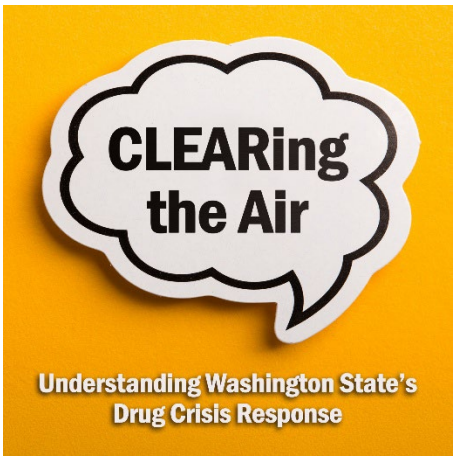
CLEARing the Air



Episode 1: Services for People Who Use Substances

Introduction: With the increase in overdose deaths in our state and over the years, what we're doing in Washington State is recognized as a crisis response.

In this series, we want to explore the system currently in place to respond to drug use in our state. This series is not intended to change minds, only to expand understanding of our current systems. It's complex and at times complicated. There's often an urge to call a system broken, but is it really broken, or is the system operating as each part was designed to, and it just doesn't meet our needs or expectations?

Through firsthand knowledge and storytelling from those inside the system, we can look at the parts and hopefully gain a better perspective of the whole. Each episode will feature different perspectives of our crisis response from the criminal legal system, health and social services, and those with lived experience of drug use. You can listen to them in order or jump to a specific topic. Before we discuss the past, we're starting from the present, because that's where the failures and the successes of the system currently can be found.

This series is presented by the University of Washington's Addictions, Drug & Alcohol Institute under the Department of Psychiatry and Behavioral Sciences with funding from the Healthcare Authority. This is CLEARing the Air: Understanding Washington's Drug Crisis Response.

Allyn Hershey: Hi everyone. My name is Allyn, and I work with the UW CLEARS team. I've been working with people experiencing houselessness, are actively using drugs, or in recovery for the better part of eight or nine years, and I come from a background of using drugs, which influences the way I approach this work in Thurston County.

Mandy Owens: And hey, everyone, my name is Mandy Owens. I'm an assistant professor with the Addictions, Drug & Alcohol Institute under the Department of Psychiatry and Behavioral Sciences at the University of Washington. The perspective that I'll be bringing to this conversation goes back to the mid-2000s where I worked as a substance use counselor at an outpatient treatment center here in Seattle, and then going on to work as a research therapist and outpatient therapist in Albuquerque, New Mexico, and then most recently, coming back to Seattle in 2015 and working as a licensed clinical psychologist in an outpatient setting.

Allen: So in this episode, we're going to give a brief overview of treatment and services for substance use and substance use disorder. But before we can get into those different types of treatments and services, we need to talk about what factors goes into people seeking treatment or services? So Mandy, in your experience, what are the biggest factors that go into the type of treatment or services someone wants?

Mandy: Thanks. Allyn, so just to kind of start us off, I want to make sure to clarify that in this episode, we're being inclusive of treatment and services for substance use and substance use disorder, so meaning we're going to be including more quote, unquote services for people actively using drugs, whether or not they meet criteria for substance use disorder, as well as kind of more formal treatment with a capital T for people who might meet criteria for substance use disorder and other mental health disorders.

So back to your question: What are the biggest factors that go into the type of treatment or services somebody wants? I think there's really two big factors. The first one, which we'll go more into, is somebody's goals. You know, for a long time in the field of substance use treatment, which really stemmed out of Alcoholics Anonymous, there was always this idea that abstinence or completely discontinuing any alcohol, drugs or other mind-altering substances was the only goal that people should have or could have for dealing with their substance use disorder. But more recently, in the last three or four decades, there's been more of this understanding that for a lot of folks, not only are they maybe not interested in abstinence, that might not be where they are at in this moment. And for some, they might be interested in maybe moderating their substance use rather than complete abstinence or interested in services or help for using alcohol and drugs in more safe manners. So just trying to, inviting folks to kind of think about services and treatment for that spectrum of goals that a person might have.

The second biggest factor, I would think, is where somebody wants to seek treatment. You know, for many folks, they are only interested, or primarily interested in, getting treatment for substance use or substance use disorder in a setting that completely removes them from their current environment. Either that's because they're surrounded by other people, maybe, who are drinking or using drugs, or they might be – and that makes it difficult for them to stop using on their own – or maybe they're experiencing houselessness, and so in order to really focus on learning skills or changing their substance use, they need to be housed, or for a whole other kind of multitude of reasons, folks might be only interested in those types of services.

So similarly, you know, for some folks, they want to go someplace where they can get treatment and sleep there. And for other folks, there's many reasons why they can't go to those types of settings. Maybe they are working or taking care of kids, and so that is a huge factor about why they might seek services.

And then, as we'll kind of talk about a little bit more, for some folks, they've been so harmed by our more traditional healthcare settings that they're not open to or don't feel comfortable seeking treatment or services for help in those more traditional places. Rather, for them, they feel more comfortable in more community-based

services like syringe service programs. So that's kind of my thought. Allyn, I'm kind of curious if you would add anything to that.

Allen: Yeah, I think there is, like you mentioned earlier, and thanks for everything you said, it was, I think it's a spectrum of everyone's individual needs and wants in terms of what their direction of health is, and safety, most importantly. So, when working with individual people, some people don't want to get sober or don't even want to approach that path in that moment, and so the idea of working with someone is okay, then how can I make sure you're safe in this process. And when you do want to go that route, make sure that I'm a welcome figure for you to approach. And sometimes, on the farther end on the spectrum, it's abstinence based, it's: I have to get sober, I have to not be around it, I have to not touch it, look at it, or anything like that. And to not judge and understand where everyone's direction is going. And treatments I've seen work excessively well where people have been sober for decades now because of treatment, and also, I've seen treatment hurt people in many ways, where they not only don't want to go to treatment ever again, but they also don't want to work with service providers ever again, which can make it really difficult for being sober. And sometimes, if they want to navigate their part of their lives to becoming sober by their own definition, they have to do that by themselves, which can be a really challenging and unsafe process. And personally, I think about safety along that whole spectrum, and how we can support that for every individual.

Mandy: Some really good points, Allyn. So you talked about like the importance of spectrum, of people's goals, of where they're at with their own use. And so I want to dive in deeper into this importance of personal choice, and as a clinician, meeting somebody where they're at. And so when I think about the importance of somebody's own goals, I think about, I want their buy-in. I also want to be on the same page with them, because at the end of the day, I want to make sure that they are as successful as possible, and then also as a, on the resource side, right, I want to make sure that the resources I'm providing somebody is a good use of our time, too, rather than offering these services or treatments to somebody who's just not interested in them.

Which makes me think about an example of where I didn't consider somebody's choice as much as I would have liked to. So I was working with somebody in jail doing motivational interviewing, which is an approach that a lot of us know. It's about helping somebody to resolve ambivalence and make change in a direction that they want to go in.

And I was talking to him about his alcohol use and why that was continuing to land him in jail. He had mentioned that when he gets out of jail, he didn't want to continue drinking because he didn't want to go back to jail. And so when I asked him about his experiences with treatment, he said that he had been to abstinence-only facilities before, and that those really didn't work out for him. He said, like, he just wasn't ready at that point to completely stop, even if, in the long run, he knew that abstinence was his goal.

And so when I heard that, I was like, Oh my gosh. Well, you should come to our clinic. We have a harm reduction approach, so we meet folks where they're at, and you should definitely come here. When you get out of jail, it'll give you everything that you need. It's so different from those abstinence-only facilities. Started asking about like,

what are some reasons why he might want to come to the clinic? What would that look like?

At the end of that, did he come to our clinic after he got released from jail? No. And so I think about him a lot because I'm like, Man, oh man, could we have used our time better if I had actually explored something he really wanted for when he got out of jail? You know, could we have used our time better together to explore what that might actually have looked like, instead of me kind of forcing my own agenda on him about what I thought was going to be helpful for him? And so, yeah, just really think about that and consider that with the folks that I work with, for me to kind of take a step back and take a breath and try to truly understand what somebody wants rather than what I think they should have, or what they think I think they should have, and what that might look like. So I'm kind of curious, from your perspective, Allyn, like, can you think of those examples where the system didn't meet somebody's goals or meet them where they're at?

Allen: I really wish your approach that you have now was there when I was younger, because I'll share a personal experience from when I went to treatment, when I was 14 years old. I went there forcefully. I was forced to go there. I spent about 30 days there, and it left a really horrible impression on me, on what treatment is.

You know, they made me watch movies that basically said, if you continue down this path, this is what's gonna, what you're going to turn into, and they actually put me in an environment where – I went there for smoking weed, and I met people who were using meth and heroin and other drugs, and it actually led to me being turned on to those drugs.

So, I don't think, in hindsight, that that was conducive to me exploring what I thought sobriety should be for me and how I define it. Therefore, when I approach the work today, I, for the longest time, was so hesitant to recommend treatment to people, but now, as I understand more, I think I see when people come to me and they're like, I need treatment, it's easier for me to make that referral, because I am meeting someone where they're at. But a time where I also had difficult with it is when I was do outreach – and I was an outreach worker for years, doing syringe exchange and going to homeless encampments – I would meet people where they're at both figuratively and literally, and I would go there with the resources in hand, with naloxone in hand, and people sometimes they're just resistant to services. And I had these expectations that they would come and meet me, and I would help them in how they defined it. But sometimes people don't even want to engage with service providers, and when I think back to my own personal experience, I understand why that person might not want to do that, because of the horrible experiences that they may have experienced in their time using drugs or being homeless.

Mandy: Yeah, thanks for sharing that, Allyn. It makes me think about when we do force folks into treatment and then they just don't want to be there, and now they've had this, like, bad experience with treatment that potentially could turn them off from engaging in services somewhere down the road, which is, of course, the complete opposite of what we're trying to do in those situations.

Allen: Yeah, absolutely.

Mandy: So I can also think about examples, like, as a clinician, of where I had to meet somebody where they're at. So most of the patients or clients that I've worked with over the last 15 years were continuing to use alcohol or drugs when they saw me, and that was because, for a lot of folks, they would have been turned away from treatment if they tried to access it, because where they were at in their life, they were not totally ready for abstinence. And some folks they didn't want abstinence, they wanted to just kind of moderate their use. But for some folks, they did eventually want to get to abstinence, but they couldn't even seek out those services because they were having such a hard time quitting or stopping where they're at.

Like I can think of a patient, she, when I was seeing her, had been drinking daily for about six years, and she had the ultimate goal of wanting to be completely abstinent, because she had a lot of medical comorbidities that were all tied to her drinking. And so when she had tried to seek out services before, she would get kicked out or turned away, but she desperately wants to be abstinent, but just wasn't where she was at. And so we worked together for over a year and helped her to kind of bring down her drinking, even into the single digit drinks-per-day, which for her still ultimately wasn't the goal of where she wanted to be, she still wanted complete abstinence. But when I think about that fact that she started with close to 30 drinks per day and ended at four to six drinks per day, you know, from an abstinence perspective, that's a failure, right? But for her, I gotta think that that was a success, and she couldn't have gotten that if she had tried to go somewhere else where they required abstinence from day zero.

And I just can't think of any mental health disorder where we would turn somebody away day one for exhibiting signs and symptoms of their disorder, like, "I'm sorry you're depressed, and you missed our session on Monday because you slept through the appointment because you couldn't get out of bed. So now I'm going to kick you out of treatment." We would never do that, and yet we do it for substance use, which just continues to baffle my mind. So that's kind of one example I can think of from the outpatient perspective. Curious for Allyn, what have you seen? How's that played out?

Allen: First, I want to say this: I think going from, what did you say, 40 drinks to four to six, that's monumental for a lot of people.

Mandy: I agree!

Allen: Yeah, when I think about experience, I've had similar experiences where people were using heroin and going into detox, they were like, you cannot use methadone or Suboxone or anything. You would just basically be in D… in withdrawal for the entire time you're in detox before you went into treatment, which can be unbearable. As a previous opioid user, a heroin user, withdrawals are the worst.

So to kind of put someone into detox for 10 days, or at some places, it's three days. being in withdrawals for that amount of time, it makes sense that people would want to leave to be like, I feel so unwell, I just want to get out, and so I think people sometimes are set up for failure in that sense. So I've worked with people kind of similar. I mean, it was opiates rather than alcohol, where they were, like, I want to go from injecting drug use to smoking it, and then maybe no longer using heroin to go into Percocet. And when that person would come to me, they would, I would always

ask them, “How do you feel about where you're at now?” And they would be like, I feel so much better that I'm less reliant on that and I don't have to use those things. And then gradually they went to the point where they did want to be abstinence-based, and it was a lot easier for them to transition into detox because the withdrawals weren't as hard. And then treatment was successful for a certain degree.

Mandy: Nice. And I just think about like, where would those folks have ended up if they couldn't have gotten those services, right? For some folks, it could have gotten worse, could have died, and I don't think that, from a treatment or service system perspective, is our goal. So why wouldn't we want to meet them where they're at?

Allen: Yeah, absolutely. And I think there's just danger in, you know, the route that people choose is, as your example, with alcohol, you know, alcohol withdrawals can kill people, and also with, you know, using heroin, especially on the streets, that can lead to going to jail, or, if you're using alone, potential high risk of overdosing and dying. And so, creating a system in which we can acknowledge the different routes that people take to get into sobriety that isn't incarceration or forced abstinence, we can actually see a bunch of people take their own personal routes into sobriety, and I think that's a really healthy way to look at the system, and I hope that's like a door we can open

Mandy: Perfect. Which is a great segue into talking about the different types of treatments or services out there.

Allen: Yeah, do you want to run through the types of formal treatments for SUD [substance use disorder], since that's your experience, and then I can kind of share about community and other non-traditional settings for people who use drugs?

Mandy: Yeah, that sounds good, Allyn. So I'll kind of run through with kind of the most intense settings for the formal treatments of substance use disorder, and so right, recognizing that some of these can overlap for folks who have comorbide substance use and other mental health disorders, or, you know, could look differently for folks without substance use disorder, but we’ll zeroing in on SUD or substance use disorder.

So, to kind of start us off with the most intensive in terms of medical and restrictions, you're going to have medically assisted detoxification services for substance use disorders. So that tends to be the highest level of care for folks. That's going to look like somebody often being in a locked unit where they are receiving medications like Librium or benzodiazepines for the treatment of alcohol withdrawal, or, most commonly, buprenorphine, for the treatment of opioid use withdrawal, as well as a host of other types of comfort meds, like for nausea or pain or things like that.

There also are non-medical detoxification sites where folks can kind of just go, and if they're not deemed to be high risk or needing medically assisted detoxification, they can go and spend time to kind of detox through their own withdrawals. You know, maybe most commonly that might be something like for stimulant use disorders, like methamphetamine or cocaine use disorder, although in Washington there was a recent law that is going to require behavioral health agencies to provide warm handoff to medications, including those non-medical detoxification sites. So just know that that is

kind of ongoing and might look different in Washington State, but in other states, they will certainly continue both the medical and the non-medically serviced detoxification for substance use disorders.

So, kind of the next level down, you have inpatient, which tends to be specific for locked hospital units, but kind of day-to-day gets tossed around in the same way that residential treatment gets serviced. So residential and inpatient for substance use disorder, those are going to be often locked facilities, but not always, where folks are engaging in groups throughout the day, and for a lot of folks receiving medications along the way. So, inpatient tends to be more in that hospital setting. Like I said, residential is kind of a broader term, but for some folks in residential facilities, they might not be in a locked facility, they might be just spending the night there and allowed to leave, and so that one has a little bit more range in terms of what residential and inpatient-type treatment services for substance use disorder looks like.

Now, when you more move outside of that into outpatient treatment services for substance use disorder, so that's where people are not spending the night at a certain place. And that can include intensive outpatient, which tends to be three to six hours, multiple days a week, all the way down to kind of like the lowest level of outpatient, which is about one hour a week. And so that tends to be mostly psychotherapy type or group therapy, and whether or not they have medications on site depends on the facility.

Now you could also get that medication management through your primary care for substance use disorder. So, the types of medications that folks can receive from their primary care provider, that can be buprenorphine or naltrexone, injectable naltrexone, for the treatment of opioid use disorder, or there are medications for alcohol use disorder that you can receive through primary care physicians. So the FDA-approved medications for alcohol use disorder are acamprosate, disulfiram, and naltrexone. And then oftentimes, you can see off-label medications that have research evidence for the treatment of alcohol use disorder but haven't been formally FDA-approved, and that can include things like topiramate and gabapentin. Now kind of similar in terms of receiving medication on an outpatient basis, somebody could receive methadone or buprenorphine through an Opioid Treatment Program, or kind of like a methadone program.

So those are kind of the more formal places that folks can receive treatment for substance use disorder. When you start to look a little less formal, that could include jail or prison based treatment. So, right, that's obviously outside of a formal health care setting, but somebody could receive similar types of treatment that they might get in the community, like, kind of residential treatment, outpatient type therapy or groups are really common in jails or prisons, and increasingly, medications for opioid and alcohol use disorder are being offered in jails or prison settings.

Now, moving outside of that setting, back into the community, you can see sober housing specifically for people with substance use disorder. So this might be something like Oxford housing, which are all around the state. They are geared specifically for people in recovery for substance use disorders and often require abstinence and might require other things like attendance of Alcoholics Anonymous and other self-help groups.

Which leads me to the self-help groups. So that can be Alcoholics Anonymous, Narcotics Anonymous. These are informal groups provided in the community where there is no formal, clinically trained person leading the groups. It is far more peer based. And there is a lot of evidence for these types of groups. You also could see groups called Smart Recovery, which does have somebody who is clinically trained kind of running them. And these are kind of just more considered to be community based and either offered in person or virtual.

Now, when somebody is kind of thinking about what types of those formal treatments they are thinking about or considering, most of them require completing an assessment for substance use disorder in order to place them into a setting that is going to be most appropriate given their level of need. Now, a small asterisk before I toss this over to you, Allyn, is when people often call me and they're like, oh my gosh, I have a loved one or a family member, and I'm really worried about them, do they. but they refuse to go to rehab -- that's where I try to provide a little bit of education about these different types of services that could be out there, and that "rehab " -- most people think about like residential treatment, but what we know from the research literature is residential or inpatient doesn't have better outcomes than outpatient treatment. And so when I talk to those family members, and I hear that their loved one doesn't want to go to, quote, rehab, well, I encourage them to consider these other alternatives, like outpatient treatment, recognizing that where that person wants to go is a huge consideration, and the evidence supports that as well.

So that's kind of where we think about treatment for substance use disorder as a bubble and maybe more traditional type settings. And then there's been huge movements to provide services in more community-based settings, recognizing that for a lot of folks, they don't feel comfortable engaging in these types of settings. So over to you, Allyn.

Allen: Yeah, and thanks for providing all that. Because I just want to acknowledge, like, going back to the spectrum idea, like so many of what you just talked about, fit in different parts of the spectrum, and I've seen them work really successfully for a lot of people and individuals. And to your point about families, I've had the same experience where, you know, they want rehab for other people, and then they find maybe the medication is actually the right route. And then again, it's very individualized.

But I think the movement that is kind of happening now, and you know, I could really dive into this word or phrase however you want to call it of "harm reduction," as you're seeing that more and more now, and what that really looks like is just the idea of providing safety for folks. I think that, what I've participated in is syringe exchange programs, which started as an HIV and AIDS kind of to control the spread of that. And that's where the syringe exchange started.

And now we're seeing more of the benefits of syringe exchange for other spread of diseases, like Hep C, amongst other things, and with the syringe exchange, I'll call it SSPs for now, just to keep it more brief, but with SSPs, we're seeing that there are also successful ways to incorporate naloxone with that, so it provides the reversal of people who overdose on opiates.

So, when I think about that as a community, you think about safety and survival. If safety and survival exists, then other avenues can present themselves for people who when they want to get ready to get sober, if they do or not, then we can make sure they're alive to do that. So I think those are really important things, and when you have a community that's vulnerable enough to come together and access those services, we can create a community that looks out for one another, so that people don't use alone, so that when naloxone is there and someone overdoses, they can use it.

And we're also seeing models, specifically in Canada, where it's a safe consumption site, where people can go into a building and inject drugs if they want to, and smoke drugs if they want to, and they have nurses on site to help with overdose and help to use the drugs safely. Alongside that, inside those buildings, there are the resources there so when people come in and they build relationships with another, build relationships with service providers. There's also all these resources available, whether it's pamphlets or whether it's just knowledge from the providers to make sure that they are aware of those services. And it's been successful.

The US has not adopted that model. If that model comes to the US, I, you know, we'll see how it goes, but currently, that's just a kind of more specifically in Vancouver, Canada's happening.

And also going back to my experience of not wanting to engage with treatments or services. I got my buprenorphine or Suboxone off the streets. It wasn't available at the time, and I had to pay for it off the streets, and I didn't feel comfortable going to a provider. And so I also have to recognize, and I think it's important for people to understand, that people don't want to engage in services, and getting methadone or getting buprenorphine off the streets is a form of safety and also understanding and trying to figure out why people don't want to access those services. And I think that goes back to the form of community is: how can we make sure people feel comfortable and safe in totality with everyone?

Mandy: Those are really great points, Allyn, thank you for sharing those. When we've done surveys with folks accessing syringe service programs and ask them where do they want to get services, a lot of folks don't say they feel comfortable going into primary care or these formal treatment centers. And so it's unfortunate that during kind of your experience of drug use, you had to get things like buprenorphine to treat your opioid use disorder, whereas now syringe service programs are increasingly offering a whole lot more of those services than just syringes, like you said, the naloxone, but a lot of these programs also have pathways or on-site medications for opioid use disorder programs. They can offer things like food, snacks, safer smoking supplies. Some of them even have, like, on-site wound care, dental care and even primary care. So I really love your point about trying to think holistically about how do we just take care of people, if that's our number one goal, and then really importantly, as we've talked about throughout this whole episode, how do we do that is by considering their goals, their choice, and where do they want to receive those services.

Allen: Absolutely. And I think harm reduction at its core is safety. So when we think about that, a lot of syringe programs, syringe exchange programs, have evolved into

these places where they do provide wound care, which is a form of safety, and the more things that SSPs can provide, whether that's wound care, whether that's case management, whether that's referrals and safe smoking supplies, as you mentioned, the more advantageous it can be for people to figure out what they want for each of their individual lives, and I think that's really important.

Mandy: Well, thanks for taking the time to chat with me about things. If folks are interested in kind of getting one-on-ones on law enforcement or from the perspectives of people with lived experience of drug use, feel free to check out those episodes, as well as the other ones coming down the pipeline. Thanks so much. I'm looking forward to seeing you there!