Thinking About the Opioid Epidemic in the Context of Trauma and Domestic Violence: Framing the Issues

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US DHHS, Administration on Children and Families, FVPSA-Funded Special Issue Resource Center Dedicated to Addressing the Intersection of DV, Trauma, Substance Use and Mental Health

- Comprehensive Array of Training & Technical Assistance Services and Resources
- Research and Evaluation
- Policy Development & Analysis
- Public Awareness
Overview

- Introduction
- Background on the opioid epidemic
- Framework for thinking about opioids in the context of trauma and DV
- Specific concerns of rural and Tribal communities, including the impact on DV advocates and programs
- Strengthening advocacy through innovative strategies at the program, community and policy level
Introduction

Why Think About Opioids in the Context of Trauma and Domestic Violence?

Background on the Opioid Epidemic: Growing Attention, But Why Now?

- High rates of opioid non-medical use and addiction
  - 11.8 million people or 4.4% of population
- High rates of opioid-related overdose (OD) deaths
  - Drug OD deaths: 563,600 from 2000-2016
  - Opioid OD deaths: 2/3 of 2016 OD deaths
- Synthetic opioid deaths (other than methadone): Illicit fentanyl/analogs drove the 88%/year increase from 2013-2016. Rate doubled from 2015 to 2016.
- Changing demographics

SAMHSA 2016 National Survey on Drug Use and Health (NSDUH) N=67,942

In 2016, 11.8 Million People Used Prescribed Opioid Pain Relievers for Other Than Prescribed Purposes (4.4% of Population)

- 11.5 Million Use Opioids Other Than Prescribed
- 10.9 Million Pain Reliever Only
- 6.9 Million Rx Hydrocodone
- 3.9 Million Rx Oxycodone
- 338,000 Rx Fentanyl
- 948,000 Use Heroin
- 307,000 Heroin Only
- 641,000 OTP Rx Pain Meds + Heroin
Opioid Use in the Context of Other Substance Use Disorders
SAMHSA NSDUH 2016

20.1 million people had a substance use disorder

2.1 million had an opioid use disorder, including
1.8 million who had a prescription pain reliever use disorder and
0.6 million who had a heroin use disorder.

Overdose deaths from all drugs, including non-opioids stood at 63,600 in 2016, an increase of 21% from 2015. 2/3 were opioid ODs.
Shift in the Drug Death Rate by State per 100K

Drug Overdose Deaths by Race

Top 10 States with the Highest Rate of Opioid Overdose Deaths Among Whites, African Americans and the General Population in 2015

The Henry J. Kaiser Family Foundation
What About Opioids and Women?

- **Overprescribing of Opioids 2008-2012:**
  - Over ¼ of privately insured women and over 1/3 of Medicaid enrolled women ages 18-44 filled a prescription for an opioid medication (MMWR 2015)

- **Non-Medical Use of Prescription Opioids:**
  - 4% of women and girls ages 12 and older engaged in NMU of prescription pain relievers in past year (SAMHSA NSDUH 2015)
  - Every 3 minutes a woman goes to the ER for NMU of prescription painkillers (CDC Vital Signs 2013)
  - Women tend to use in combination with other drugs, especially benzodiazepines

- **Opioid Overdose Deaths:**
  - More men die from drug ODs than women,
  - Percentage increase in opioid deaths between 1999 and 2010 was 5x for women and 3.6x for men. 2016 data shows greater increase for men. Greatest impact is on Native American communities (CDC 2017, US DHHS OWH 2017)

Between 1999 and 2011, the amount of prescription opioids sold in the U.S. nearly quadrupled, yet there had not been a quadrupling in the amount of pain that Americans reported.
**Women, Opioids & Trauma**

**Greater Risk for Over-Prescription:**
- More likely to experience painful medical conditions. More likely to experience depression/PTSD.
- More likely to be prescribed opioids for chronic pain (physical and emotional pain), given higher doses, use for longer time.

**Greater Risk for Non-Medical Use**
- More likely to initiate hazardous use, particularly after introduction by partner or spouse.
- Women with OUDs more likely to have experienced DV, SV, and childhood trauma (CSA). Opioid use associated with depression and PTSD (3x).
- More likely to self-medicate to manage distressing feelings.

**Increasingly High Risk for Opioid OD**
- Telescoping (shorter time to addiction, more cravings); 3x less likely to receive naloxone and to receive Tx; Additional barriers to care (stigma, childcare, transportation, DV).

Phifer et al., 2011; Sumner et al., 2016; OWH 2017

**Women, Opioids and Pregnancy**

**Antepartum maternal opioid use increased nearly 5-fold from 2000 to 2009** (hospital discharge codes study). SU is a major risk factor for pregnancy-associated deaths (MMRs).

**NAS rates increased from 1.5 to 6.0 per 1,000 births between1999 and 2013.** States with highest rates of opioid prescribing have highest rates of NAS.

**MAT is treatment of choice** for OUD during pregnancy. Withdrawal is contraindicated. NAS expected and treatable.

**Concerns about losing children:** Infants with NAS do better when they stay connected with their mothers. 24 states + DC consider SU during pregnancy to be child abuse, 23 states + DC mandatory reporting, 7 states require drug testing if suspect OU.

**Women more likely to enter treatment, stay in treatment, and maintain abstinence if they can stay with their children**

ACOG 2018; OWH 2017, APA 2018

**Past Year Non-Medical Use of Prescription Pain Relievers Among Lesbian/Gay/Bisexual and Heterosexual Adults Aged 18 and Older - 2015 NSDUH**

<table>
<thead>
<tr>
<th>Age at First Use</th>
<th>Overall</th>
<th>Sexual Minority</th>
<th>Sexual Majority</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-11 years</td>
<td>15.6%</td>
<td>14.0%</td>
<td>17.0%</td>
</tr>
<tr>
<td>12-17 years</td>
<td>14.3%</td>
<td>12.6%</td>
<td>16.2%</td>
</tr>
<tr>
<td>18+ years</td>
<td>10.0%</td>
<td>9.0%</td>
<td>11.0%</td>
</tr>
</tbody>
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Higher rates of prescription opioid use associated with higher rates of trauma, stress, and discrimination and with earlier age of use*

* Differences between the estimates and the sexual minority estimates is statistically significant at the .05 level.
* Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.
* Miller et al., 2017; Nuttrock et al., 2014; Bueller et al., 2012; Kasevich et al., 2012.
What About Access to Treatment?

- **Types of Treatment**
  - Medication Assisted Treatment (MAT): Methadone, Buprenorphine (+/- naloxone), Naltrexone
  - Non-pharmacological forms of treatment:
    - Cognitive behavioral therapies/DBT
    - Comprehensive multi-modal approaches (e.g. GR/TI/TS/PC)
    - 12 or 16-step approaches
    - Culturally-based approaches
  - OD prevention: Naloxone, Harm reduction

- **Access to Treatment**
  - 2016 NSDUH: 21 million needed SUD Tx, 1:10 received specialty SUD Tx.
  - Many areas lack services; Disparities in types of services available

Exhibit 2: Substance Abuse Facilities Offering Medication-Assisted Treatment, 2016

Exhibit 3: Substance Abuse Facilities Offering All Three Forms Of Medication-Assisted Treatment, 2016

SAMHSA National Survey of Substance Abuse Treatment Services
Considering the Data in Context

- Chronic Pain and Opioid Overprescribing
  - Role of pharmaceutical industry and other factors
  - Impact of policies to restrict supply
- Overprescribing vs. Social Determinants
  - Targeted overprescribing: "diseases of despair"
  - Impact of factors that increase demand
- Clinical vs. Criminal Justice Approach
  - Differential responses re: clinical vs. CJ approach and access to treatment and resources
- DV and Gender-Based Violence
  - Coercive Control, Gender Roles, Trafficking

Framework for Thinking about Opioids in the Context of Trauma and DV

Complex Connections: Substance Use, Mental Health, and DV

- Higher rates of MH and SU conditions among people who experience DV
  - Cis Women: Substance abuse 2×-6× as high; Range from 18% to 72%; Increased likelihood of opioid use; Increased PTSD, depression, suicidality
  - Gay men: Higher rates of depression and substance use
  - Trans women: Increased SU associated with gender abuse
- High rates of DV among women accessing SUD treatment including OUD treatment
  - Lifetime DV: 47% to 90%; Past year DV: 31% to 67%; Women attending methadone clinic: 90% experienced DV
- High rates of substance use among people accessing DV services

References:
- Dasgupta et al., 2017; Case et al., 2017; Schneider et al., 2009; Davis et al., 2013; Matyas et al., 2008; Exiguards et al., 2012; Bennett et al., 1994; Haring et al., 2015; Smith et al., 2018; Smith et al., 2015; Madlock et al., 2012; Seddon et al., 2014; Liello et al., 2014; Luken et al., 2014; Bending et al., 2010
Complex Connections: DV, Trauma and Substance Use

- Higher rates of chronic pain
- More likely to receive prescription pain medications including opioids
- Self-medication common
- May be coerced into using
- Using increases risk for coercion

People who abuse their partners engage in behaviors designed to:

- Undermine their partners’ sanity and sobriety
- Control their partners’ ability to engage in treatment
- Sabotage their partners’ recovery efforts
- Discredit their partners with potential sources of protection and support and to jeopardize custody
- Exploit their partners’ substance use for personal or financial gain

Substance Use Coercion
National Domestic Violence Hotline & NCDVTMH Survey

N = 3,224

- Pressured or forced to use alcohol or other drugs, or made to use more than wanted? 27%
- Afraid to call the police for help because partner said they wouldn’t believe you because of using, or you would be arrested for being under the influence? 24.4%
- Ever used substances to reduce pain of partner abuse? 26%
- Tried to get help for substance use? 15.2%
- If yes, partner or ex-partner tried to prevent or discourage you from getting that help? 60.1%
- Partner or ex-partner threatened to report alcohol or other drug use to someone in authority to keep you from getting something you wanted or needed? 37.5%

Substance Use Coercion & Opioids: Mechanisms of Control

- Introducing partner to opioids
- Forcing or coercing partner to use (e.g., dirty needles, noxious substances)
- Forcing partner into withdrawal
- Coercing partner to engage in illegal acts (e.g., dealing, stealing, prostitution)
- Using opioid history as threat (deportation, arrest, CPS, custody, job)
- Isolating partner from recovery and other helping resources
- Sabotaging recovery efforts: Stalking when accessing MAT
- Blaming abuse on partner’s use and benefiting from:
  - Lack of services for women dealing with OUD: Societal beliefs re: women & addiction

Bland 2013, Warshaw & Tinnon, 2018

Substance Use Coercion and the Neurobiology of Relapse Triggers

- Relapse triggered by:
  - Exposure to addictive/rewarding drugs
  - Conditioned cues from the environment
  - Exposure to stressful experiences
  - Involves activation of neural circuitry (e.g., reward, incentive, salience, and glutaminergic pathways, including pathways involved in the stress response).
  - These can be “deliberately” activated by an abusive partner who engages in substance use coercion

ASAM (Hajela et al, 2011); Warshaw et al, 2014

Trauma, Opioid Use, and DV: Examining the Connections

Impact on DV/SV Survivors & Their Children

Abusers actively undermine recovery, sobriety, and parenting

Abusers use these issues to control their partners and undermine their credibility and access to support

DV/SV & other mental health issues increase risk of DV, suicide, & other MHL

Stigma compounds abuse of SSI, CPS and CJ, negative impacts, and impacts of DV

Positive responses and lack of access to DV and trauma-informed OUD treatment and resources increase abusers' control

Warshaw-NCDVTMH 2013
Opioids and Criminalization in the Context of DV

- Substance Use Coercion and Stigma
  - Risks specific to survivors using opioids who are pregnant
  - Risks specific to survivors using opioids who are parenting
  - Risks to survivors at risk for deportation
  - Risks to survivors related to criminalization of substance use, in general

Opioids and Chronic Pain in the Context of DV

- DV survivors higher rates of chronic pain and painful medical conditions
- Restricted access to prescribed opioids may adversely impact DV survivors and others living with chronic pain whose physicians have prescribed these medications responsibly.
- Access to comprehensive pain management services for DV survivors is critical, particularly services that address the impact of DV, SU coercion and trauma

Trauma, Opioids and Domestic Violence

Multiple Pathways; Multiple Risks

Over-prescribing of Opioids, Self-medication, Coerced Use, Shorter Time to Addiction for Women, Restricted Access to Pain Management, Limited Access to SU Treatment, Sabotaged Recovery, Risk for Incarceration and CPS Involvement
Political and Economic Context: What Are the Implications for DV Survivors?

- Political Factors
- Financial Factors
- Interpersonal and Gender-Related Factors
- Opioid Epidemic

Before We Continue...

Specific Concerns of Rural and Tribal Communities:

What Are We Hearing from DV Advocates, Coalitions and Programs?
Domestic Violence and Opioids: Rural Considerations

Where West Virginia Stands

- Highest rate of drug overdose deaths in the country (39.5 deaths per 100,000 residents), more than double the national average.
- In 2016, more than 867 people died of an overdose, 354 of which included Fentanyl as the leading ingredient.
- West Virginia’s rate is 20 drugs per capita, compared to 12.6 nationwide.
- West Virginia has ranked number one in the nation for incidence of Acute Hepatitis B from 2007 to 2015.
- According to 2014 – 2016 data from the West Virginia Health Statistics Center, NAS is reported in 37 per 1,000 West Virginia live births.
- Nationally, in 2013, nearly 7 out of every 1,000 babies were diagnosed with NAS according to Reuters.

Issues for Rural Communities / West Virginia

- State with highest rate of Opioid OD deaths
- Lack of access to SUD treatment
  - Shortage of local services (both MH and SA)
  - 2-3 hours to services
  - No follow up after residential treatment
  - Privacy/stigma in small communities
- Transportation
- Isolation
  - Geography
  - No Internet access in some areas
  - so often no telemedicine
Issues for Rural Communities / West Virginia

- Massive overprescribing
  - Groups who receive prescriptions for pain issues
  - Aging population
  - High-risk injury work (Mining, Logging, Nurse Assistant, etc.)
  - Impact on all socio-economic groups
- Few / No jobs
- Insurance / Money issues
- Despair / Sadness
- Other

Impact on Advocates and DV Programs

- STAFF
  - Want to help / Dedicated
  - "In my own family"
  - Overwhelmed
  - Frustration / Guilt
  - Sadness
  - Self-Care issues
- PROGRAMS
  - "Not a rehab facility, but being asked to be one"
  - Shift in working with the community

Impact on Survivors Who Are Using

- Drugs are a Band-Aid to get through the day…….
  How do you get out?
- More women showing up without their children
  - Priorities have changed
  - Working on trying to get children back rather than the DV
- Easy access/over prescription – medicate rather than looking at what is really going on
- Needs include, jobs, housing, etc.
  - All can be difficult to access with history of drug use / passing drug screens / criminal history
Responses / Initiatives

- DV programs
  - Trained in Naloxone use / access in program/shelter
  - Trauma-informed strategies / responses
  - Self-Care

- Partnering with the Community
  - HELP4WV / WV Opioid State Plan
  - Local Behavioral Health programs
  - Programs such as Home Visitation
  - Faith-based programs
  - Emerging initiatives
    - Low Barrier transitional housing
    - Infant / Parenting Programs
    - Research / Grant initiatives

Opioids and Domestic Violence
Cultural Considerations

AI/AN Opioid Related Deaths 2014

- Opioid related deaths among AI/AN 15-64 years old was higher than all other racial groups in US
- 1 in 10 AI/AN’s age 12 and older used prescription painkillers for non-medical reasons
- AI/AN’s are twice as likely as the general population to become addicted to drugs and alcohol and three times as likely to die of a drug overdose
The Role of Trauma

- There is a long history of trauma in Native American families, communities, and across Tribal Nations.
- Trauma is a part of the circle of life.
- Impact of historical trauma and unresolved grief.
- Stolen generation (child removal).
- Violence in our communities.
- Violence against Indian women.

Soul Wounds

- Depression
- Anger
- Isolation
- Violence and suicide
- Shame
- Substance Use
- Anxiety
- Increases vulnerability.

Forced Removal of Indian Children

Source: Healing the Soul Wound: Counseling with Native Americans and Other Native Peoples.
Native American women experience domestic violence at a rate that is 50% higher than the national average. Native Americans are the most raped, assaulted, stalked, and murdered of all ethnicities.


3 in 5 will be physically assaulted in their lifetime
Indian women suffer from violent crime at a rate 3 ½ times the national average
Homicide is the 3rd leading cause of death for Indian women
75% of Indian women murdered, were killed by an intimate partner
Indian women live their lives in “the dangerous intersection of gender and race”
38% of AI/AN women, victims of domestic violence, were unable to receive necessary services

In the US there are 567 federally recognized tribes representing approx. 3.3 million AI/ANs
IHS provides services to 2.2 million AI/ANs
There are fewer than 200 healthcare facilities, including 20 off reservation health centers and 25 hospitals
Unmet need is tremendous
Connections to Domestic Violence

- Self-Medicating—to deal with the violence they are experiencing, including all the trauma
- Coercion—getting her addicted, taking photos of her using and under the influence to control her and take the kids away
- Trafficking—opiods either led them to being trafficked or keep them in a cycle of control and exploitation

The “Perfect Population”

“If you're a trafficker looking for the perfect population of people to violate, Native [American] women would be a prime target. You have poverty. You have a people who have been traumatized. And you have a legal system that doesn't step in to stop it.”

Source: Sarah Deer, attorney and author of “The Beginning and End of Rape: Confronting Sexual Violence in Native America.”

Promising Practices

- Community Education and Awareness
- Legal strategies
- Safer prescribing practices
- Naloxone dispensing, training emergency responders, DV programs/shelters, community members
- Healing to Wellness Courts
- Treatment and prevention programs
- Creating innovative partnerships
Intergenerational Trauma

To understand how to move forward, we must first talk about what has happened.

Understanding the Connections

Indigenous way of thinking, all things are related, all things are connected, holistic
Need to understand the connections between domestic violence, health care, trauma, mental health, substance abuse, AIDS/HIV, trafficking and child welfare

Harm Reduction is Our Way of Life
Where Does This Leave Us?

Strengthening Advocacy Through Innovative Strategies at the Program, Community and Policy Level

Implications for DV Advocates and Programs

- Remember that people who perpetrate DV use stigma associated with SU to prevent their partners from accessing DV services.
- Recognize that substance use coercion is a common tactic of abuse and that both SU and DV present dangers to survivors.
- Provide information and perspective about SU coercion, trauma and DV and incorporate into safety planning along with harm reduction strategies.
- Collaborate with local substance abuse treatment providers and state Women’s Services Coordinators to develop a continuum of DV/SU services and supports.
- Support survivors in navigating services that may not be as responsive to their needs.
- Participate in community-wide initiatives.

Implications for Primary Care and/or Behavioral Health Providers

- Recognize that DV is prevalent among the people you are serving.
- Incorporate questions about DV and substance use coercion into routine SU assessments and treatment planning as well as chronic pain management.
- Address DV and SU coercion as part of ongoing opioid treatment and relapse prevention.
- Partner with DV programs to ensure a continuum of services and supports for DV survivors and their children.
Where Does This Leave Us? Implications for Policy and Practice

- **Prevention**
  - Community education and outreach initiatives; Opioid take back programs; DV training for opioid hotlines
  - Safer prescribing: Opioid prescriber guidelines/education
  - Overdose prevention: Harm reduction, naloxone, safe spaces, Good Samaritan Laws
  - Addressing DV, individual and community trauma, social determinants and resource disparities

Phillips and White-Domain, 2018; Warshaw and Tinnon, 2018

Where Does This Leave Us? Implications for Policy and Practice

- **Access to Treatment and Healing Resources**
  - Full range of Medication Assisted Treatment options
  - Comprehensive gender responsive, culturally resonant, LGBTQ2SIA-affirming, DV- and trauma informed treatment including detoxification
  - Two-generational services for pregnant and parenting women and infants with neonatal abstinence syndrome (NAS)
  - Comprehensive chronic pain management
  - Sufficient resources and support

Phillips and White-Domain, 2018; Warshaw and Tinnon, 2018

Opioids, Trauma and Domestic Violence: Policy Implications

- Attend to DV and SU coercion in local, state and federal opioid policy and workforce development initiatives, including support for non-punitive approaches
- Promote and support collaboration between mental health, substance abuse and DV service providers
- Ensure that state, territory and Tribal DV coalitions and local programs and shelters have access to opioid prevention, intervention, treatment and harm reduction resources for the survivors they serve
Ensure state, territory and Tribal DV coalitions and local programs are at the table to partner in shaping opioid policy and practice in their states, Tribes and communities.

Thoughts? Questions?

Selected Resources
