in treatment professionals • (Kelly & Westerhoff, 2010; Ashford, Brown & Curtis, 2018)
Opioid Addict	• Opioid Addict versus OUD invoked greater negative explicit bias in the general population • (Goodyear et al., 2018; Ashford, Brown, & Curtis, 2018)
Alcoholic	• Alcoholic versus AUD invoked greater negative implicit bias in the general public • (Ashford, Brown, & Curtis, 2018)
Relapse	• Recurrence of Use versus Relapse invoked greater positive implicit bias in the general public • (Ashford, Brown & Curtis, 2018)

What does the research say?

Medication-Assisted Treatment (MAT)	• Pharmacotherapy versus MAT invoked greater positive implicit bias in the general public • (Ashford, Brown, & Curtis, 2018)
Medication-Assisted Recovery (MAR)	• Both MAR and Long-term recovery invoked greater positive implicit bias in the general public • (Ashford, Brown, & Curtis, 2018)
Addict	• Addict versus SUD invoked greater negative implicit bias in the general public • (Ashford, Brown & Curtis, 2018)

Emerging Research: Delphi Study To Expand Language

Digital delphi group study of individuals in recovery, family members and loved ones, and treatment professionals.

Most stigmatizing and most non-stigmatizing (positive) words for each group over 3 rounds of testing and scoring.

Table 3. Delphi Round 3. Rank scored phrases for all groups.

People in Recovery (N=15):

Negative Word/Phrase | (M) (SD)	Positive Word/Phrase | (M) (SD)
1. Crackhead | (1.833) (.408)	1. Person in long-term recovery | (1.333) (.516)
2. Junkie | (2.333) (1.366)	2. Person in recovery | (1.500) (.837)
3. Abuser | (2.833) (1.602)	3. Recovered / Recovering Person | (1.833) (1.169)
4. Addicts | (3.333) (1.366)	4. Person / People | (2.000) (2.000)
5. Felon | (3.117) (2.137)	5. Person with a substance use disorder | (3.167) (2.401)
6. Criminals | (3.333) (2.338)	6. Person with an alcohol use disorder | (3.333) (2.733)
7. Alcoholics | (4.500) (2.810)	7. Recurrence of Use | (3.500) (3.017)
8. Drunk | (4.50) (2.074)	8. Former Drug User | (4.333) (2.066)
9. Boozer | (4.500) (2.881)	9. Sober | (4.500) (3.271)
10. Sinners | (4.833) (4.070)	10. Drug User | Substance User | (6.667) (2.733)

Family Members (N=15):

Negative Word/Phrase | (M) (SD)	Positive Word/Phrase | (M) (SD)
1. Junkie | (1.000) (0.00)	1. Long Term Recovery | (2.286) (3.402)
2. Dope Fiend | (2.143) (1.676)	2. Substance Free | (3.571) (1.902)
3. Drug Abusers | (2.571) (1.718)	3. Person with a Substance Use Disorder | (3.714) (3.729)
4. Dirty / Clean | (3.143) (2.116)	4. Positive / Negative Urinalysis | (3.857) (2.035)
5. Addict | (3.286) (1.496)	5. Impacted Loved One | (3.857) (3.079)
6. Alcoholic | (4.000) (1.915)	6. Honest | (4.714) (3.817)
7. Drunk | (4.286) (2.812)	7. Period of abstinence | (5.000) (3.464)
8. Rock Bottom | (5.571) (3.867)	8. Drug Free Person | (5.429) (2.637)
9. Codependent / Enabler | (6.000) (3.742)	9. Sober | (6.571) (2.299)
10. Relapse | (7.000) (2.769)	10. Law Abiding Citizen | (8.714) (2.628)

Professionals (N=15):

Negative Word/Phrase | (M) (SD)	Positive Word/Phrase | (M) (SD)
1. Junkie | (1.083) (.269)	1. Person / Human Being | (2.417) (3.118)
2. Dope Fiend | (1.583) (.669)	2. Person in Recovery | (2.750) (3.194)
3. Addict | (3.916) (2.503)	3. Multiple Pathways of Recovery | (3.667) (2.902)
4. Criminal | (4.083) (2.109)	4. Free from addiction | (3.750) (2.633)
5. Pothead | Stoner | (4.583) (2.151)	5. Person with a Substance Use Disorder | (3.833) (1.946)
6. Drug Injector | (4.667) (2.640)	6. Recurrence of Symptoms | (4.333) (2.934)
7. Alcoholic | (5.083) (2.065)	7. Abstinence | (4.833) (2.406)
8. Substance Abuser | (5.167) (2.330)	8. Survivors | (5.083) (3.147)
9. Relapse | (6.667) (2.570)	9. Returning Citizen | (5.250) (2.006)
10. Recovering Addict / Alcoholic | (8.667) (1.970)	10. Person who uses drugs | (5.750) (2.701)

Negative Group: 1 = most stigmatizing, 10 = least | Positive Group: 1 = most positive (least stigmatizing), 10 = least

Emerging Research: Effects of Recovery Status and Profession

Secondary analysis of our full linguistics study (“addict” and “substance abuse” data only.

Subset to individuals in recovery and health professionals

Main effects of language remained across all experiments, with a main effect for health professionals (“substance abuse” only), as well as an interaction effect for those in recovery (“addict” + bad only)

Table 2. d-prime positive and negative association scores by label and group

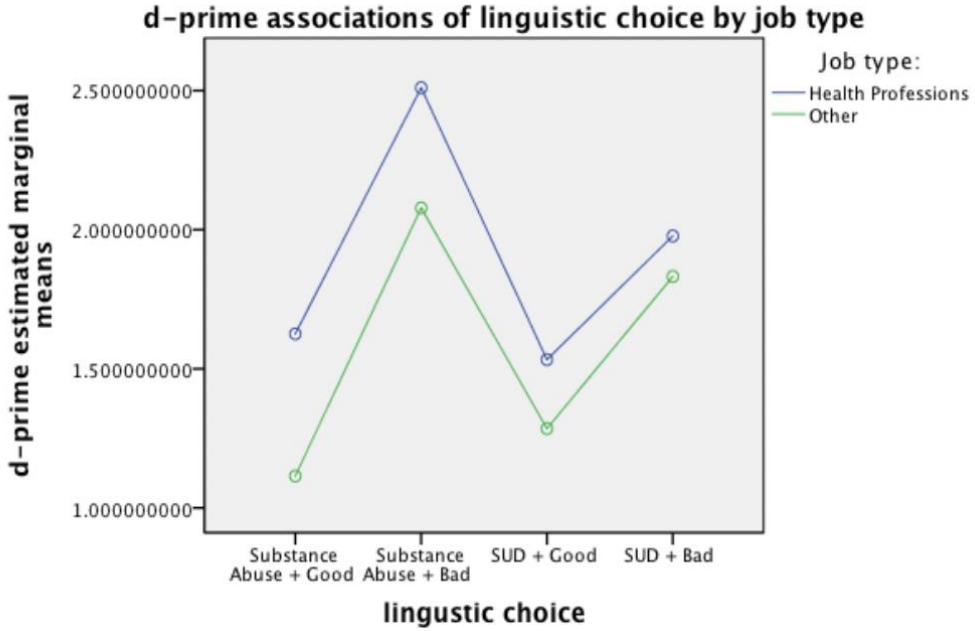
Group	Label	Positive Association MS (SD)	Negative Association MS (SD)
In Recovery			
Trial 1 (n = 51)	Substance Use Disorder	1.26 (0.95)	1.79 (1.19)
Trial 1	Substance Abuser	1.20 (0.92)	2.03 (1.13)
Trial 2 (n = 36)	Addict	1.34 (.85)	2.58 (1.45)
Trial 2	Substance Use Disorder	1.52 (1.01)	1.96 (0.66)
Not in Recovery			
Trial 1 (n = 102)	Substance Use Disorder	1.37 (1.00)	1.90 (1.03)
Trial 1	Substance Abuser	1.23 (0.94)	2.24 (1.21)
Trial 2 (n = 110)	Addict	1.66 (0.98)	2.33 (1.16)
Trial 2	Substance Use Disorder	1.61 (0.83)	2.10 (0.79)
Health Professional			
Trial 1 (n = 32)	Substance Use Disorder	1.53 (0.98)	1.98 (0.88)
Trial 1	Substance Abuser	1.63 (0.99)	2.51 (1.43)
Trial 2 (n = 31)	Addict	1.58 (0.73)	2.75 (1.46)
Trial 2	Substance Use Disorder	1.63 (0.74)	2.07 (0.65)
Other Professional			
Trial 1 (n = 121)	Substance Use Disorder	1.29 (0.98)	1.83 (1.13)
Trial 1	Substance Abuser	1.11 (0.89)	2.08 (1.09)
Trial 2 (n = 115)	Addict	1.56 (1.01)	2.30 (1.16)
Trial 2	Substance Use Disorder	1.57 (0.91)	2.06 (0.80)

MS = d-prime Mean Score, SD = d-prime Standard Deviation

Emerging Research: Effects of Recovery Status and Profession

Main effect for health professionals (“substance abuse” only)

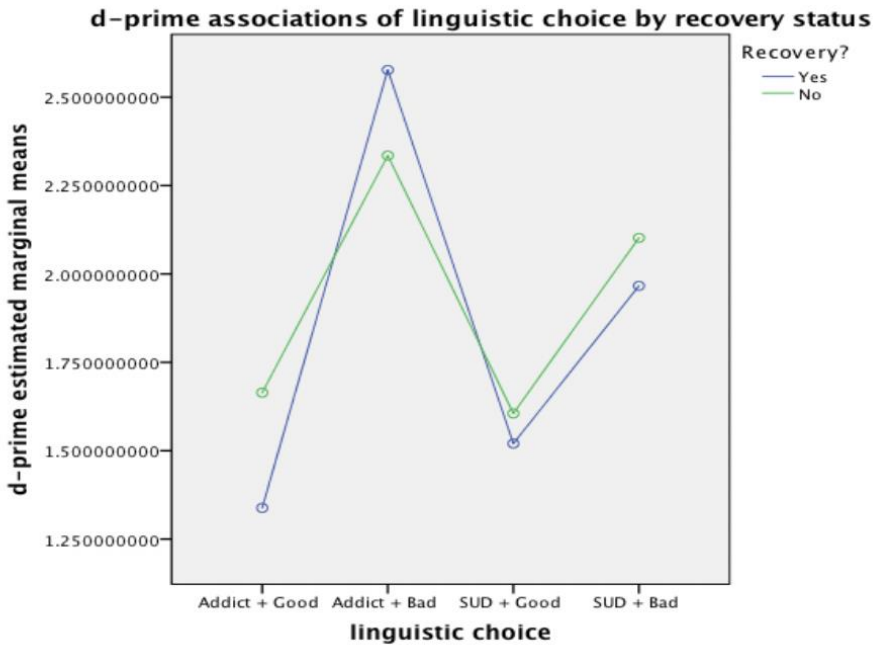
Figure 2. Effects of Employment Type and Linguistic Choice on Automatic Attitudes



Emerging Research: Effects of Recovery Status and Profession

Interaction effect for those in recovery (“addict” + bad only)

Figure 1. Effects of Recovery Status and Linguistic Choice on Automatic Associations



The labels we use result in external and internal bias...

- Stigma is a direct barrier to accessing SUD treatment among individuals who have a substance use concern
- Stigma also results in a lack of general public support for legislation that provides meaningful reform and fiscal support to prevention, treatment, and recovery
- It impacts the quality of healthcare delivery given by medical professionals
- And, most recently, in the midst of the opioid crisis, can result in death

However, it is never so simple

- In many recovery pathways, the use of negative labels serves a purpose
- The identity of being an “addict” and “alcoholic” may serve as a mechanism for change and empowerment
- It reminds people who they once were compared to who they are now...and for many, that is believed to be a necessity to remain vigilant in the recovery process

The right to self-label and identify

Yes...it exists and should be supported

- Preliminary research has found that people in recovery also have greater levels of implicit negative bias towards labels that are re-affirming in some recovery pathways
- However - within these settings, the potential harm from the continued use of stigmatizing labels may be minimized
- BUT - that doesn't mean using this type of language publicly, or in non-recovery settings, is helpful
- In fact, we know it is harmful for a variety of reasons

Emerging Research: Catharsis and Recovery Identity

We still don't know a great deal about how self-labeling affects those in recovery

Small sample pilot attempting to tease out when and where people using certain self-labels.

High degree of discernment amongst the sample. With people often using both stigmatizing and non-stigmatizing labels dependent on context (i.e., dynamic label discernment"

Table 5. Settings Where Labels are Used by Participants

	Addict[a] (n = 36)		SUD[a] (n = 21)		Addict Only (n = 19)		SUD Only (n = 4)		Both (n = 17)			
									Addict		SUD	
	N / (%)		N / (%)		N / (%)		N / (%)		N / (%)		N / (%)	
MA Meetings (12-step)	33	(94.3)	4	(19.0)	17	(94.4)	1	(25.0)	16	(94.1)	3	(17.6)
MA Meetings (Non12-step)	7	(20.0)	1	(4.8)	3	(16.7)	-	-	4	(23.5)	1	(5.9)
With Family	22	(62.9)	8	(38.1)	13	(72.2)	4	(100)	9	(52.9)	4	(23.5)
With Friends	27	(77.1)	9	(42.9)	14	(77.8)	3	(75.0)	13	(76.5)	6	(35.3)
With Co-workers	17	(48.6)	9	(42.9)	10	(55.6)	3	(75.0)	7	(41.2)	6	(35.3)
Speaking in Public	20	(57.1)	13	(61.9)	12	(66.7)	4	(100)	8	(47.1)	9	(52.9)
On Social Media	17	(48.6)	9	(42.9)	9	(50.0)	4	(100)	8	(47.1)	5	(29.4)

Note: percentage totals greater than 100% due to multiple selection options

[a] non-mutually exclusive

Recovery Dialects

The words we use matter.

Positive	Negative
Person who uses substances	Substance Abuser
Recurrence of Use	Relapse
Pharmacotherapy	Medication-Assisted Treatment
Accidental Drug Poisoning	Overdose
Person with a Substance Use Disorder	Addict
	Alcoholic
	Opioid Addict

While some negative language is okay to use in mutual aid meetings, its use should be avoided in public, when advocating and in journalism.

SOURCE: Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Substance use, recovery, and linguistics: The impact of word choice on explicit and implicit bias. Drug and Alcohol Dependence, 189, 131–138.

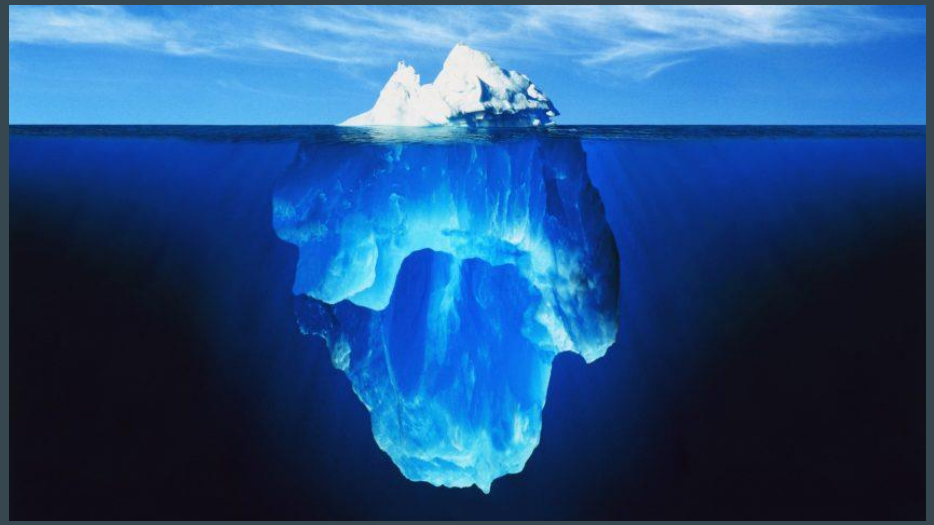
Recovery Dialects

	Mutual Aid Meetings	In Public	With Clients	Medical Settings	Journalists
Addict	✓	STOP	STOP	STOP	STOP
Alcoholic	✓	STOP	STOP	STOP	STOP
Substance Abuser	STOP	STOP	STOP	STOP	STOP
Opioid Addict	✓	STOP	STOP	STOP	STOP
Relapse	✓	STOP	STOP	STOP	STOP
Medication Assisted Treatment	STOP	STOP	STOP	STOP	STOP
Medication Assisted Recovery	✓	✓	✓	✓	✓
Person w/ a Substance Use Disorder	✓	✓	✓	✓	✓
Person w/ an Alcohol Use Disorder	✓	✓	✓	✓	✓
Person w/ an Opioid Use Disorder	✓	✓	✓	✓	✓
Long-term Recovery	✓	✓	✓	✓	✓
Pharmacotherapy	✓	✓	✓	✓	✓

Language matters but can change depending on the setting we are in. Choosing when and where to use certain language and labels can help reduce stigma and discrimination towards substance use and recovery.

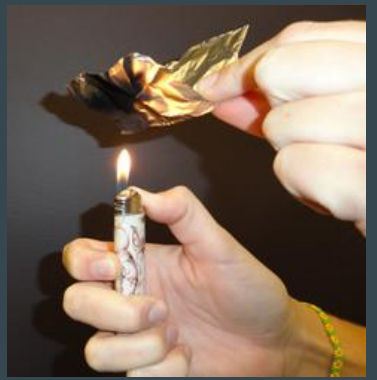
SOURCE: Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Substance use, recovery, and linguistics: The impact of word choice on explicit and implicit bias. Drug and Alcohol Dependence, 189, 131–138.

Language is just the tip of the iceberg



Imagery can have a similar impact

- Pictures and video that have negative content are used often by the media and law enforcement, and likely reinforce the negative stereotypes that are held about individuals in recovery and with a SUD
- Many times, this type of imagery is accompanied by language we also know to be stigmatizing



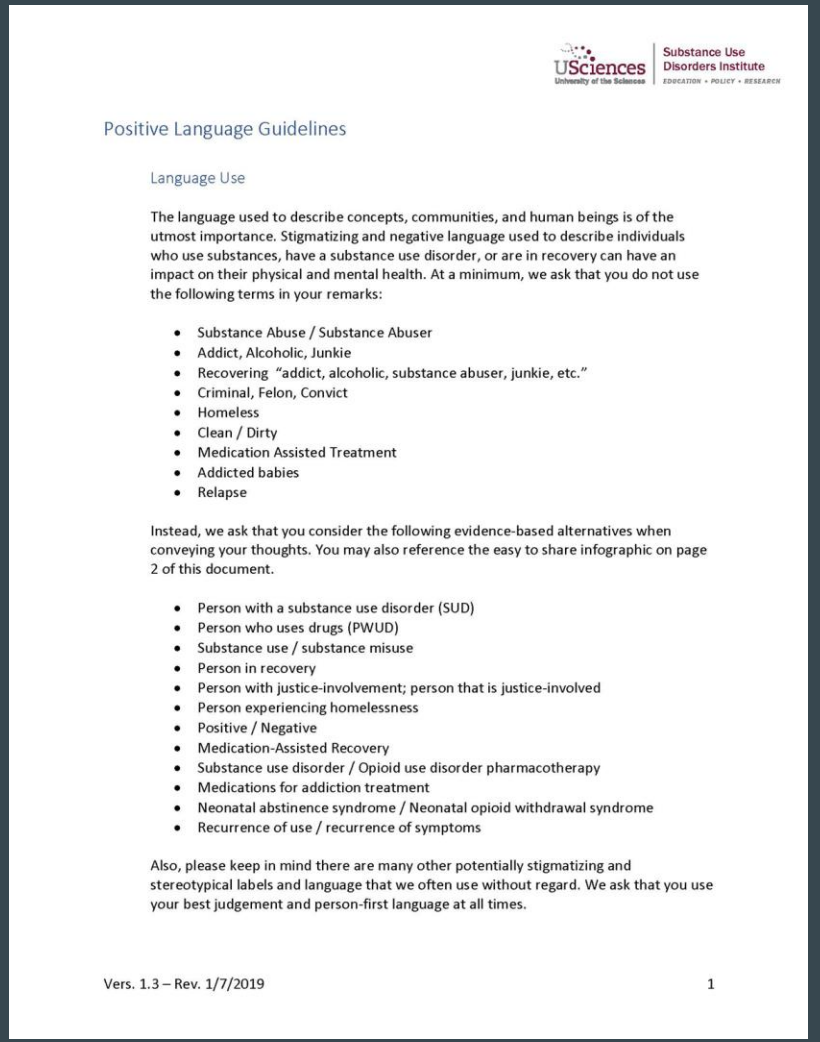
It starts with us...

- Changing the language of substance use and recovery begins with those it impacts
- This is those in recovery, actively using substances, family members, friends, scientists, media, and advocates
- Language changes constantly, and even in the SUD field, it has changed before due to public opinion and perception
- It starts with changing your own language, and gently telling others when their language is perpetuating stigma and discrimination

Say This	Not That
Person with a substance use disorder	Addict, Alcoholic, Substance Abuser
Person with an opioid use disorder	Addict, Substance Abuser
Person with an alcohol use disorder	Alcoholic, Substance Abuser
Recurrence of use	Relapse
Pharmacotherapy	Medication-Assisted Treatment
Person in recovery	Recover(ing/ed) addict, alcoholic, etc.

Media Guidelines

- The media plays a critical role in shaping the narrative of the country
- Adjustments may not always be possible (editorial prerogative), but should be encourage
- Begin with the following guidelines, employing them wherever possible
- Also consider using more humanistic imagery with your stories in print and live media



USciences University of the Sciences | Substance Use Disorders Institute EDUCATION • POLICY • RESEARCH

Positive Language Guidelines

Language Use

The language used to describe concepts, communities, and human beings is of the utmost importance. Stigmatizing and negative language used to describe individuals who use substances, have a substance use disorder, or are in recovery can have an impact on their physical and mental health. At a minimum, we ask that you do not use the following terms in your remarks:

- Substance Abuse / Substance Abuser
- Addict, Alcoholic, Junkie
- Recovering "addict, alcoholic, substance abuser, junkie, etc."
- Criminal, Felon, Convict
- Homeless
- Clean / Dirty
- Medication Assisted Treatment
- Addicted babies
- Relapse

Instead, we ask that you consider the following evidence-based alternatives when conveying your thoughts. You may also reference the easy to share infographic on page 2 of this document.

- Person with a substance use disorder (SUD)
- Person who uses drugs (PWUD)
- Substance use / substance misuse
- Person in recovery
- Person with justice-involvement; person that is justice-involved
- Person experiencing homelessness
- Positive / Negative
- Medication-Assisted Recovery
- Substance use disorder / Opioid use disorder pharmacotherapy
- Medications for addiction treatment
- Neonatal abstinence syndrome / Neonatal opioid withdrawal syndrome
- Recurrence of use / recurrence of symptoms

Also, please keep in mind there are many other potentially stigmatizing and stereotypical labels and language that we often use without regard. We ask that you use your best judgement and person-first language at all times.

Healthcare Professional Guidelines

- Healthcare professionals are often the first point of contact, and have the chance to be most impactful
- Rates of bias towards individuals with SUD may be higher among healthcare professionals, which can lead to detrimental interactions
- Identify where language can be changed and change it!

Where to modify language
• Interactions with patients • Interactions with loved ones • Interactions with other healthcare professionals • In the patients medical record • In marketing materials, internal memos, etc.

Thank You!

Robert Ashford, MSW

@rdashford

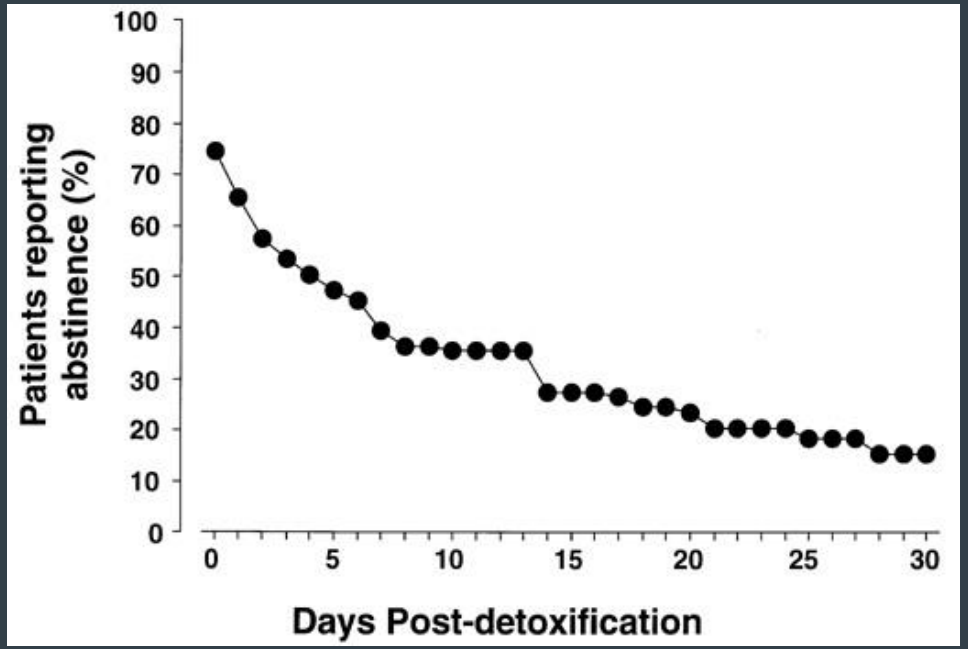
The Buprenorphine Team

and

Support Hospital Opioid Use Treatment (**SHOUT**) Texas

Rich Bottner, PA-C

Brief Medically Assisted Withdrawal (“detox”): **Ineffective**



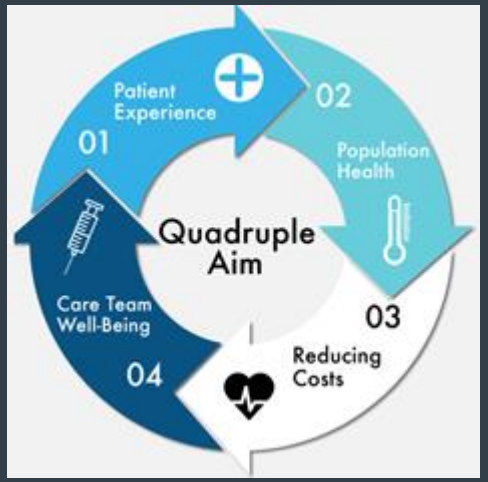
Chutuape, M et al. One-, three-, and six-month outcomes after brief inpatient opioid detoxification. The American Journal of Drug and Alcohol Abuse. Vol 27:1, 2001.

Why Opioid Agonist Therapy

- **Medical Benefits**
  - Reduces injection and illicit drug use
  - Increases completion of inpatient therapy
  - Reduces HIV, HCV, and bacterial transmission
  - Increases abstinence
  - Majority of patients will return to use at discharge if MAT not started
- **Psychosocial Benefits**
  - Promotes return to work and family obligations
  - Reduces criminal behavior
- **Systems benefits**
  - Readmission
  - Cost
- **Emergency Department**
  - Buprenorphine > traditional meds / SBIRT in the ED setting
  - Less likely to return to ED within 30 days
- **Obstetrics**
  - Reduce risk of preterm delivery, miscarriage, low birth weight
  - Neonatal abstinence syndrome
  - Buprenorphine recommended by ACOG

Hospitalization: An Opportunity

- Experiencing uncomfortable withdrawal and cravings
- Motivated for change
- Away from triggering environment
- Surrounded by supportive staff
- Start of ongoing medical treatment
- 25-30% of patients leave the hospital against medical advice:
  - Withdrawal
  - Fear of mistreatment
  - Cravings
  - Financial and social pressures



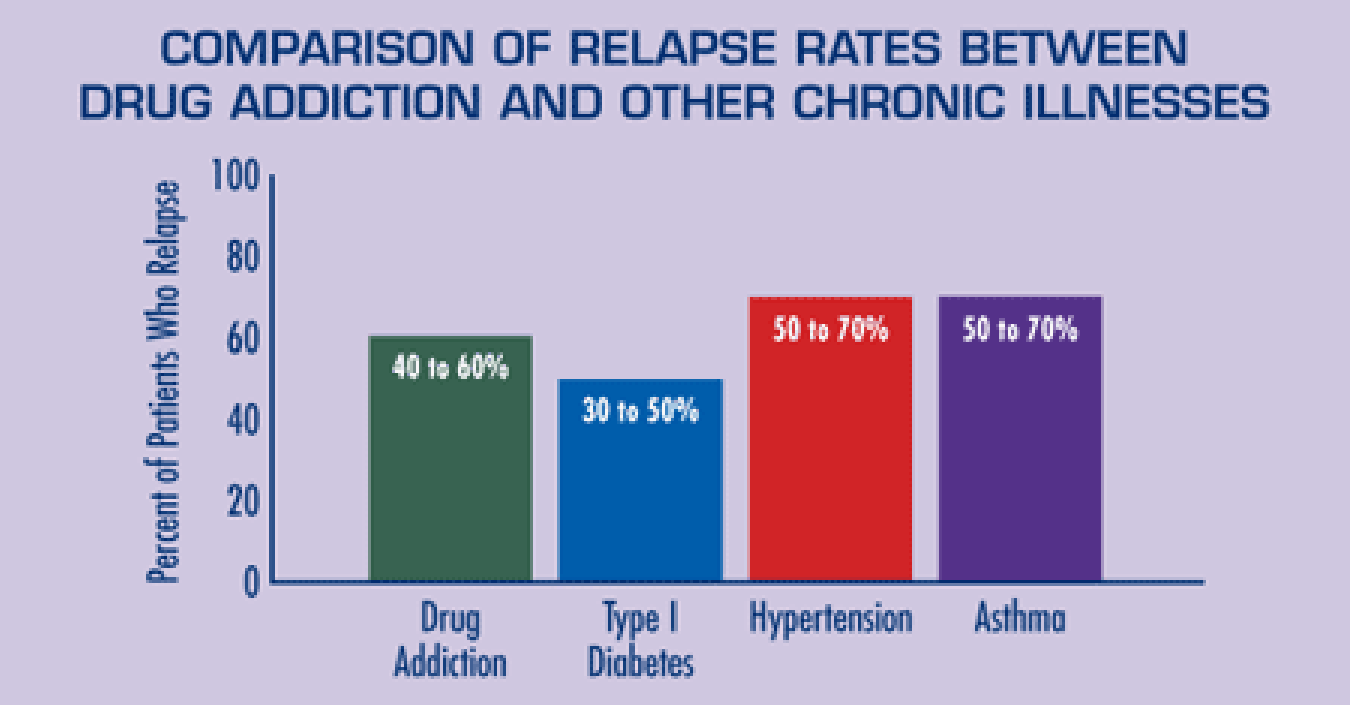
Predictors for 30-Day and 90-Day Hospital Readmission Among Patients With Opioid Use Disorder

Moreno, Jessica L., PharmD; Wakeman, Sarah E., MD; Duprey, Matthew S., PharmD; Roberts, Russell J., PharmD; Jacobson, Jared S.; Devlin, John W., PharmD

Journal of Addiction Medicine: January 8, 2019 - Volume Publish Ahead of Print - Issue - p

Conclusions: Among patients with OUD taking buprenorphine at the time of hospital admission, 30-day and 90-day hospital readmission was reduced by 53% and 43%, respectively.

Stigma Reduction and Relapse Rates



What is the Buprenorphine Team?

An interprofessional and multidisciplinary group that works to:

1. **Screen** appropriate patients for buprenorphine induction,
2. Assists in the **starting of this treatment** while patients are hospitalized,
3. Facilitates **linkage with an outpatient** MAT clinic, and
4. Provides institutional education in an effort to **reduce stigma** and raise awareness about opioid use disorders.


Dell Seton Medical Center at The Universit


Dell Seton Medical Center at The Universit
Evan Solice, Chaplain


Dell Seton Medical Center at The Universit
Ken Giorgi, Nurse

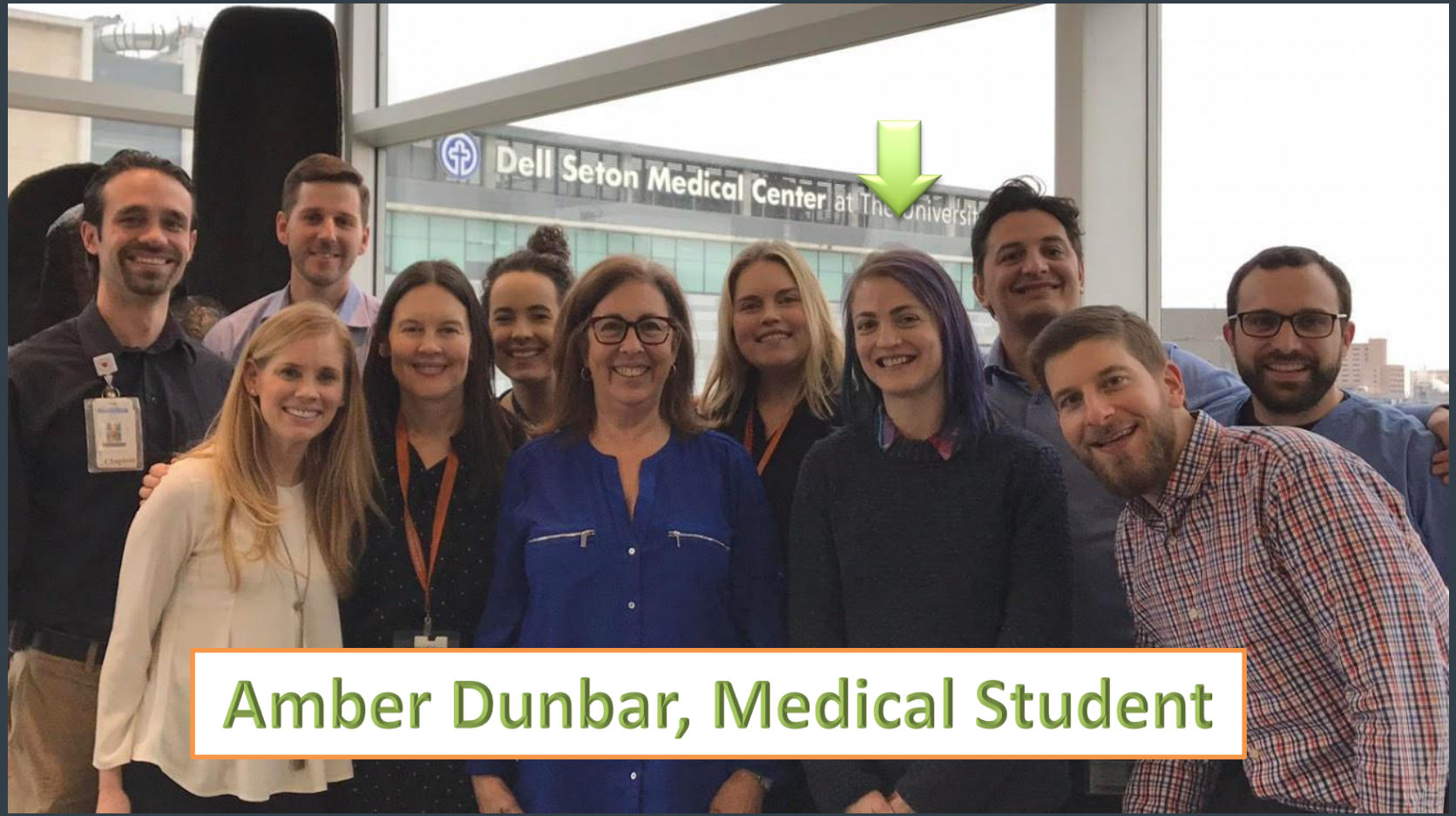

Dell Seton Medical Center at The Universit
Kirsten Roberts, Pharmacist


Dell Seton Medical Center at The Universit
Clarissa Johnston, Physician


Rachel Holliman, Social Worker


Elise Carper, Advanced Practice Nurse


Blair Walker, Psychiatrist



Amber Dunbar, Medical Student

Chris Moriates, Physician


Dell Seton Medical Center at The Universit
Rich Bottner, Physician Assistant

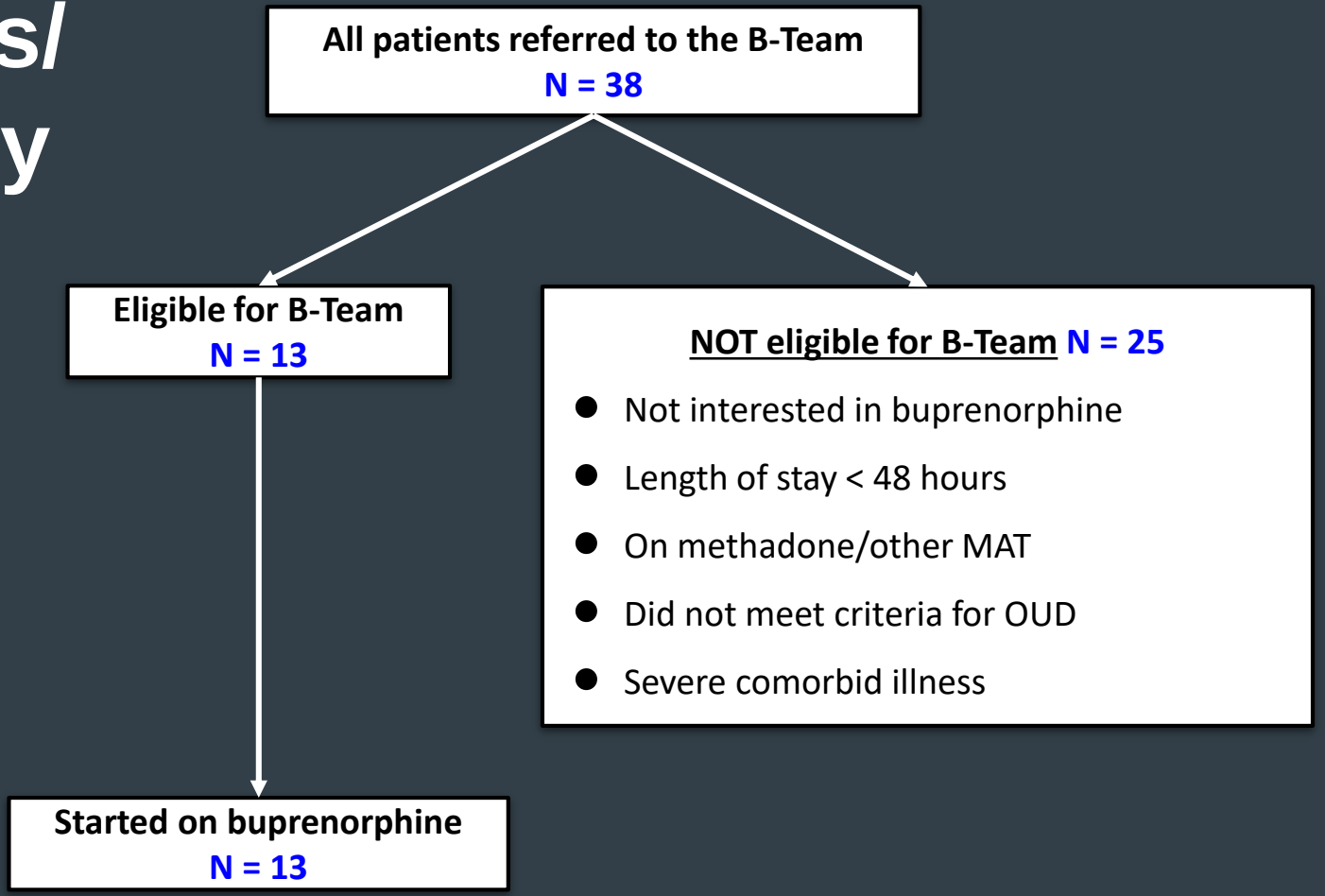

Dell Seton Medical Center at The Universit
Nick Christian, Resident

2018 RESULTS

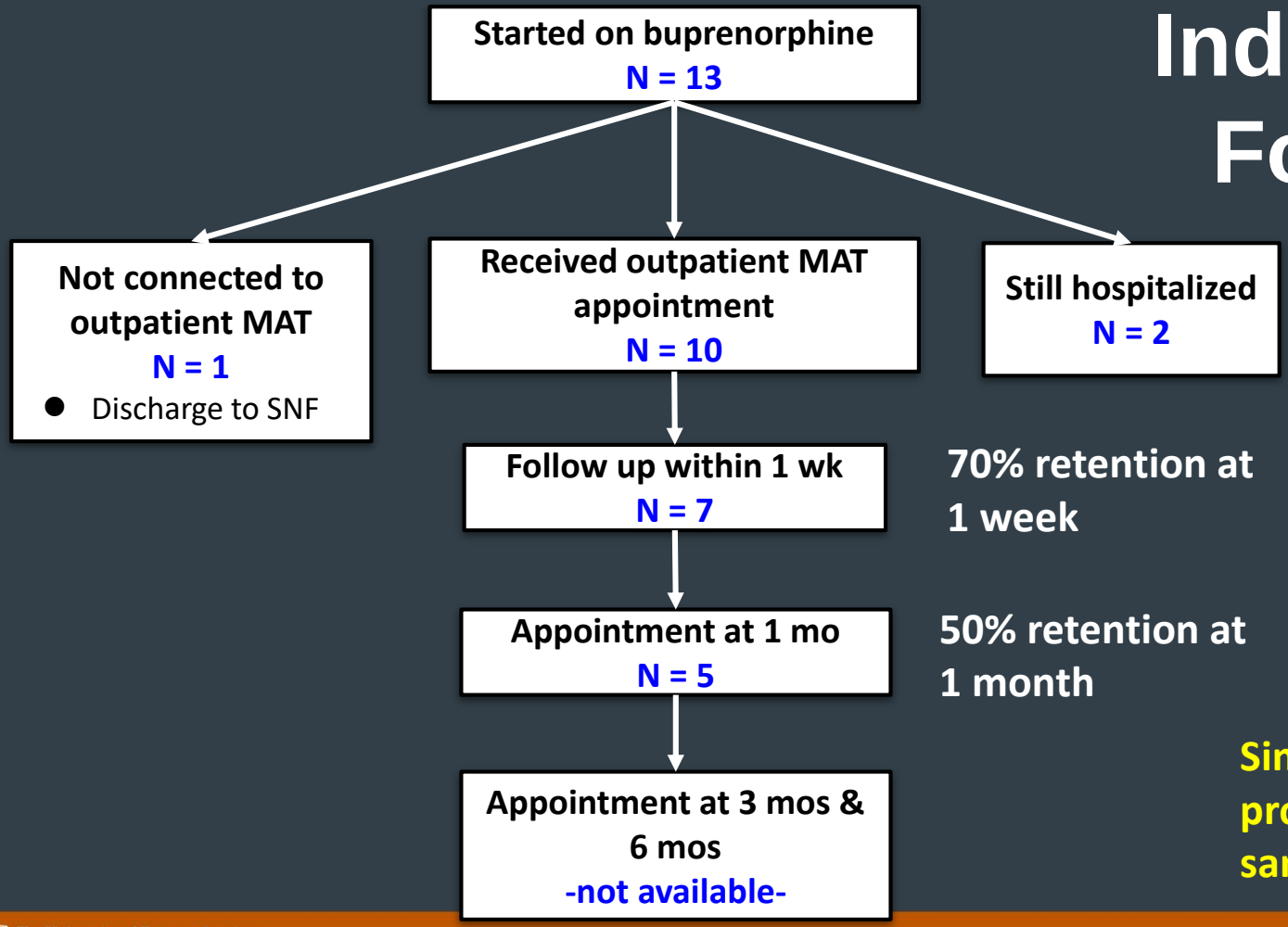
First 2.5 months of the B-Team

Referrals/ Eligibility

34% screening eligibility rate



Inductions/ Follow up



70% retention at 1 week

50% retention at 1 month

Similar to other programs without the same resources.

- 42 y/o AA male w/ PmHx of OUD, from east Austin.
- “Hustling” on the street since age 12 – selling marijuana → crack → jail → violence.
- Mom passed away at age 52 from ETOH and Hep C cirrhosis.
- Has over 10 nieces and nephews.
- Admitted for THIRD episode of endocarditis.
- Found to have used heroin from street during hospitalization.
- About to leave the hospital against medical advice…

ADM Brett P. Giroir @HHS_ASH · 2h

Honored and excited to provide Grand Rounds and engage faculty and staff at UT @DellMedSchool – an institution re-defining the role of academic medical centers in #PublicHealth!

1 3 10

ADM Brett P. Giroir Follow
@HHS_ASH

Until today, I would never want to be on the "B-team." But at UT @DellMedSchool the B-team is the Buprenorphine-Team, pioneering national best practices for treatment of #opioid addiction. Their work is innovative, bold, and life-saving.

7:36 AM - 15 Jan 2019

Statesman

Dell Medical School, Dell Seton care team forges innovative path toward opioid recovery

By Mary Huber
Posted Feb 25, 2019 at 3:09 PM
Updated Feb 25, 2019 at 10:21 PM

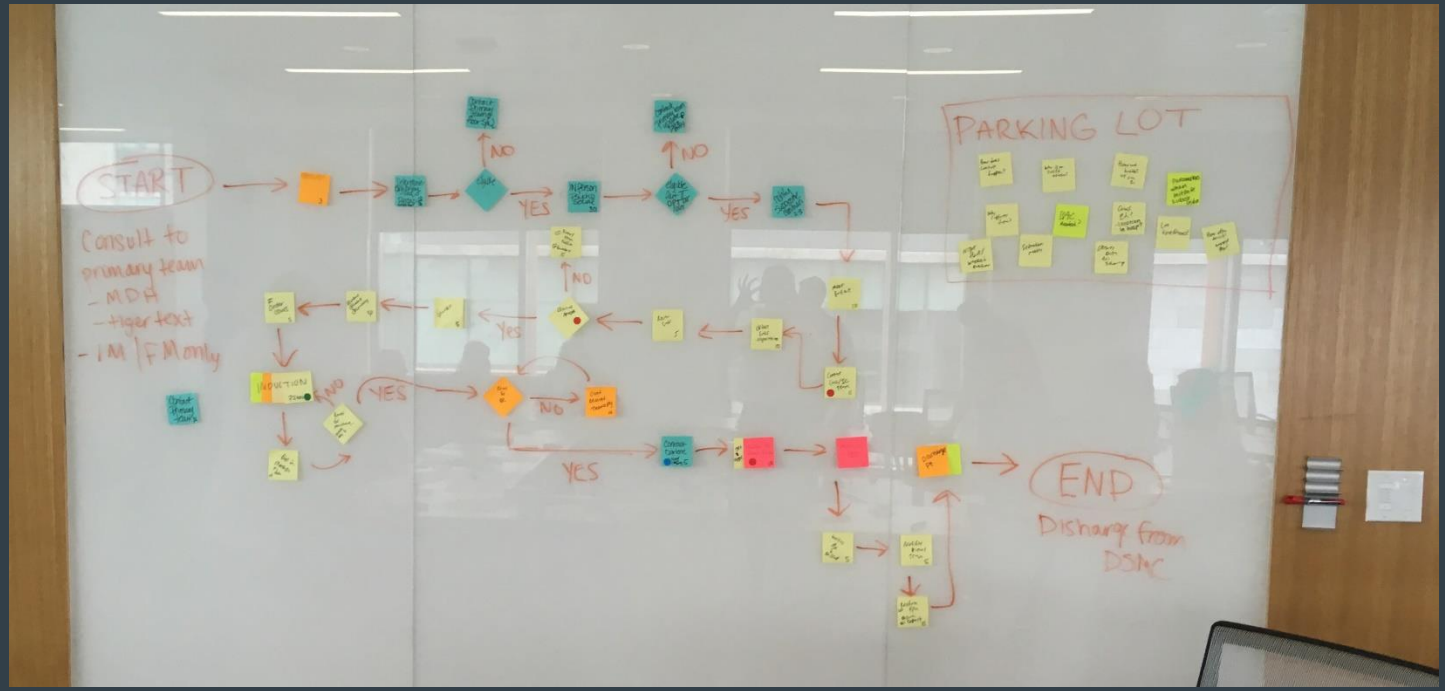
Stephanie McCurry, a 33-year-old Air Force veteran, had been using heroin steadily for about four years. She was the last person anyone expected to become addicted to the drug, she said.

Lessons Learned

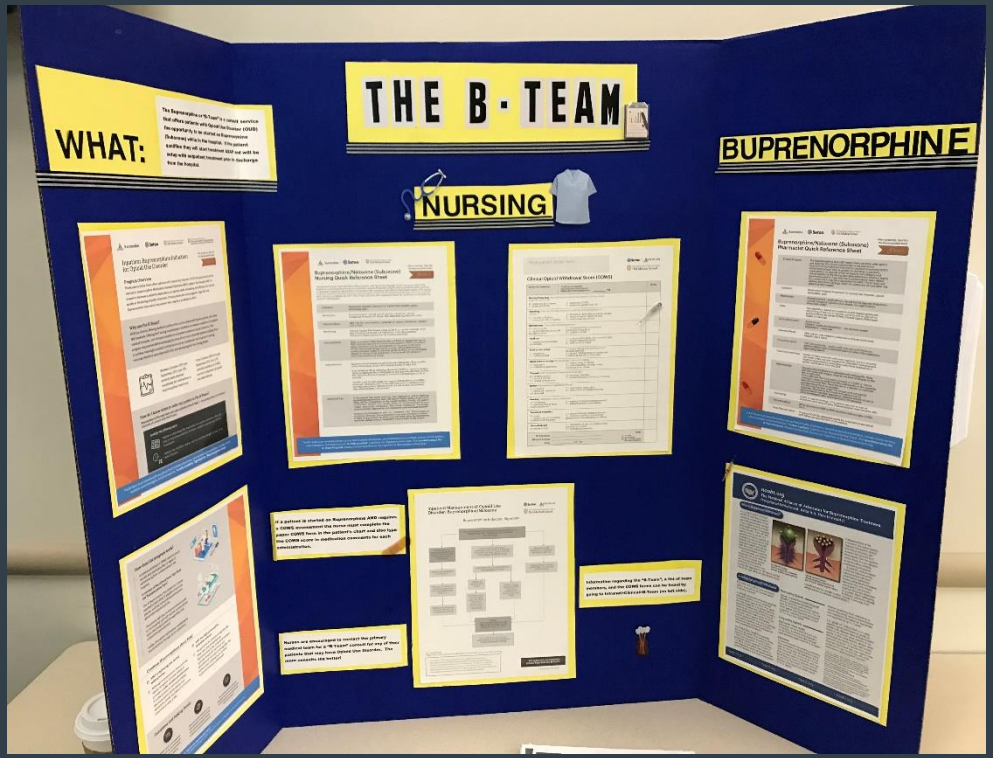
Growing Organically from the Bottom-Up

Executive Support

Process Mapping



Nurse Education



↓Stigma and ↑Buzz Through Stories

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Official Blog of SHM

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A New Light in the Darkness: Using Hospital-Based Medication-Assisted Treatment to Tackle the Opioid Crisis

By Guest Post | August 21, 2018 | 2

By:
Richard Bottner, PA-C
Hospitalist, Division of Hospital Medicine, Dell Seton Medical Center
Assistant Clinical Professor, Internal Medicine, Dell Medical School at The University of Texas at Austin

Alvin is a 42-year-old man who was never really given a chance. His parents both had severe alcohol use disorder. At age 12, his parents encouraged him to skip school to sell marijuana in order to fund their drinking. As his parents began using various illicit drugs,

Patient-Centered Language…

Showing Scientific Evidence…

Simultaneously…

Resident Lectures

Faculty Meetings

Graduate Medical Education Grand Rounds

Process Improvement Council

Medical Executive Committee

Creating conversation around opioid addiction.

Meaningful Interprofessional Collaboration

↓Stigma and ↑Buzz

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Are You Committing Malpractice By Not Treating Opioid Use Disorder in the Hospital?

By Chris Moriates | December 12, 2018 | 1

There are a limited number of things in hospital medicine that we do that decrease the risk of all-cause mortality by up to half. Usually these are the type of things that we don't even think about possibly missing. Does your hospital give people with STEMIs an aspirin? Even that has a number needed to treat of 42. Do you treat pneumonia with antibiotics? Good.

A study published earlier this year in *Annals of Internal Medicine* found that treatment with buprenorphine or methadone after a nonfatal overdose was associated with a **40-60% reduction in all-cause and opioid-related mortality. Yet only 3 in 10 of these**

Lessons Learned

- X-Waiver for hospital-based work
- 42 CFR Part 2 compliance
- “Just do it” – [sort of] PDSA cycles
- Stakeholder communication
- Nurse and prescriber empowerment

Lessons Learned

- Interprofessional and multidisciplinary
- Every member has their own role
- Clear pathways for communication
- Data collection best practices
- Perioperative management
- Time – this **is** the *new* **standard of care**

So, **now what?**

Sustainability, Growth, and Dissemination


Dell Seton Medical Center at The University of Texas
five2 media

Shout-out to SHOUT

https://www.ProjectShout.org/

What is SHOUT Texas?

- A center of excellence and thought leadership for the hospital-based treatment of Opioid Use Disorders
- Housed at Dell Medical School at the University of Texas at Austin
- Multidisciplinary
- Toolkits, webinars, evidence-based guidelines, grand rounds presentations, and coaching.

@RichBottner

Contact

Richard Bottner, PA-C

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- Director, Support Hospital Opioid Use Treatment (SHOUT) Texas at Dell Medical School
- Richard.Bottner@austin.utexas.edu
- (c) 201-390-9245

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Casa Mia: A Community Partnership Supporting Recovery for Women & Children

Lisa M. Cleveland PhD, RN, CPNP, IBCLC, FAAN

Associate Professor of Nursing, UT Health San Antonio

Joe Shaffer MPA

Crosspoint, Inc., San Antonio

UT Health San Antonio

Opioid Use Disorders (OUDs) in Women

- More likely to misuse prescription opioids due to psychological or emotional distress
- May become physically dependent more quickly than men
- May be more prone to cravings
- Highly correlated with co-occurring conditions such as depression & anxiety
- Low socioeconomic status, domestic violence and ***trauma***

Trauma

- **55-99% of substance using women have a lifetime history of trauma**
  - ❖ **Compared to 36-51% of the general population**
- **Traumatic events in childhood strongly correlated with SUDs in women**
- **Severity of childhood trauma is a significant predictor of SUD relapse in women**
- ***Trauma informed care***

Stigma

- Reluctance to seek help for a substance use disorder due to social stigma
- Fear of Child Protective Services involvement and losing custody of children
- Nearly 90% of pregnancies in this population are unintended
  - ❖ Access to affordable contraception without coercion

Written permission obtained for use of photos

Women as Caregivers

- Few women who are caregivers seek treatment
- Only 19 states offer funded treatment options for pregnant women
  - Only 12 give priority to pregnant women
- 70% of women entering treatment have dependent children
  - Only 3% of treatment facilities offer beds for women and children
- Women who stay with children during treatment, are more likely to complete treatment and enter long-term recovery

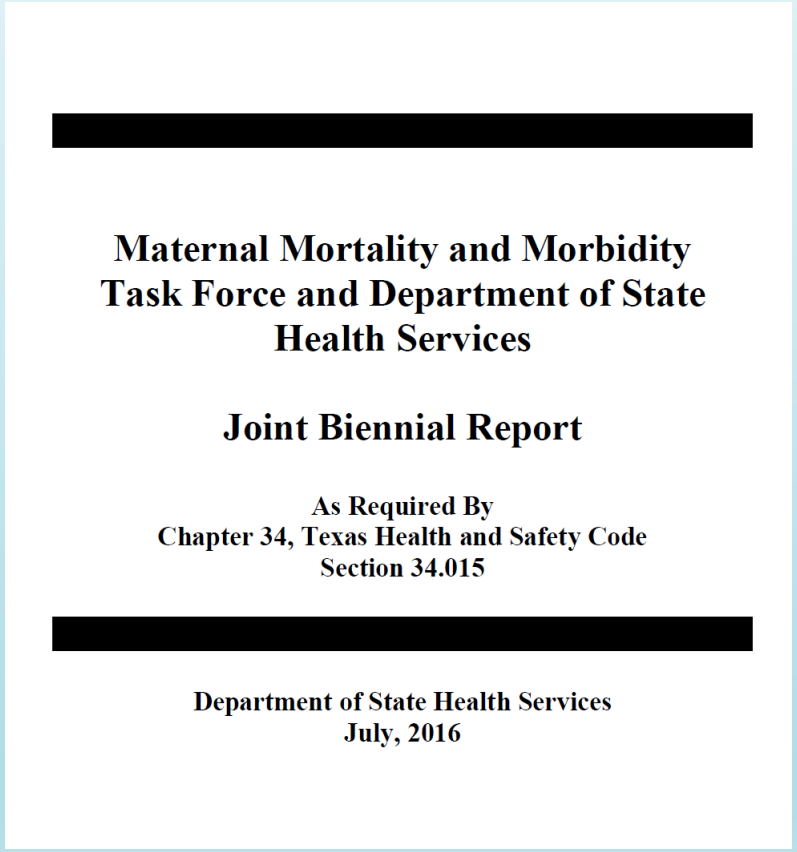
Overdose and Women

- **Accidental poisoning deaths (largely prescription opioids) increased 121% between 2005 and 2013 for white, non-Hispanic women aged 15-44**
  - **Compared to an 80% increase in men**
- ***As of 2016, in TX overdose is the leading cause of maternal mortality during the first year following birth***

Texas Maternal Mortality Task Force

- TX HHSC
- Many deaths occurred *after 42 days*
- CDC definition: A pregnancy-related death is defined as the death of a woman while pregnant or within 1 year of the end of a pregnancy –regardless of the outcome, duration or site of the pregnancy–from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html



Maternal Mortality and Morbidity Task Force and Department of State Health Services

Joint Biennial Report

As Required By
Chapter 34, Texas Health and Safety Code
Section 34.015

Department of State Health Services
July, 2016

Maternal Opioid Mortality Study (MOMS)

Cleveland PI

- **Purpose is to explore circumstances surrounding maternal opioid mortality**
  - **Final outcome-brief screening questionnaire to help identify women at risk**

Funded by the Texas Health & Human Services Commission

Preliminary Findings

- **Stressful Life Events Questionnaire**
- **Participants experienced high rates of exposure to multiple stressful and traumatic life events beginning early in life and extending into adulthood**
- **Of 13 individual stressful/traumatic event items, women indicated having experienced an average of 5.4 (SD = 2.91) stressful/traumatic events in their lifetime**
- **80% of women indicating 4 or more items**
  - ***Loss of a loved one to a violent death, and physical, sexual, emotional abuse***

Preliminary Themes

- **Losing the baby/losing hope**
  - *"Losing the baby [to CPS]…all bets are off. You don't want to feel that pain….and you feel empty. You don't want to feel the pain. The guilt is huge. Guilt, trauma and…like mourning."*
- **Need for support**
  - *"What would have made a difference is moral and physical support. First of all, anyone that has an addiction, a stress overload, that is our escape. It's a welcoming, loving environment because if I'm pregnant and my boyfriend is beating me, I'm going to go get high."*

Preliminary Themes

- **Trauma**
  - ***I was sexually abused when I was little. My cousin's boyfriend's Dad…he used to always feel on us and everything. We were like 5 and 6 years old. I still remember that."***
- **Mental health symptoms**

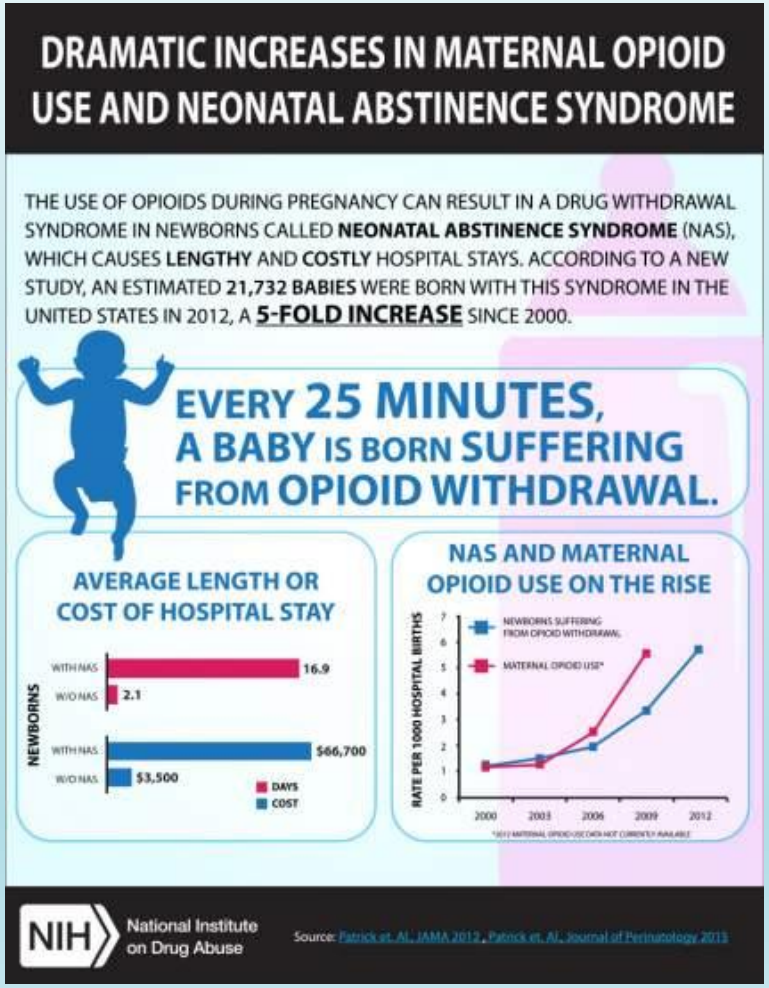
"I have anxiety. I've really had it for years, but I feel like it's getting worse. When I'm driving…I guess because my cousin died in a car crash…so now I'm like watch it or slow down. I just freak out - my anxiety is getting where I need medication to calm me down. I get real irritable with it because I know what it is."

Opioid Use in Pregnancy

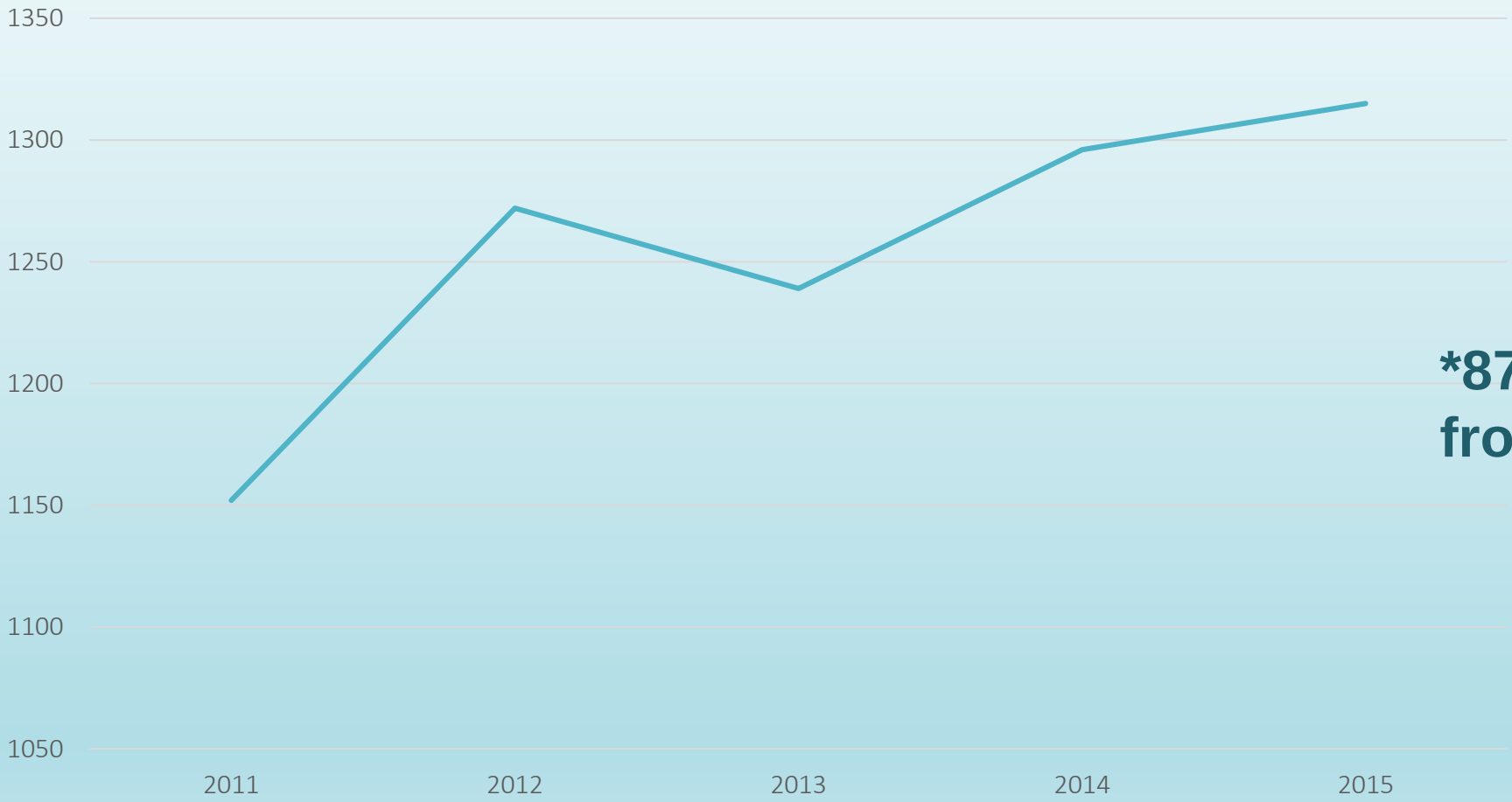
- **Between 2000 and 2009, national rates of opioid use in pregnancy increased fivefold**
- **Impact on pregnancy:**
  - **Prematurity**
  - **Low birth weight**
  - **Neonatal abstinence syndrome (NAS)**
    - ❖ **An *anticipated* and *manageable* condition of physical withdrawal**
    - ❖ **No reliable evidence of long-term effects**
    - ❖ **No clear relationship b/w amount or duration of prenatal opioid exposure and onset and severity of NAS**
    - ❖ **Likely genetic predictors**

NAS National Trends

- Parallel rising trends in prescription opioid misuse and incidences of NAS
- U.S. rates of NAS have increased fivefold between 2000 and 2012



Texas NAS Trends



***87% increase from 2009 -2015**

Texas Medicaid NAS by County

	2011	2012	2013	2014	2015
Bexar	32%	33%	30%	26%	29%
Dallas	9%	12%	14%	14%	13%
Tarrant	9%	10%	10%	9%	10%
Harris	12%	13%	9%	7%	6%
Nueces	5%	4%	5%	7%	5%

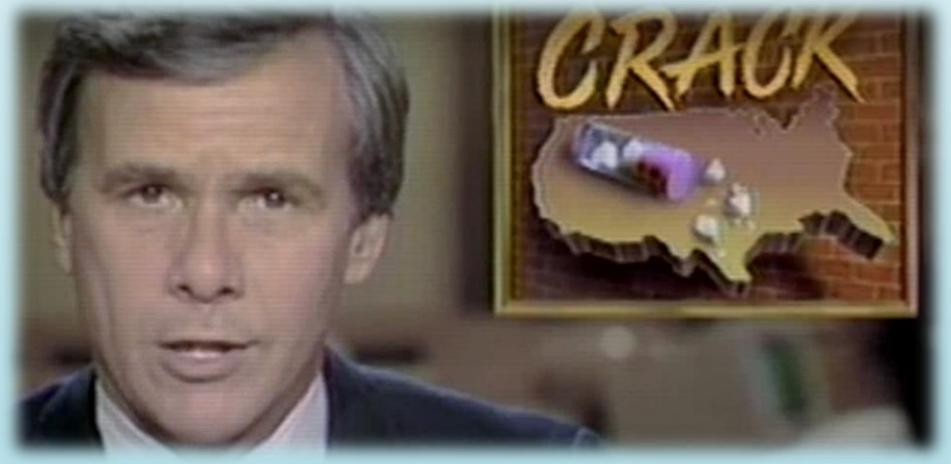
~300-400 babies born with NAS in Bexar County per year; 1/3 of cases in TX

Cost of NAS

- Nationally, cost of NAS has risen from $190M/year in 2000 to $1.5B in 2012
- Average hospital expenses are $53,400 when compared to $9,500 for all other births
- 81% of these costs are paid for by state Medicaid dollars
- Between 2009-2015, 102% increase (from $28M to $59M)in TX Medicaid spending during first year of life
  - ❖ Cost of care for NAS nearly 10x that of typical birth ($45,344 vs. $5,401)

A Cautionary Tale...

- 1980s response to “crack” cocaine should serve as cautionary
- U.S. government shifted drug control from public health to criminal system
- Media warned of “crack baby” epidemic
- “No convincing evidence that prenatal cocaine exposure is associated with developmentally toxic effects”



“The “Epidemic” that Wasn’t”

WHAT'S PUSHING MORE KIDS INTO FOSTER CARE?

THE NUMBER OF WEST VIRGINIA CHILDREN IN FOSTER CARE HAS GROWN BY 24 PERCENT BETWEEN 2012 AND 2016-OZY

“It used to be that 99 percent of the cases were neglect. Now 99 percent are substance-abuse-related.”

Management of OUD in Pregnancy

Management of OUD in Pregnancy

- **Opioid detoxification *is not* recommended during pregnancy**
- **Medication Assisted Treatment (MAT), opioid replacement therapy, using medications such as methadone or buprenorphine**
  - ❖ **The *only* truly evidence-based treatment for OUD**
- **Tapering of MAT dose is also not recommended**
  - **Associated with greater treatment failure**
  - **Higher risk of relapse and potential for overdose**
- **Women with OUDs stabilized on MAT have much better birth outcomes**

NAS Management

- 1st line of management
  - ❖ Non-pharm soothing techniques
- 2nd line of management
  - ❖ Medication: morphine, methadone, etc.
  - ❖ *Significantly increases length of stay and separation from mom*
- Need to consider different treatment modalities
- ❖Is the NICU really the best place for these babies?

Written permission obtained for use of photo

NAS Research

- **Kangaroo Mother Care Study (KMC)**
  - ***An exploration of the impact of this soothing technique on NAS symptoms and maternal attachment behaviors***
- **Maternal Infant Interaction and Physiological Attunement (MISSA)**
  - ***Longitudinal follow-up study to explore mother-infant dyad behavior and ability to respond to and recover from stressful events***
  - ***Biological markers of behavioral organization***

Funded by the Texas Health & Human Services Commission

The Bexar County NAS Collaborative (BCNC)

PI: Cleveland; Co-I: Puga

- To improve the well-being of families impacted by NAS through education, research, practice, social equity, and community engagement
  - Focus on outcomes that matter to families
  - Partnership between researchers, clinicians, community stakeholders and families

Funded by the Patient Centered Outcomes Research Institute (PCORI)

Our Partners

UT Health San Antonio, School of Nursing

Department of Family Protective Services

TX Health & Human Services Commission

TX Department of State Health Services

Crosspoint
The Doctors for Social Responsibility
New Season

San Antonio Council on Alcohol and Drug Awareness
UT Health San Antonio, School of Medicine

Metro Health

University Health System

Baptist Health System

Methodist Health System

South West General

MedMark Treatment Centers

Our parent/family partners: Yolanda, Vaeh & Andrew 3rd, Candace & McKayla; Aaron, Emily, Mia & Aaron Jr.; Donna & Moses; Sophia & Leland; Misty

The Joint Opioid Taskforce
Children's Hospital of San Antonio
Alpha Home

The Center for Health Care Services

San Antonio Fire Department
San Antonio Police Department
The Office of Judge Nelson Wolff

The Office of Representative Ina Minjarez

The Office of Councilwoman Shirley Gonzales

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Keepingfamiliestogether.org

Casa Mia: Recovery Residence for Women & Children

PI: Cleveland

- Partnership between UT Health, SON and Crosspoint, Inc.
  - Social model of recovery
- Provide a safe, sober, living environment for women and children (20)

Funded by the TX Heath & Human Services and the Baptist Foundation

Casa Mia: Recovery Residence for Women & Children

PI: Cleveland

- **Women are accessing intensive, outpatient, treatment**
  - **Mommies Program**
  - **Or other treatment programs**
  - **All paths to recovery including MAT**
- **Crosspoint provides recovery expertise**
- **The SON is offering primary care, women's health, and nutrition services**
  - **Undergrad. population health students provide education**

Casa Mia: Recovery Residence for Women & Children

PI: Cleveland

- Focus on education completion, gainful employment, and long-term housing (housing first!)
- Funding from TX HHSC, the Baptist Foundation, the Sisters of the Holy Spirit