SUD Technical Assistance Webinar Series

VIRGINIA MEDICAID: 14—
STIGMA IN SUD TREATMENT
& HARM REDUCTION
PAUL BRASLER, LCSW, CAIP
DECEMBER 7, 2021

Department of Medical Assistance Services
Welcome & Meeting Information

• WebEx participants are muted
  ▪ Please use Q&A feature for questions
  ▪ Please use chat feature for technical issues

• Focus of today’s presentation is practice-based – please Contact SUD@dmas.virginia.gov with technical or billing questions

• We are unable to offer CEUs for this webinar series
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Naloxone Resources

- Get trained now on naloxone distribution
  - REVIVE! Online training provided by DBHDS every Wednesday
  - [https://getnaloxonenow.org/](https://getnaloxonenow.org/)
    - Register and enter your zip code to access free online training
- Medicaid provides naloxone to members at no cost and without prior authorization!
- Call your pharmacy before you go to pick it up!
- Getting naloxone via mail
  - Contact the Chris Atwood Foundation
  - [https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422](https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422)
  - Available only to Virginia residents, intramuscular administration
SUPPORT ACT GRANT WEBSITE - HTTPS://WWW.DMAS.VIRGINIA.GOV/#/ARTSSUPPORT
The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.

We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.

The link for transcription can be found on the Webinar schedule and will be sent in the chat.
Fall 2021 Webinars

- Contingency Management: 12 - 14, 10 - 11 AM & 12 - 16, 1 - 2 PM
Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.
Language

• We want to use “Person-Centered language”
  • Not “Addict,” but Person who uses drugs or Person with a substance use/behavioral disorder
  • Not “Addiction,” but Substance Use Disorder (SUD)
  • Not “Abuse,” but Use
  • Not “Clean,” but In Recovery or Testing Negative
  • Not “Dirty,” but Testing Positive
  • Not “Relapse,” but Return to Use

• At the same time, out of habit, I may inadvertently use some of these older words/terminology—and some of the sources I quote use older terms

• Be cognizant that some people may describe themselves as “alcoholics,” “junkies,” etc., or may refer to “clean time” as how long they have been in recovery (and we need to respect this)
Two Important Things You Must Do Before Working With Any Client

I. You must care! You must like people in general regardless of their circumstances, behaviors or opinions of you

II. Find something to like in the person you are working with—connect with them on a human level
What Got You Here?
NO ONE sets out to become addicted to chemicals or behaviors.
### Myths & Stereotypes

<table>
<thead>
<tr>
<th>Myth</th>
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<tbody>
<tr>
<td>Drug exposure alone causes SUD</td>
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<tr>
<td>Drug treatment does not work</td>
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<tr>
<td>We are winning the “War on drugs”</td>
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<td>Addiction is completely a choice</td>
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<tr>
<td>Addiction is totally due to genes</td>
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<td>A person can love someone enough to change them</td>
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<tr>
<td>Most people with SUD are homeless and/or unemployed</td>
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<td>A person will only stop using drugs when they “hit bottom”</td>
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Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Adopted by the ASAM Board of Directors September 15, 2019
Addiction/SUD Defined: The 3 P’s
(Filbey, 2019, P. 1)

**Pervasive:** SUD affects all aspects of a person’s life

**Persistent:** SUD effects persevere despite efforts by the individual

**Pathological:** SUD effects are uncontrollable
“Addiction is a multi-determined phenomenon with layers within layers of mutual influences, internal and external, all interacting concurrently, leading to a pathological outcome. It is no more true [sic] to say that addiction is simply a brain disease, or a flawed personal choice, or an experience of learning than it is to say that falling in love is nothing but biochemistry.”

( Italics in original )

(Morgan, 2019, p. 4)
Recovery Defined

“...A lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings. Recovery is a process rather than an end state, with the goal of being in an ongoing quest for a better life.”

(Best & Laudet, 2010 as cited in Morgan, 2019, p. 191)
Alternate Definition of Recovery

“Any positive change!” (Szalavitz, 2021)
“Stigma is a social phenomena whereby individuals who deviate from the accepted norm are perceived by society as less desirable and are judged or punished accordingly” (Avery & Avery, 2019, p. 94)
Why Is This Important?

Remember what we started with: People matter, regardless of what they are going through.

Stigma is one of the main reasons that people with SUD do not seek treatment.
Model of Addiction Dictates the Approach to Addiction

Moral Model (Avery & Avery, 2019, p. 96)

- Addiction is a moral failing
- Hold people accountable for immoral behavior
- Criminal Justice System
Biopsychosocial Model  (Avery & Avery, 2019, p. 96)

- Addiction is a disease influenced by multiple interrelated determinants
- Prevent, treat, relapse supports
- Health Care System
Ways Stigma Manifests (Avery & Avery, 2019)

• Self-Stigma
• Family Stigma
• Language
• Stigma in the Medical Community
• Stigma in SUD Treatment
• Stigma & Race
• Stigma in the Legal System
• Stigma in the Workplace
• Stigma in the Media
Shame: Negative association with a stigmatized group

“It greatly depends on the sources of shame as to whether its possession may become a force for recovery or a factor that prolongs addiction” (Avery & Avery, 2019, p. 21)

“Consider now one example of a specific effect of looping and self-stigma: Addictive consumption in response to shame, where the shame of use turns out to be cyclical and self-perpetuating - individuals with SUDs consume in order to wipe out the shame they are feeling, and in the process they perpetuate the very condition from which they are attempting to free themselves” (Avery & Avery, 2019, p. 11)
“Estimates are that for every person with a substance use problem, at least one family member and as many as five other individuals are negatively impacted” (Avery & Avery, 2019, p. 36)

“When compared with families who have a loved one with a mental illness like schizophrenia, family members of an individual with SUD are more often deemed responsible for the disorder” (Avery & Avery, p. 37)

Given the choice between the stigma associated with SUD and SUD treatment, many families choose isolation...
The Language of Stigma

“The term abuse has been used for shameful and willful commissions since the fourteenth century, with its roots in the word *abusion* meaning a ‘wicked act or practice, a shameful thing, a violation of decency.’ Abuse or abuser is also not a term we use for any other medical condition”

(Avery & Avery, 2019, p. 73)
Factors that worsen clinician’s attitudes toward individuals with SUD (Avery & Avery, 2019, p. 86)

- Clinical experiences primarily with individuals with severe SUD
- Lack of exposure to individuals in recovery
- Lack of time and resources
- Poor role models and mentorship
- Perception of SUD as a moral failing
Strategies to improve clinicians’ attitudes toward individuals with SUDs (Avery & Avery, p. 89)

• Increase awareness of negative attitudes
• Provide forums to discuss common attitudes
• Continue to increase and improve addiction treatment options
• Intervene at all levels of professional development
“The fact that any person with a medical license can prescribe addictive opioids to treat pain but those who wish to treat people addicted to those opioids with proven medication therapies require extensive government scrutiny is the clearest sign that stigma is deeply entrenched in how addiction treatment is delivered in the United States” (Avery & Avery, 2019, p. 120)
• In addition to racial inequalities in terms of economics and institutional barriers, there are differences in the types of treatment available

  • “Buprenorphine patients who were enrolled in primary care differed demographically and clinically from those enrolled in OTPs [Methadone clinics]. Compared with the patients in the substance abuse OTP, primary care patients [OBOT, or buprenorphine] were more likely to be white, employed, stably housed, to hold at least a bachelor’s degree, and to be new to addiction treatment” (Avery & Avery, 2019, p. 139)

  • “Medicalization of addiction and the increased accessibility of treatment for OUD offered by OBOTs were predicted to decrease stigmatization, but access to this treatment is not evenly distributed or experienced the same way across race, ethnicity, and social class” (Avery & Avery, p. 145)
What Can We Do About Stigma?

<table>
<thead>
<tr>
<th>Educate</th>
<th>Educate yourself: Stay up to date on the latest information</th>
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<tbody>
<tr>
<td>Educate</td>
<td>Educate others: Speak to community and political leaders</td>
</tr>
<tr>
<td>Listen</td>
<td>Listen to the experts: Our clients</td>
</tr>
<tr>
<td>Point out</td>
<td>Point out misinformation whenever you can to correct other people’s biases</td>
</tr>
<tr>
<td>Take Care</td>
<td>Take care of ourselves as clinicians and people</td>
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Brasler, DMAS
Harm Reduction

- Does not view abstinence as the only measure of success
- “Success” means any reduction in substance-related harm
- The goal is to meet clients “where they are” and minimize the harmful effects of substance use
  - Abstinence can be viewed as an ideal end goal, but there is flexibility either getting to this point or simply reducing the harm
- Includes a variety of strategies that can be effective for many clients
- Not appropriate for clients who are highly motivated for abstinence; let the client decide their direction
Harm Reduction Successes

- Limiting the transmission of Hepatitis C & B, HIV/other STIs (condom distribution; needle exchange programs; supervised injection sites)
- Reducing the number of people dying from drug misuse (Naloxone distribution)
- Limiting violence and/or crime (medication-assisted therapy)
- Decreasing the amount or type of substance(s) used
- Minimizing contact with associates who use
- Decreasing the impact of comorbid psychiatric/mental health problems (treating a mental illness that could be linked to the substance use disorder)


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