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STIGMA KILLS

Addressing Opioid Use Disorder by Changing Culture

RICHARD BOTTNER, DHA, PA-C
Affiliate Faculty, Internal Medicine | Director, Support Hospital Opioid Use Treatment (SHOUT) Texas
Dell Medical School at The University of Texas at Austin
Twitter: @RichBottner

DISCLOSURES

No commercial interests to disclose relating to the educational content of this webinar.

But, I'm from New Jersey and am very passionate about this content. I will try not to speak too quickly.

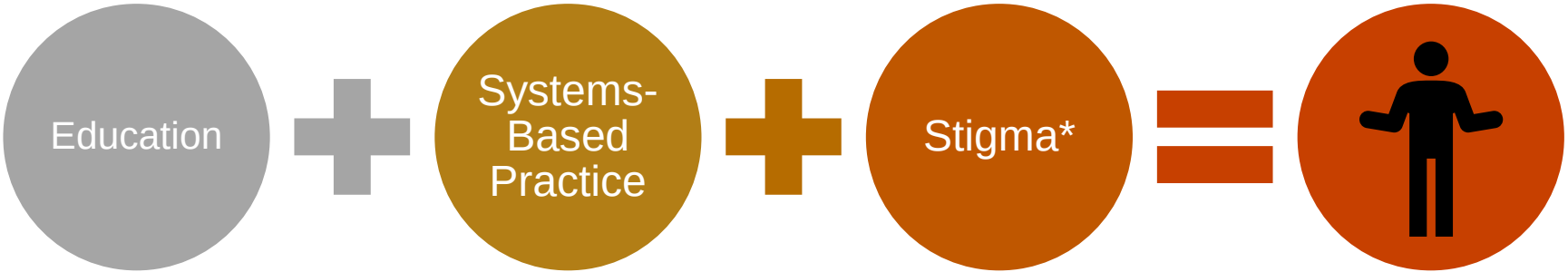
WHY AM I SPEAKING TODAY?

Our Journey: A Brief Story

OBJECTIVES:

- Define stigma and its different forms
- Describe the impact of stigma on care delivery
- Identify opportunities to offer hospital-based Opioid Use Disorder (OUD) treatment

WHY ISN'T HOSPITAL-BASED TREATMENT THE STANDARD OF CARE?



DEFINITION OF STIGMA

Originates from Greek “stizein”

A mark burned onto the skin of slaves to signify their low place in the social hierarchy in ancient times.[1]

“An attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one.”[2]

“A social construct whereby a distinguished mark of social disgrace is attached to others in order to identify and to devalue them. Thus, stigma and the process of stigmatization consist of two fundamental elements: the recognition of the differentiating ‘mark’ and the subsequent devaluation of the person.”[3]

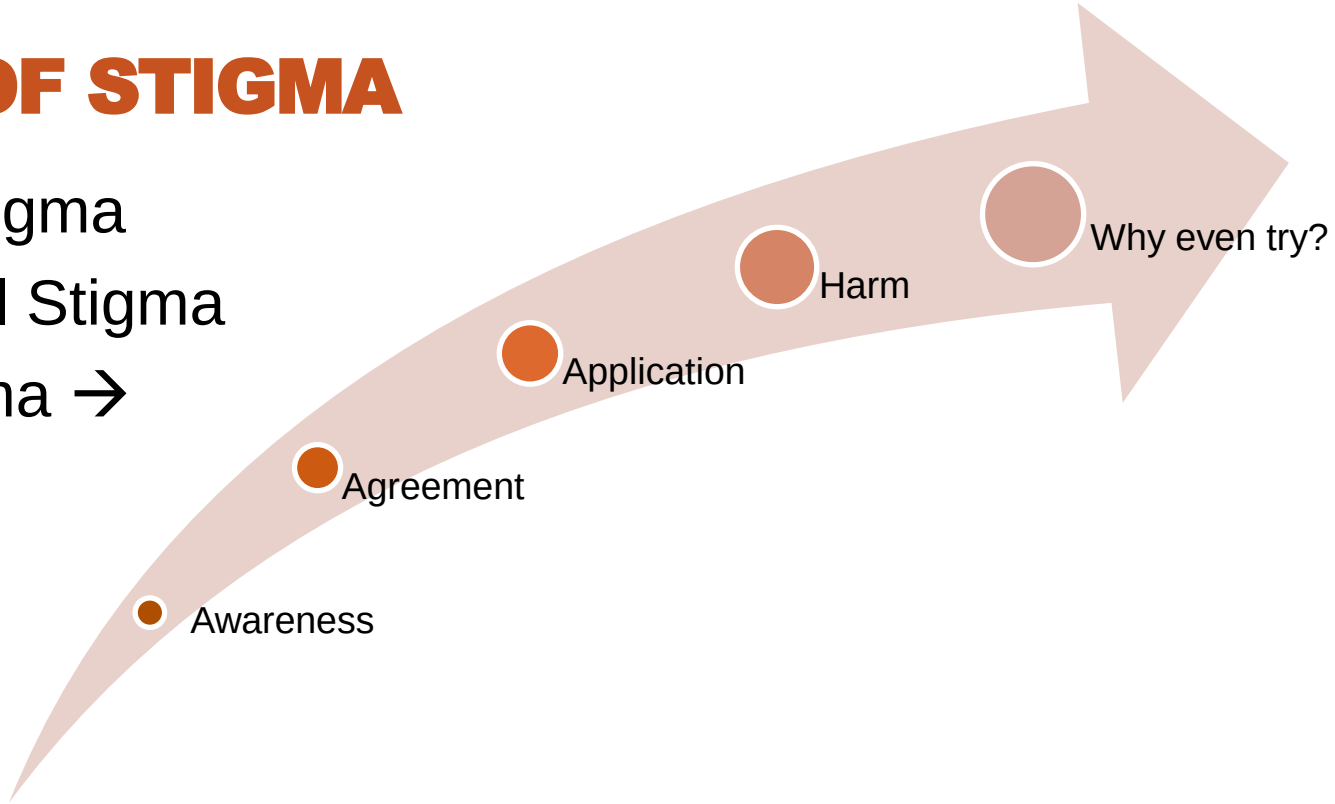
1. *Link & Phelan, 2001*
2. *Goffman, 1963, p. 11*
3. *Jacobsson & Arboleda-Flórez, 2002, p.25*

WHAT EXACTLY IS STIGMA?

Corrigan & Nieweglowski, 2018

TYPES OF STIGMA

- Social Stigma
- Structural Stigma
- Self stigma →



Corrigan & Rao, 2012; Akdağ et al., 2018; Can & Tanrıverdi, 2015

STIGMA IS COMPLICATED

Describing Stigma:
What stigma looks and feels like

- Negative attitudes, judgements, and stereotypes
- Problematic labels and language use
- Negative client-provider interactions
- Shame and the internalization of addiction
- Punitive and exclusionary policies and practices

Impacts of Stigma:
How stigma gets in the way

- Affects how we conceptualize, frame, and prioritize the current crisis
- Leads to hiding and creates barriers to help seeking
- Contributes to ongoing system mistrust and avoidance of services, particularly among marginalized populations
- Results in poorer quality care and response

Sources of Stigma:
Tension points and contributing factors

- Punitive views about addiction, treatment, and recovery
- Illegality of illicit opioids and other drugs
- Viewing people with opioid use problems through a paradigm of worthiness and deservingness
- Trauma, compassion fatigue, and burnout

Tackling Stigma:
Promising approaches

- Education on addiction, treatment, and recovery
- Interventions focused on building client-provider trust
- Social contact as a key stigma reduction tool
- Training in trauma informed practice and care
- Inward-facing training to build resilience and mitigate burnout
- Address system gaps and barriers

MHC Canada, 2019

HOW DO PATIENTS REFER TO THEMSELVES?

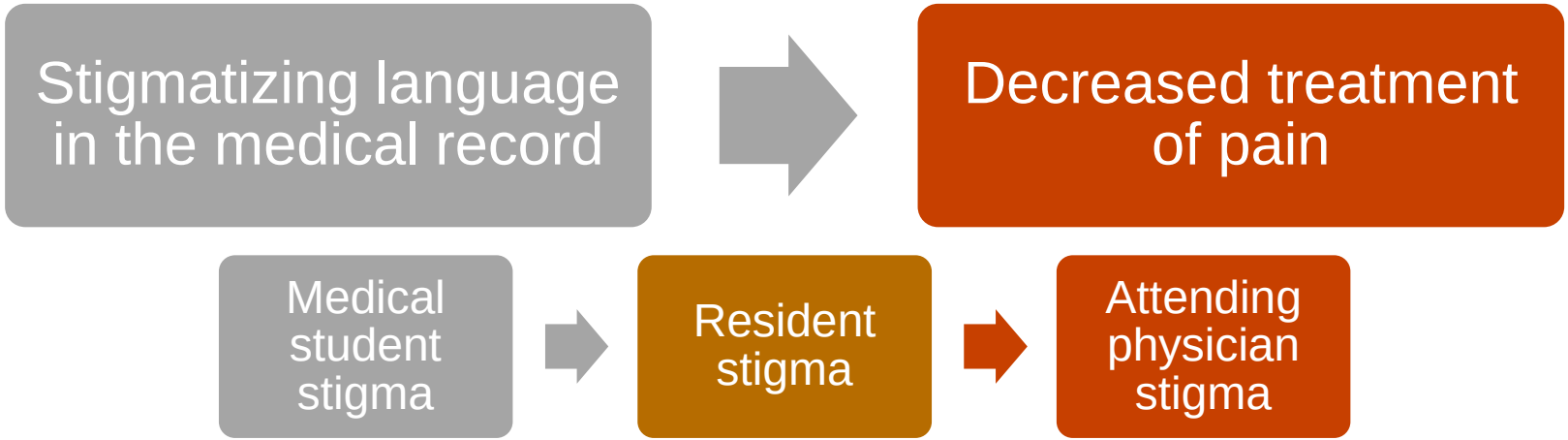
- 250+ patients evaluated at a Massachusetts substance use clinic

Preferred Terms	Negative Terms
Person who uses drugs	Abuse
Person with a heroin addiction	Abuser
Person with a heroin dependence	

Pivovarova & Stein, 2019; Ashford, Brown, & Curtis, 2019

HOW DOES STIGMA MANIFEST IN CLINICAL PRACTICE?

Health professionals have a negative attitude towards patients with SUDs.



Goddu et al., 2018; Goddu, Anna et al., 2018; van Boekel et al., 2013

HOW DOES STIGMA MANIFEST IN CLINICAL PRACTICE?

- Discontinuation of life-saving treatment to receive liver transplant.
- Denial of valve repair surgery in endocarditis.
- Shame, prolonged hospitalization, and potential justice-system involvement for pregnant patients.

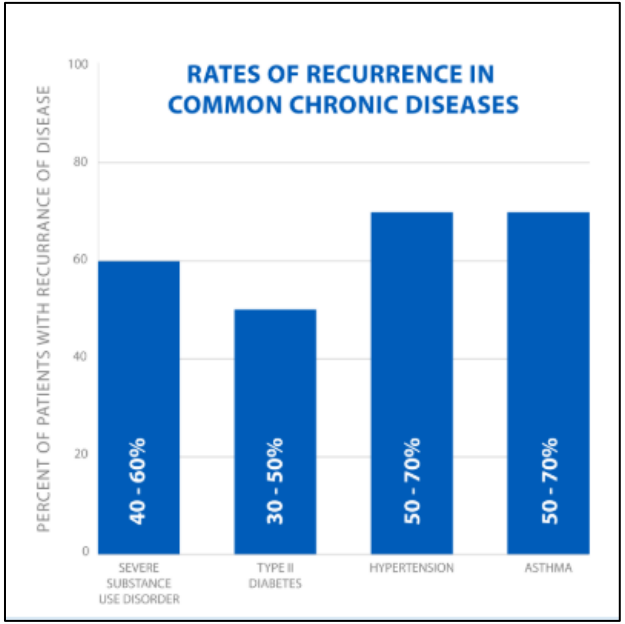
Wakeman et al., 2018; Aultman et al., 2018; Howard, 2015

HOW DOES STIGMA MANIFEST IN CLINICAL PRACTICE?

Substance use disorders are treated as a moral failing.

In reality:

- SUDs are driven by genetic and environmental factors
- Rates of recurrence very similar to other chronic diseases



NIDA, 2005

DEFINITION OF ADDICTION

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.

-American Society of Addiction Medicine, 2019

HOW DOES THE GENERAL PUBLIC THINK ABOUT SUDs?

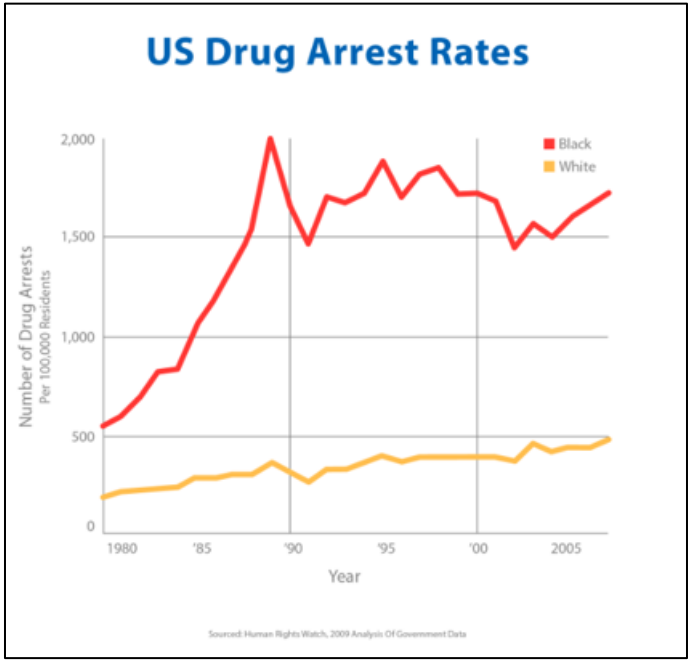
- SUDs are seen as being intimately linked to HIV, hep C, and DUI.
- In a survey of 1,000 adults, 75% felt patients with OUD were, themselves, to blame.

Nieweglowski et al., 2019; Kennedy-Hendricks et al., 2017; Furr-Holden et al., 2016

DRUG POLICY

1970s “War on Drugs”

- Cocaine then, heroin now.
- Responsible for large disparities among individuals of racial minority groups.
- Today, White patients are **35 times more likely** to receive treatment for OUD compared to Black patients. →



Santoro & Santoro, 2018; Lagisetty et al., 2019

HOW DO HOSPITALS COME INTO PLAY?

Hospitals are **CRITICAL** access points.

and…

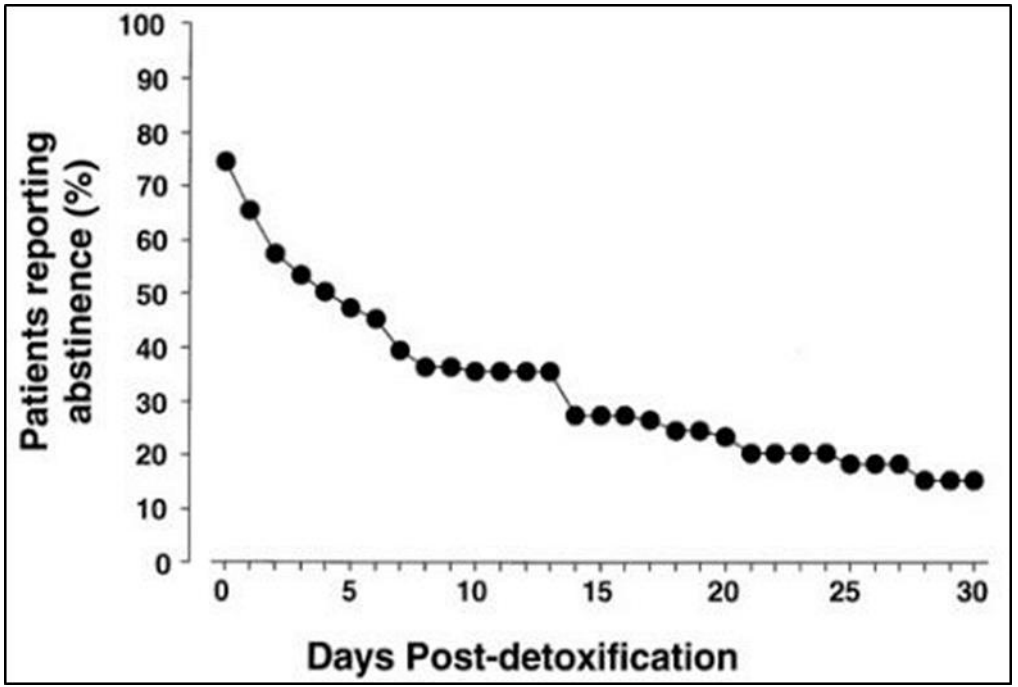
OUD screening, management, treatment, and harm reduction must be better addressed in hospitals.

(True of all SUDs.)

Furr-Holden et al., 2016

WHAT WE DO AT MOST HOSPITALS TODAY:

- “Treat” withdrawal
- No long term treatment plans



Chutuape, et al., 2001

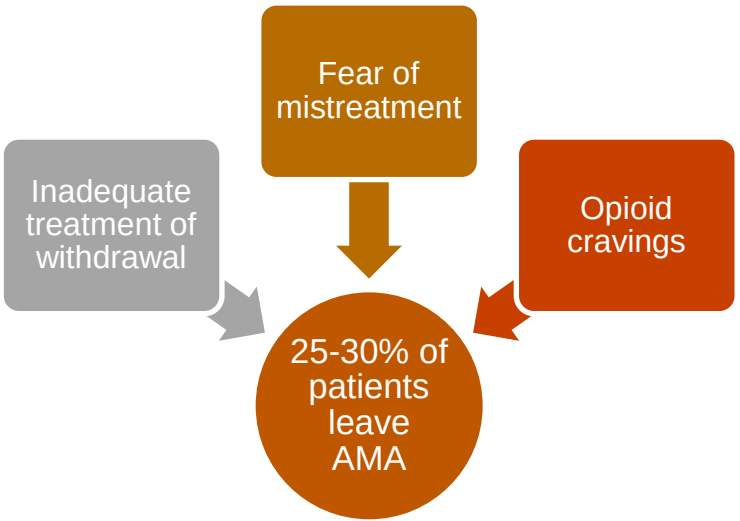
PATIENTS HOSPITALIZED FOR OUD CONSEQUENCES

- Overdose/ Poisonings
- Withdrawal
- Sexually transmitted infections
- Hepatitis C
- Endocarditis
- Epidural/ spinal abscesses
- Cellulitis

Chutuape, et al (2001)

HOSPITALIZATION: A RECOVERY OPPORTUNITY

Hospitalization is a reachable moment.



12% of patients provided **ONLY** a follow-up appointment enter outpatient treatment

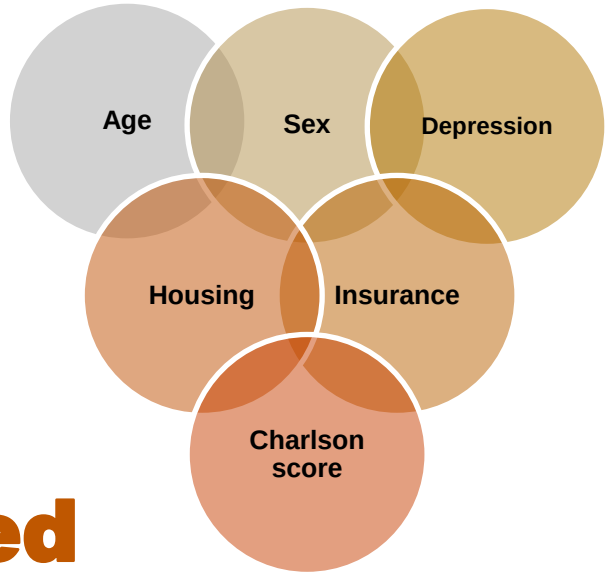
72% of patients started on buprenorphine enter outpatient treatment

Lianping Ti et al. (2015); Liebschutz et al. (2014)

READMISSIONS

Patients with SUDs are more likely to be readmitted within 30-days.

Even when adjusted for:



1.7 times more likely to be readmitted

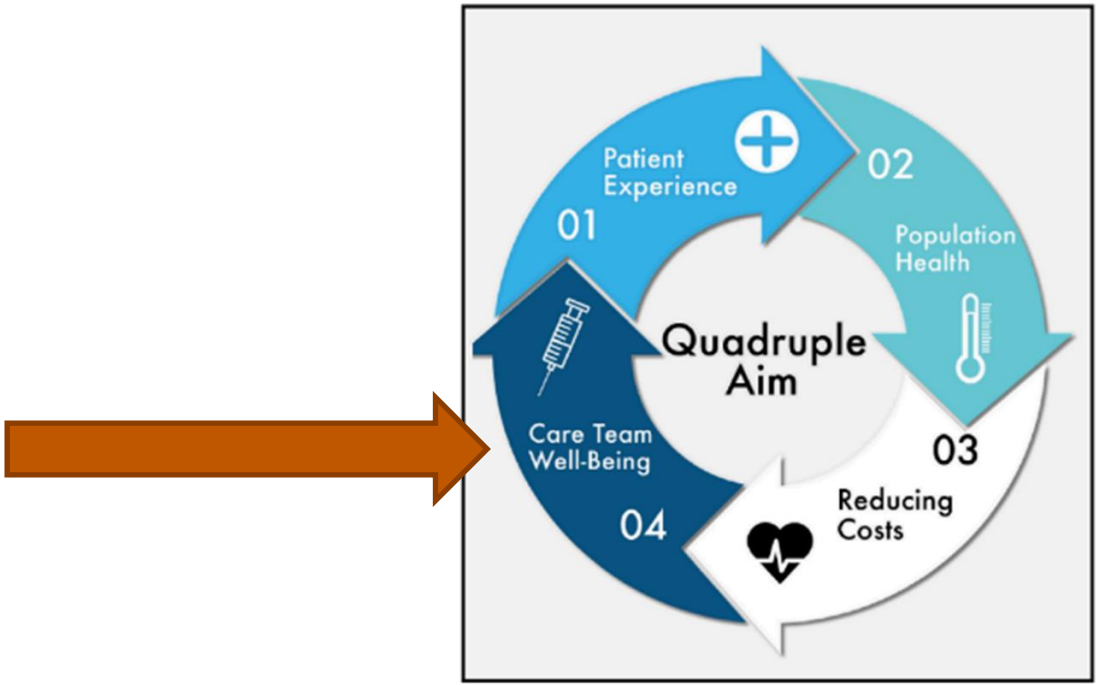
Walley, 2012

Among patients with opioid use disorder taking buprenorphine at the time of hospital admission...

53% reduction

Moreno, Jessica L., PharmD; Wakeman, Sarah E., MD, et al. Predictors for 30-Day and 90-Day Hospital Readmission Among Patients With Opioid Use Disorder. J Addict Med. doi: 10.1097/ADM.0000000000000499

THE QUADRUPLE AIM



BACK TO OUR JOURNEY

Our problem:

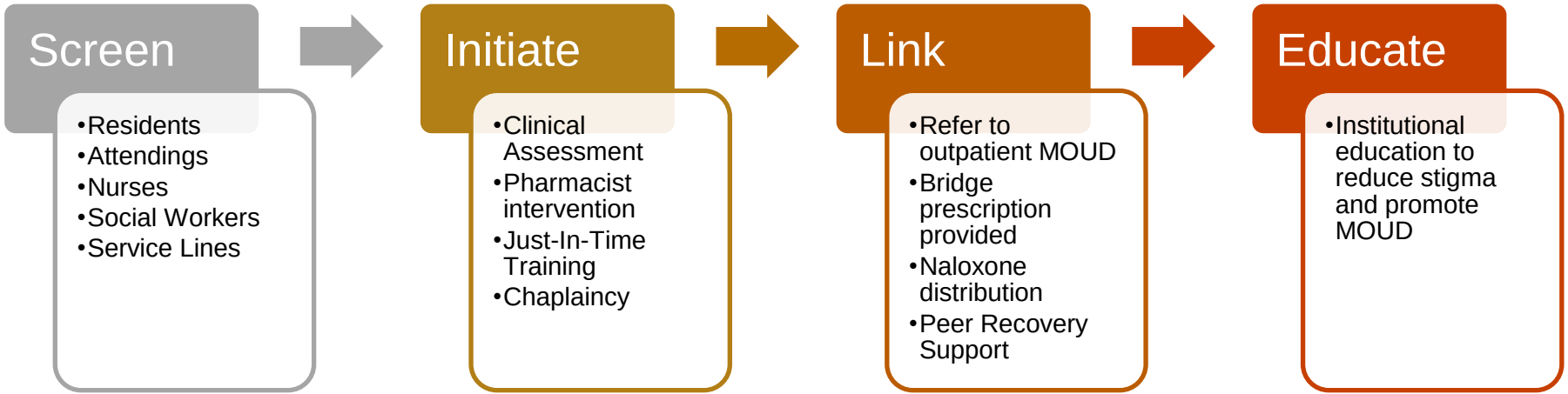
How can we treat hospitalized patients with opioid use disorder at our 200-bed academic hospital **without** a formal addiction medicine service?

Our solution:

Empower existing teams

THE BUPRENORPHINE TEAM

An interprofessional and multidisciplinary group that works to:



* Without the presence of addiction medicine consultation service but with planned obsolescence

WHAT WE LEARNED ABOUT OUD TREATMENT AND STIGMA

Our initial focus was on medication administration but we inadvertently reduced stigma by:

The Bottom Line:

We recognize our hospital as a critical access point. Addressing OUD is now our standard of care.

WHAT CAN YOU DO?

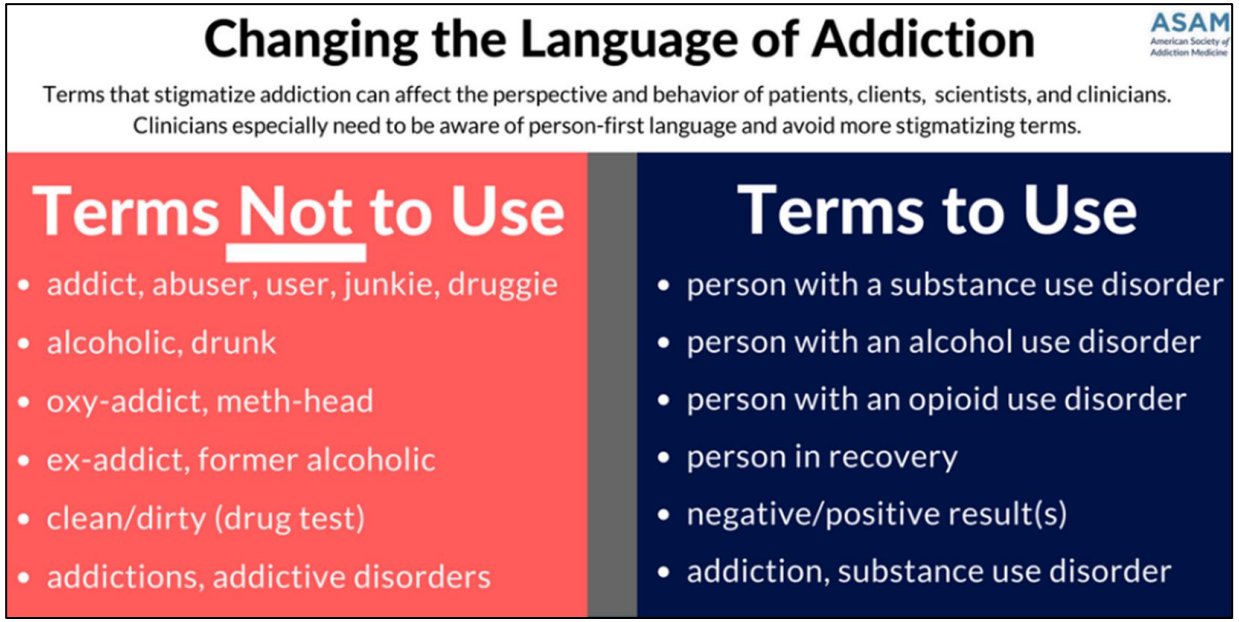
- Use person-first recovery-centered language

- Identify and eliminate structural barriers

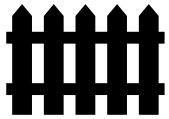
- Sympathetic narratives → share patient stories

- Focus on solutions, not “problems”

USE APPROPRIATE LANGUAGE



IDENTIFY STRUCTURAL BARRIERS

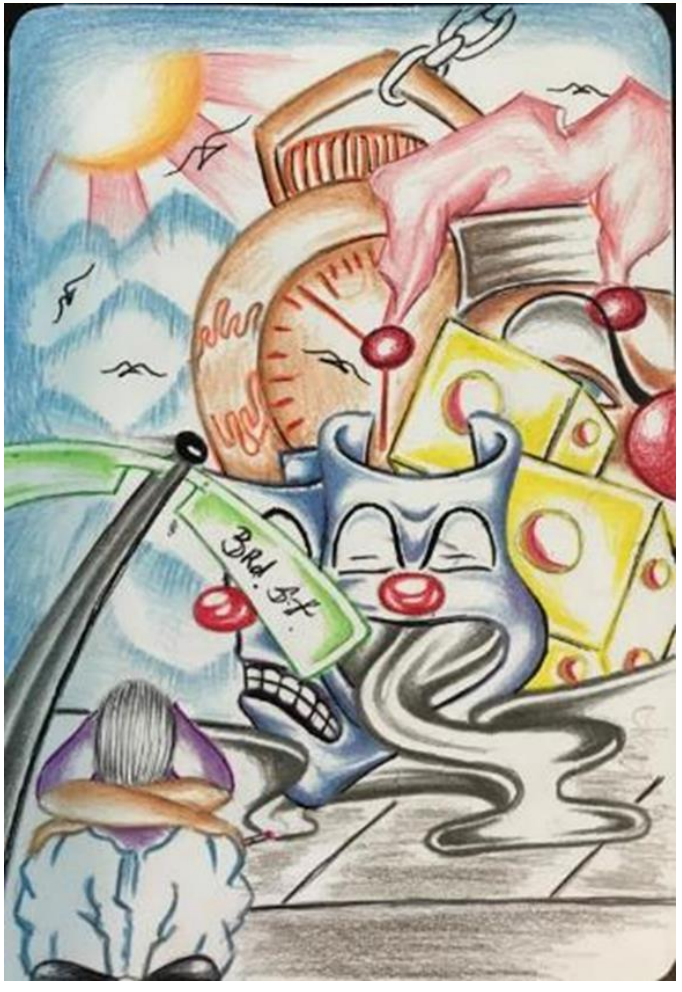


Policies or institutional actions that restrict the opportunities of targeted groups, whether intentional or not.

- Starting or continuing MOUD during hospitalization
- Formulary restrictions
- Care coordination
- Misunderstanding of regulatory environment (x-waiver)

Corrigan, 2004

SYMPATHETIC NARRATIVE AND PATIENT STORIES



CONTINUE LEARNING

Reducing Stigma Educational Tools (ReSET)

www.ResetStigma.org

CONTINUE LEARNING

SHATTERPROOF™

www.Shatterproof.org

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THANK YOU

Please reach out with questions and collaborations!

Richard Bottner, DHA, PA-C
richard.bottner@austin.utexas.edu
@RichBottner
www.ResetStigma.org