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ASAM Practice Pearls Transcript

Social Determinants of Health: *Making an Impact in Addiction Care*

Dr. Stephen Taylor: Welcome to ASAM Practice Pearls, where we turn clinical expertise into everyday addiction care, one conversation at a time. I'm your host, Dr. Stephen Taylor. Hopefully, we all know that addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences.

The definition does not imply that addiction is solely biological, but it considers addiction from a biopsychosocial perspective. Earlier this year, NPR shared a story about a physician whose approach to treating opioid and stimulant use challenged one of the oldest myths in our field, that anything short of abstinence is failure.

Instead, she focused on whether patients were safer, more stable, and more engaged in care based on their environmental needs, even if they were still using. She focused on the social aspect of the biopsychosocial construct of addiction. Unfortunately, despite the positive impact on her patients, she faced significant backlash because her approach didn't align with the local "norm."

But the backlash she received raises a question: how much room does our addiction treatment system really have for individuals whose lives are shaped by housing instability, poverty, trauma, and chronic illness? Today, we're going to talk about social determinants of health and why they may be the most undertreated factor in addiction medicine, and what you can do to address these factors in your practice.

I am lucky enough to have the ideal expert to discuss this topic with us, Dr. Sharon Stancliff. Welcome to ASAM Practice Pearls.

Dr. Sharon Stancliff: Thank you so much for inviting me.

Dr. Stephen Taylor: Sharon, I am super excited to have you here. You have so many perspectives that are extremely enlightening and, in some ways, really come at this issue of addiction treatment, and particularly addiction treatment with people who are experiencing difficulties with various social determinants of health from a direction that many folks just don't even think about.

And so, I'm eager to pick your brain and get your insights to share with our listeners. One of the things that I know that you have done that I'll start us off with is the fact that you helped review and, in fact, draft ASAM's definition of addiction. Could you briefly explain how social determinants of health are considered in ASAM's definition of addiction and how they fit into the biopsychosocial model?

Dr. Sharon Stancliff: Sure, I'd be glad to. First, I want to say that Dr. Olson invited me to be part of the committee redefining addiction for ASAM because she knew I didn't like the word addiction, and I'm not in the substance use disorder camp either. I use both of the words because they communicate stuff, and I'm very glad that the definition includes environment and especially life experiences. That definitely takes it out of simply the biological. In fact, with some kinds of addiction, it doesn't look quite so biological.

But I think we always think about all the use as pathological, and I think there's patients out there that function better on opioids. There's people that have had such difficult experiences in their lives that in a way, some of their substance use may have helped to keep them alive and surviving. As one friend and colleague said to me, "It works until it doesn't." So, at some point, it had some possibly real positive impact on their life, and then things change, and it becomes too difficult to manage. And that's when we start to see people, or we start to see them fall apart, overdose, lose contact with family and friends.

Dr. Stephen Taylor: That's true. And I think you also have some unique or some interesting perspectives on the whole definition of addiction as a disease, which many of us who are physicians, in particular, really cling to. If you wouldn't mind, please share that.

Dr. Sharon Stancliff: I do believe there's something biological about it, but I don't currently use the word disease when I talk to my patients, let alone brain disorder.

I think that the work that's come out since we came up with the concept that addiction is a disease hasn't shown that it reduces stigma. And I could give an example of labeling some behaviors as a disease that makes them more stigmatized. Specifically, schizophrenia in Zanzibar became more stigmatized when they said that's what it is, it's a disease.

So, I'm very careful about the language I use around my patients in general. They can call themselves junkies or dope fiends or whatever they want to call themselves. I'm going to call them people with addiction or a substance use disorder, but I'm going to use medical language. They laugh at me when I say that we're clean, and I'm like, "Oh, you had a shower today."

I mean, to my mind, being clean is being sufficiently together that one can be bathed. That's being clean rather than having no drugs in their urine. I don't try to change their language too much, but we have some interesting discussions.

Dr. Stephen Taylor: I'll bet, and I have to be honest, some of the more interesting discussions I have had have also been with patients of mine that I've been treating for addiction disorders and substance use disorders, or however you wanted to describe it, I tend to use the term addiction if for no other reason than because it is generally well understood by what's meant by that.

And so, yes, we have very interesting discussions with our patients. We learn a tremendous amount from our patients. And that's part of the fun of doing this work. Another question I have for you is clinicians often work with patients that face multiple competing social needs, and I know that you do as well, and those needs might include things like housing instability, criminal justice involvement, economic insecurity, social isolation.

Out of these various factors, how can clinicians prioritize them in terms of planning the care for the patients that we take care of?

Dr. Sharon Stancliff: Going back to something else you said, and then I'll go on to that. The fun of taking care of these folks - they are survivors. They have stories to tell. I learned so much from my patients, and I've been doing this a long time, but it's a fascinating group of people, and I wouldn't have wanted to miss it.

Anyway, yes, social determinants of health. Right now, in addition to working at the health department, I work in a federally qualified healthcare center inside of a men's shelter in downtown Manhattan. While all my patients are not currently in the shelter, because people keep coming back when they get housed, I mean, it's kind of a dump place, but people feel safe in our clinics, so they keep coming back.

But I mean, the first thing that I need to realize is if this person isn't housed - and not all of them are even in the shelter, some are on the street - How can they take care of their medicine? If it's take with food, how can they do that? Just realizing that the ability to take medicine is very much influenced by housing.

I also worry a lot about transportation. Yeah, we've got a fabulous subway in New York, takes us lots of places. Much of New York is rural, and so, finding drug treatment somewhere that somebody that's really short on cash can get to treatment is really important. So, I am very thankful for the existence of telehealth for lots of things, but particularly for buprenorphine, that's been huge. And we've even got some people doing it for Hepatitis C, which is really great.

But even in New York City, if you're taking care of an unhoused population, they may be way up north in the Bronx one week, and then somewhere in Brooklyn another week. Getting to the same doctor can be extremely challenging, finding doctors who are comfortable doing the kind of low-threshold medicine that Dr. Steve talked about at the beginning. There's not a whole lot of this, although that's changing.

Food is also a problem all over, but we do have a lot of food pantries and a lot of ways of getting food across New York.

Dr. Stephen Taylor: And for people who aren't familiar with New York City. Sure, there's a subway system that is extensive, and that works great if you can access it, if you have the means to be able to afford using the subway. If you don't, then there's another barrier because people don't realize that the distance between the Bronx,

where I did my residency, and Brooklyn, the example you gave, which just happens to be where I grew up, is a huge distance if you don't have easy access to the subway or some other transportation.

Those are some of the challenges that people don't even understand in many cases. And speaking of understanding the challenges of folks, what is the clinician's role in addressing these various determinants of health? It's one thing to understand that the people we take care of are facing these challenges, but what can a clinician really do about it?

Dr. Sharon Stancliff: First and foremost, I think clinicians need to get out of the clinic. The doctor we started with went to shelters to essentially seek out and recruit patients. I used to go on the streets doing needle exchange and tell people, "Yeah, come and see me on Wednesday," because they were afraid to come to the doctor.

That was a big deal, and it was kind of poignant even. I'd sometimes see them coming into the clinic as dressed up as they could be. It's like, "No, it's just a clinic, come as you are." For us to understand that social determinants of health, we need to see the varieties out there.

That's really important, although I think sometimes we can turn to our peers. I've understood that one in five medical students faces food insecurity. That's an extremely high and disturbing figure. So, it may be sitting right next to us that people are having difficulty with the social determinants of health.

But the other thing is when we go out into the world and say, hang out in a needle exchange or a shelter, it's easy to feel like oh, these poor people. Well, there's a ton of strength out there, and people do continue to feel joy, perhaps less than before, but they love, they feel joy just like everybody else.

Compassion is great, but pity sets us apart from them, and I tried very hard to avoid that feeling, although sometimes conditions are just dreadful.

Dr. Stephen Taylor: Couldn't agree more. I did my fellowship in addiction psychiatry at Bellevue Hospital in Manhattan, where our modal patient was unhoused, chronically and persistently mentally ill, and polysubstance addicted.

And a vast majority of our patients were literally living on the streets. The wealthiest of our folks lived in a shelter and had Medicaid. And yet, to your point, I was constantly impressed with the resilience and the strength and the resourcefulness of so many of the folks that we took care of. Just finding ways to even be able to survive on the streets of New York City, in many cases, required an incredible amount of ingenuity.

And I think we, in the field of addiction treatment, can help people utilize that ingenuity, not only to continue to survive on the streets or what have you, but also to

make improvements in their lives, including getting into recovery from substance use if that's something that they are willing to work on.

Dr. Sharon Stancliff: One of my joys is seeing people progress from polysubstance use disorder to using less and less, getting housed, and it's so much fun when a patient comes in and tells me that he's got an apartment or supportive living. I'm kind of shocked. I've been there about seven years now. I've seen people get jobs. One of my patients that I'd known since he was unhoused was like, "Hey, I'm having the first vacation of my life. I never worked one place for so long." That's a really exciting part of it for me.

But having people show up alive each week or each month is also really, really good because it's dangerous out there. I want to say another thing that clinicians can do is make your voice heard. You know, I first came to New York, I felt like a little pipsqueak. Who wants to hear what I have to say or think? But I've learned both from saying what I think and from working in the health department that many of the powers that be want to hear from what's happening on the ground. Whether you are contacting your state representatives about what they're doing about bills, particularly around substance use, call them up and say, you're for this one, and you're against that one.

Also, think about contacting the myriad of other agencies, like our health department. Unlike many states, Medicaid is within our health department. Advocates from the outside, some of us that are kind of translators between advocates and bureaucrats, changed New York so that all buprenorphine products have no prior authorization and a variety of other ways of easing low threshold treatment.

I do focus on buprenorphine because that's such a magic thing. But we also put together a group of community, mostly providers, but also advocates. And several years ago, before it was as accepted to do low threshold prescribing, we put together best practices in buprenorphine and we were also able to work with our addiction agency, it's called OASAS here. That's another agency that people should contact, and maybe after you've got a lot of years under your belt, maybe you want to work for one of them.

Finally. I will not leave out ASAM. I'm not currently on either board now, but I was on New York Society of Addiction Medicine Board for more years than it should have been. And then I worked with the public policy with National ASAM. Both of them were really great experiences. And when I look back at New York Society of Addiction Medicine, I believe I helped shape it for where it is right now, and I still go to their conferences and all. But make your voice heard. It's important.

Dr. Stephen Taylor: To my listeners, I will just give you a quick side note. Dr. Stancliff here is rather modest. She also has done a lot of other important work with ASAM. One example of which, where she and I co-chaired the writing subcommittee that drafted what is now ASAM's three-part series on advancing addiction medicine and

addressing racial justice in addiction medicine. And that was a tremendous undertaking. We started out to write one statement and ended up writing three full statements, and Dr. Stancliff did a masterful job working with me and co-chairing that subcommittee.

Related to that, I wanted to ask this question about what you attribute to the care that we provide for people with a substance use disorder, with addiction issues, when it also has the factor of their race that's introduced into it. How does that impact people in your experience?

Dr. Sharon Stancliff: Oh, in so many ways. When you first brought that up as a topic, somehow my mind flashed to a young Black man that I was seeing during the days when Black Lives Matter was on the streets, and I was just so afraid for him. He looked like such fodder for arrest. I don't know what finally happened to him, he came and went.

But in the broader sense, the criminalization of drugs, as can be seen in a number of articles and books, the new Jim Crow, the war on drugs has hit people of color far harder than white people. And it's not just that one individual goes to prison, often for really long periods of time, that leaves a hole in their family. It affects whole communities where we have so many, particularly Black, but also brown people, wrapped up in the criminal justice that has concentric circles all the way out. And then when they come back, first they're using opioid, they've got this huge risk of overdosing. I'm very thankful we now have buprenorphine and methadone in prison, which also took advocacy, I have to say.

Having been in prison, getting a job can be really hard. One of my patients got a dream job because he loves to cook, but it was associated with school and they found his record, which was years and years and years ago, and had to let him go. He found another great job, but I think that's really something we need to bear in mind, that we all use substances at the same rate across races and ethnicities, but some of us get hit harder than others.

Dr. Stephen Taylor: That is so true. And related to that, how do you feel social context should inform the way we treat addiction? So, for example, decisions about the medication choice, visit frequency, monitoring, the care setting, rather than just being something that we document or are aware of.

Dr. Sharon Stancliff: Well, length of prescription is a particularly interesting one. Out there, there's some studies that show that longer prescriptions, mostly talking about buprenorphine, lead to better adherence.

And yes, there's more room for medicines to go places that they're not supposed to. But if a longer duration is going to get that person to come back to me, say I give them two weeks for the first prescription - I aim for a month eventually - if that's

going to make them come back to me, even though they're really new at it, that's what I'm going to do.

On the other hand, I had a patient who was in the shelter. He just couldn't hold onto his buprenorphine, so he and I agreed - and we have this mom and pop pharmacy that's okay with it - I was giving him twice-a-week prescriptions or refills. He eventually got stable, moved back in with his wife, flew to Mexico, and got monthly prescriptions.

We need to be thinking about how hard is it for people to come back to us and where can they possibly store their medications? But we need to talk to them about that, and we need to trust them.

Monitoring is another one that the group of people at my clinic that prescribe bup, we talk about it all the time. How much urine testing should we do? We don't do a lot of urine testing unless it's going to change the plan. I don't consider the use of other substances to be a reason to bring people back more often. The only reason I bring people back more often is I think they're taking very little of their bup. They have to come often because I don't want them to wake up a day after they lost their bup and say, "I think I'm ready to get going on this for real." But if people are using cocaine or other things, I just still try to get to monthly prescriptions to keep them coming and to keep it from being a huge part of their life.

I do do some urine testing, but when people have been stable for a while, it's like I trust them and they feel trusted. And sometimes people come in and want to have a urine for a reason, and that's fine too. One of my patients says, "Yeah, I like to get my urine checked because I find out what else I've been taking."

Dr. Stephen Taylor: Which is a fascinating commentary about the landscape of substances out there in the streets today, that a person takes substances but doesn't necessarily know what they're taking, and they have to be aware of the fact that what they think they're taking may not be what they're actually taking. That's a powerful commentary on that.

Dr. Sharon Stancliff: Yep. We're lucky in New York state that we now have drug checking. They usually do it after the fact, but they can find out what's actually in that white powder they bought, as long as they're close to one of them. And that's pretty exciting and spreading around the country.

Dr. Stephen Taylor: And that, of course, saves lives, and that's so important for that reason.

I have another question for you that I got to ask about this: social networks. How do you approach patients whose environments, such as their family or their friends' substance use, or the criminal justice involvement, or the housing instability, actively undermine their treatment as they are trying to pursue it?

Dr. Sharon Stancliff: That's a really hard one. I see a lot of people that recently released from prison, and about 40% of the reentering citizens in New York City end up in the shelter system. The shelter system tries to concentrate the people that are using a lot of substances into particular places, like the shelter that I work at. But they're going to come out and they're going to be faced with all the substance use if they end up in the shelter system.

The other thing is that people are going to come out feeling like avoid persons, places, and things, but that's really hard, when you go home to your home in the projects. I do discuss loneliness with them. When you're on buprenorphine, and you're taking it on your own, there is no camaraderie. I won't say all the comradery opioid treatment programs is good for people. But they have people that they can talk to about what they're going through. So many of my bup patients don't really talk to anybody, so we have tried to make some support groups for them.

And I also talk to people, "Well, what did you use to do?" I'm not religious, but I ask people, "Did you use to go to church? Is that a place where you can go and be around people?" I tell them the problems with 12-step groups but suggest that they might want to think of that. But just trying to think about places to go socialize. There's a number of my patients that have spent most, if not their whole lives, in congregate settings. Getting housed alone is a big challenge.

Dr. Stephen Taylor: It really is. Is there anything else that you would like our listeners to know about addressing the social determinants of health? We've gone through a number of different topics. We could probably talk about this for 24 hours or more nonstop and still not touch on everything.

But what else would you like our listeners to know that you feel like is important?

Dr. Sharon Stancliff: Well, like the doctor we started with, there's creative ways to do medicine that are also fun and attack some of these problems. Some years ago, I got a small grant to go to our syringe exchange programs here in New York City and start people on buprenorphine on-site.

Now, back then, this is quite a number, like 2007, most of what we were seeing is basically white people with prescription drug problems that had jobs getting buprenorphine. Everybody else got methadone. I love methadone, I was medical director for methadone program for a while. But part of the goal of this project was to show these people that are using heroin, back when there used to be heroin, that are people of color, can also do really well on buprenorphine. And I actually, so many years later, still have, I think, three of them in my practice.

Thinking about alternate ways to practice can certainly do something for any boredom you might be feeling. I don't get bored easily, but getting out in the world.

Dr. Stephen Taylor: That's right. So with that, what are the main practice pearls, or actionable takeaways, that you would like listeners to take away from this discussion and from the vast experiences that you've had?

Dr. Sharon Stancliff: First, I think sometimes it's hard to ask questions about social determinants of health when we have so few resources. That's intimidating. But if we don't have a handle on what kind of challenges our patients are facing, we may not understand why they're not adhering to their medicines, why it doesn't appear to be working.

I also suggest that you read the policy statements on racial justice that we wrote a few years ago. I reread them the other day, and they're so powerful. I was like, "Wow! I worked on that. Cool." So have a look at them.

Dr. Stephen Taylor: I actually did the exact same thing and had the same experience. I want to echo that.

And yes, we are biased. Obviously, we were the two co-chairs of that writing subcommittee, but it really does have a lot of very rich information, and I think our listeners would benefit tremendously and learn a great deal from reading that. I could not agree more with that.

Dr. Sharon Stancliff: Listening to those and finding out the resources in your area can be important.

Oddly enough, my shelter has resources for the people in the shelter, but we don't have a whole lot for the people that are not within the shelter. We have a nurse care manager that's absolutely fabulous. I should never talk without talking about her. But being aware of what kind of resources around.

And go into the community, even if it's just a little bit. I've had medical students; I took two single room occupancy hotels to give flu shots, say, "That was just a really important experience to my life," and they just spent one evening walking around in this single room occupancy hotel.

Getting out there and seeing that, and then making your voice heard, whether it's at your church, or your government officials, town halls, writing letters, and talking to the government agencies that are funding and overseeing the services that we provide, so that they can change them in a way that suits the community better.

I love it that I work both at the Department of Health and in the field. I feel like I bring so much to each of those jobs by knowing about the other one.

Dr. Stephen Taylor: That is a rich pair of settings to work in.

Dr. Stancliffe, thank you so much for this really helpful discussion of social determinants of health.

Dr. Sharon Stancliff: Thank you so much for having me, and continue to do a wonderful job as president of ASAM.

Dr. Stephen Taylor: Thank you so much for sharing all of your brilliance with all of us.

I just want to say to our listeners: to learn more, I want you to check out ASAM's free education on social determinants of health and health disparities in addiction medicine.

Don't miss any of the four great modules designed to help clinicians eliminate inequalities, address intersectionality, and understand and combat health disparities in their practice. Check out the show notes for more information. I really want to thank our expert, Dr. Sharon Stancliffe, for sharing her impactful insights to improve addiction care for all.

Remember to visit ASAM's E-Learning Center to claim your CME credits for this episode. Also, make sure to subscribe and share this episode with colleagues who may find this information helpful. We'd also love to hear from you. What topics are you interested in? Email us at education@asam.org.

Thanks for listening, and we'll see you next time on ASAM Practice Pearls, where we turn clinical experience into everyday addiction care, one conversation at a time.