Substance Use Disorder: What employers should look for, for their employees

Eric Haram, LADC

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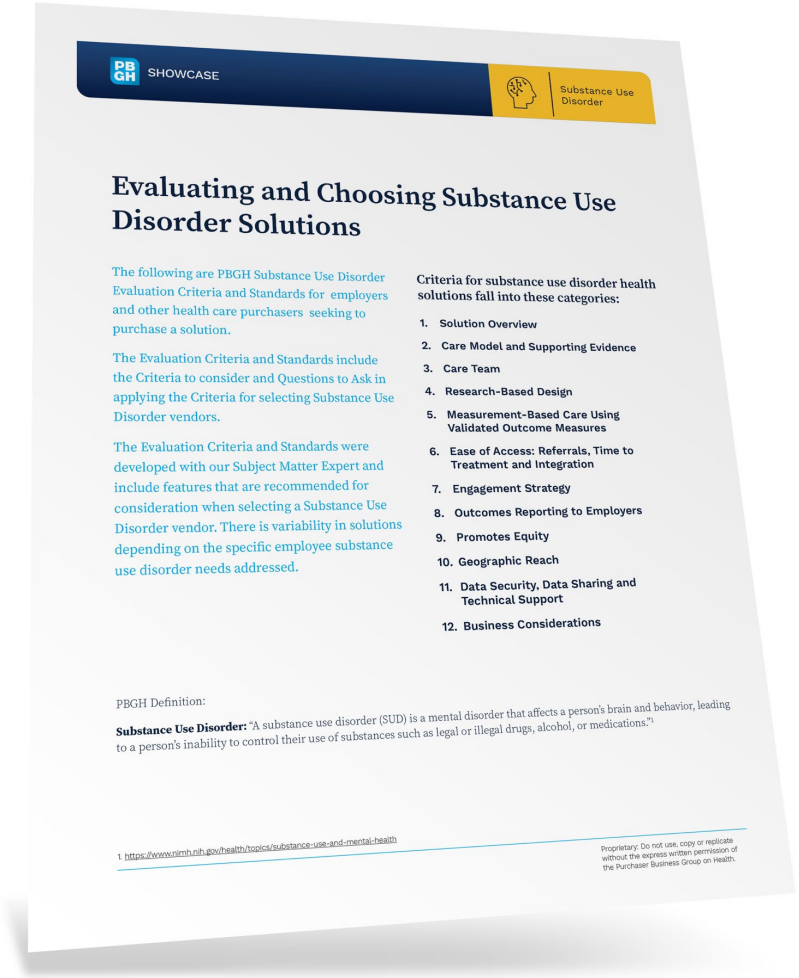
Nov. 10th, 2022

PBGH SHOWCASE

Our Objectives for Today

1. Provide you with a brief overview of substance use disorder (definitions, prevalence, and treatment)
2. Current best practices for employers
3. Framework for evaluating substance use disorder vendors
4. What employers should look for from substance use disorder vendors

Use the PBGH Evaluation Criteria



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Substance Use Disorder

Evaluating and Choosing Substance Use Disorder Solutions

The following are PBGH Substance Use Disorder Evaluation Criteria and Standards for employers and other health care purchasers seeking to purchase a solution.

The Evaluation Criteria and Standards include the Criteria to consider and Questions to Ask in applying the Criteria for selecting Substance Use Disorder vendors.

The Evaluation Criteria and Standards were developed with our Subject Matter Expert and include features that are recommended for consideration when selecting a Substance Use Disorder vendor. There is variability in solutions depending on the specific employee substance use disorder needs addressed.

Criteria for substance use disorder health solutions fall into these categories:

1. Solution Overview
2. Care Model and Supporting Evidence
3. Care Team
4. Research-Based Design
5. Measurement-Based Care Using Validated Outcome Measures
6. Ease of Access: Referrals, Time to Treatment and Integration
7. Engagement Strategy
8. Outcomes Reporting to Employers
9. Promotes Equity
10. Geographic Reach
11. Data Security, Data Sharing and Technical Support
12. Business Considerations

PBGH Definition:

Substance Use Disorder: "A substance use disorder (SUD) is a mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications."[1]

1 https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health

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Our Substance Use Disorder Subject Matter Expert

Eric Haram, LADC

- Eric is a practicing SUD clinician, treatment expert and state policy expert. He is a senior consultant to the Addiction Technology Transfer Center at Brown University and is a national implementation consultant with the University of Wisconsin-Madison, College of Engineering.

- He served as Co-Chair of the U.S. Attorney's Task Force on the Treatment and Prevention of Opioid Dependence, State of Maine.

Our Agenda

1. Brief Overview of SUD
2. Best Practices for Employers
3. Framework for Evaluating Substance Use Disorder Vendors
4. What Employers Should Look for from Vendors

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What is a Substance Use Disorder (SUD)? Clinical Definition:

- A chronic, relapsing **brain disease** that is characterized by compulsive drug seeking and use, despite harmful consequences
- The ***initial*** decision to take drugs is typically *voluntary*
- With ***continued use***, a person's ability to exert self-control can become seriously *impaired*; it is the hallmark of SUDs
- There are validated screening measures for SUD, e.g., DAST-10, AUDIT, WHO.

https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools

How Do We See This Revealed in Substance Use, Misuse and Dependence? Use, Misuse and Dependence Defined

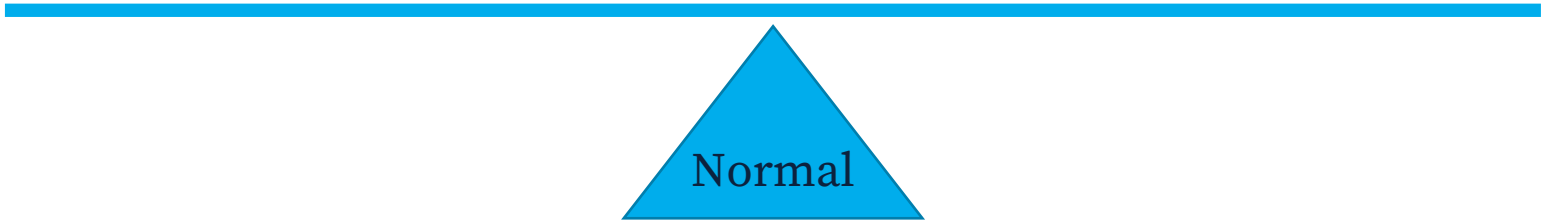
- Substance Misuse: Refers to the use of a substance for a purpose that is not consistent with the legal or medical guidelines, often prescription medications. This could mean taking more (or less) than prescribed, medication not prescribed to you, or taking a substance at a time when obligations are inconsistent with use.

- Substance Dependence/ Substance Use Disorder: Lines between misuse and dependence may become blurred in the presence of chronic use. When regular use results in one of the following a professional assessment may help identify and intervene:

  - Health complications as a result
  - Inability to carry out daily responsibilities
  - Physical dependence or withdrawal symptoms
  - Cravings and preoccupation

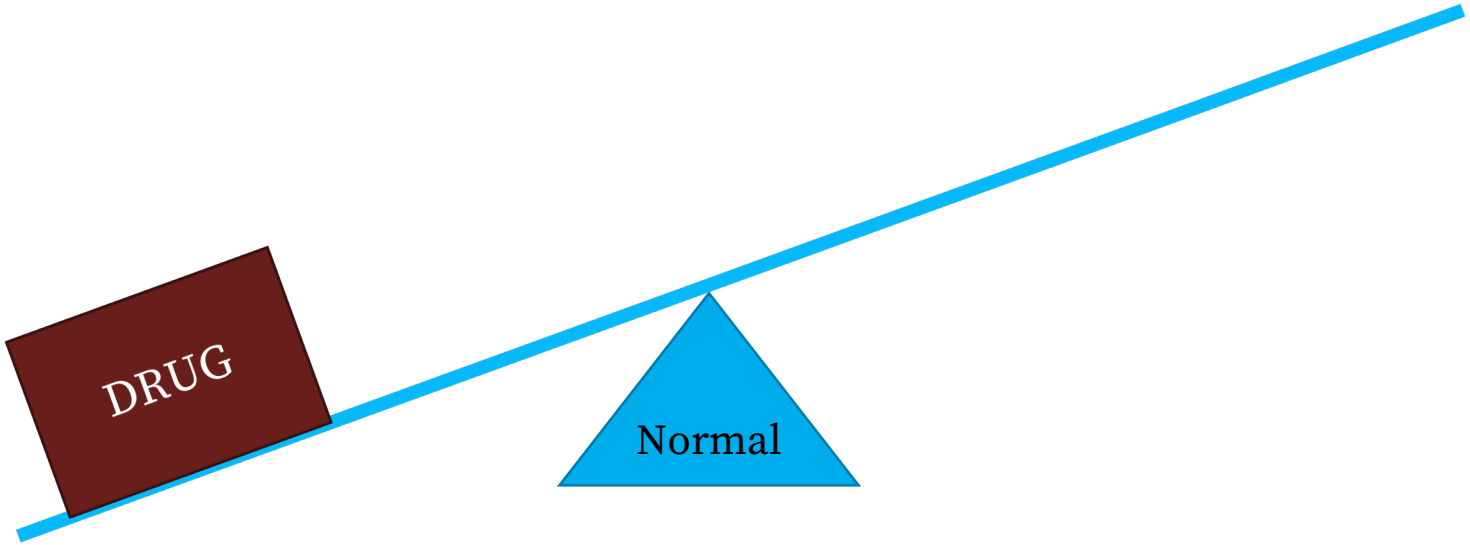
Tolerance

- Without use or tolerance, we are at “normal”
- Hedonic Tone- neurobiological action underlying one’s ability to feel pleasure. Companionship, nurturing young, self-efficacy, food/water, intimacy.



Tolerance

- Acute use leads to drug effects
  - Repeated use leads to **tolerance/reduced hedonic tone.**
  - **Anhedonia- reduced ability to experience pleasure.**



- Euphoria
- Decreased pain perception
- Sedation/energized
- Lower inhibition

Tolerance

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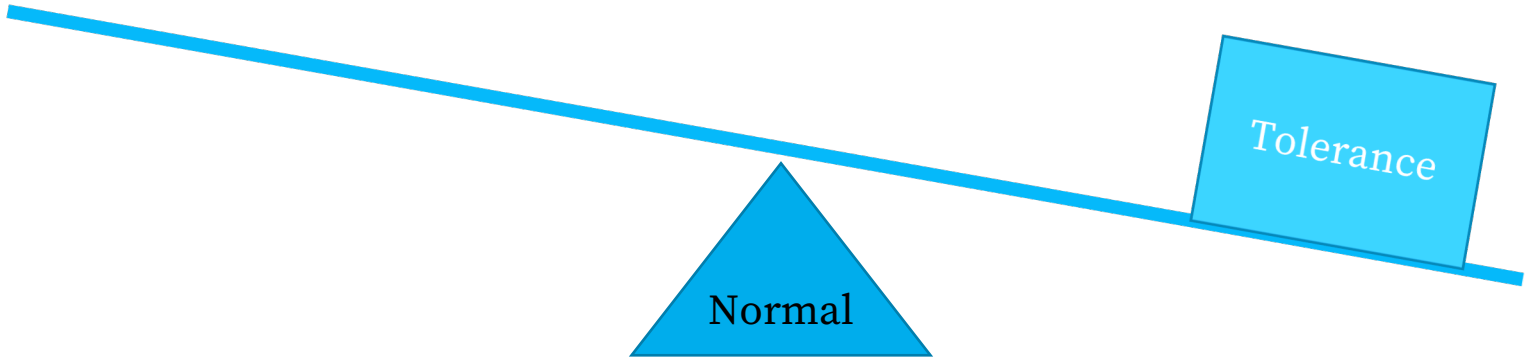
  - Repeated use leads to **tolerance/reduced hedonic tone.**
  - **Anhedonia- reduced ability to experience pleasure.**



- Dysphoria
- Hangover
- Consequences, obligations or behavior
- Withdrawal

SUD Disrupts Decision-Making

Binge/Intoxication

- Overtime drug consumption triggers smaller and smaller releases of dopamine
- Reward system less sensitive to stimulation
    - Drug and non-drug related rewards
    - Less motivated by everyday stimuli (relationships, hobbies, etc.)

Withdrawal/Negative Affect

- Repeated exposure to drugs leads to adaption in amygdala and basal forebrain
- Increased reactivity to stress
- Increased negative emotions
- Intense motivation to escape the after-effects of use

Preoccupation/Anticipation

- Down regulation or dopamine in pre-frontal cortex impact executive functioning
- Decision-making, self-regulation, attribution of salience
- Weakens ability to resist strong urges, follow through on decisions to stop using

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National Substance Use Prevalence

SUD and Mental Health Comorbidities

- 9.5 million or 3.8% of adults over the age of 18 have both a substance use disorder (SUD) and a mental illness.
- SUDs affect over **20 million Americans aged 12 and over**.
- Most common disorders are related to marijuana and prescription pain relievers.
  - 358,000 or 1.5% of all adolescents in the U.S have had both an SUD and a major depressive episode within the last year.
- In 2018, 3.7% or 9.2 million of all adults aged 18 and older in the U.S. had both an AMI and at least one SUD in the past year.

Drug Use Among Age Groups

- While younger people are more likely to use drugs, the rate of drug use among people 50 and over is increasing faster than it is among younger age groups.
  - The drug-related death rate for users over 50 increases 3% annually.
  - 75% of deaths from drug use disorders among users aged 50 years and older are caused by opioids.
  - 6% of drug deaths among 50-plus users are from cocaine and amphetamines, and 13% are from other drugs.

Summary of Key Trends in Substance Use

- As of 2022, **close to 1 in 10 of full-time working Americans** meet the diagnostic criteria for alcohol use disorder (AUD).
- The rates of alcohol use have increased substantially, including among the employed population.
  - Reports show increased alcohol use during the workday.
  - Additionally, use of alcohol and drugs among adolescents and young adults remains high.

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2790205

Community and Family Norms Have Become More Tolerant of Substance Use During COVID-19

Substance Use in COVID-19 Era

- Early studies show that social isolation and other COVID-19 related stressors are contributing factors to increased substance use.
  - In fact, **13% of Americans report increased substance use** in 2020, according to the CDC.
  - In 2020, the US saw the **highest rates of drug overdose and fatalities ever recorded**, approximately a 30% increase from 2019.
  - Fentanyl has been a significant factor in the increase in fatal overdoses over the last couple of years
    - Among adolescents, fatal overdoses **increased by 94%** from 2019 to 2020

https://nida.nih.gov/drug-topics/comorbidity/covid-19-substance-use
https://www.apa.org/monitor/2021/03/substance-use-pandemic
https://jamanetwork.com/journals/jama/article-abstract/2790949

Our Agenda

Brief Overview of SUD

Best Practices for Employers

Framework for Evaluating Substance Use Disorder Vendors

What Employers Should Look for from Vendors

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SUD in Working Populations

Alcohol Use Disorder (AUD) and Missed Workdays

- Studies show substantial correlations between AUD and absenteeism.
  - “Despite only making up 9.3% of the population, individuals with AUD accounted for 14.1% of all absences.”

AUD Severity	Average days of work missed annually
No AUD	13
Mild	18
Moderate	24
Severe	32

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2790205

AUD and Missed Workdays

- Alcohol use disorder are more common among full-time workers who are:
  - Men
  - Younger individuals
  - White or Hispanic
- Alcohol sales increased from 2019 to 2020 by about 20%. Additionally, over the course the pandemic, alcohol usage patterns have been altered substantially.

https://www.sciencedaily.com/releases/2022/03/220317111925.htm

Diverse Population of Patients with SUD

Up to 50% of SUD patients are fully or partially employed.

CHAOS

50-80%

Unstable housing or homeless

Unemployed or minimally employed

No or unreliable transportation

Uninsured

Poly-substance use, often IV use

Frequent hospitalization, prior overdoses

Transitioning

15-30%

Moderately stable housing

Some employment

Some access to transportation

Un/underinsured

Stable

5-20%

Housing

Employed

Personal vehicle

Private insurance

Adapted from Joanie Klayman, Preble St. Resource Center

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Health Equity

Health Disparity: Institutional Stigma and Bias

- Lack of cultural understanding by health care providers contributes to underdiagnosis and/or misdiagnosis of mental illness in people from racially and ethnically diverse populations.
- Black patients are **77% less likely** to receive medication assisted treatment.
- **92%** of Black and Latinx individuals who received an SUD diagnosis, did not receive treatment for SUD.
- Racist anti-drug policies have led to greater criminalization for BIPOC individuals resulting in greater reluctance of BIPOC individuals to seek substance use treatment

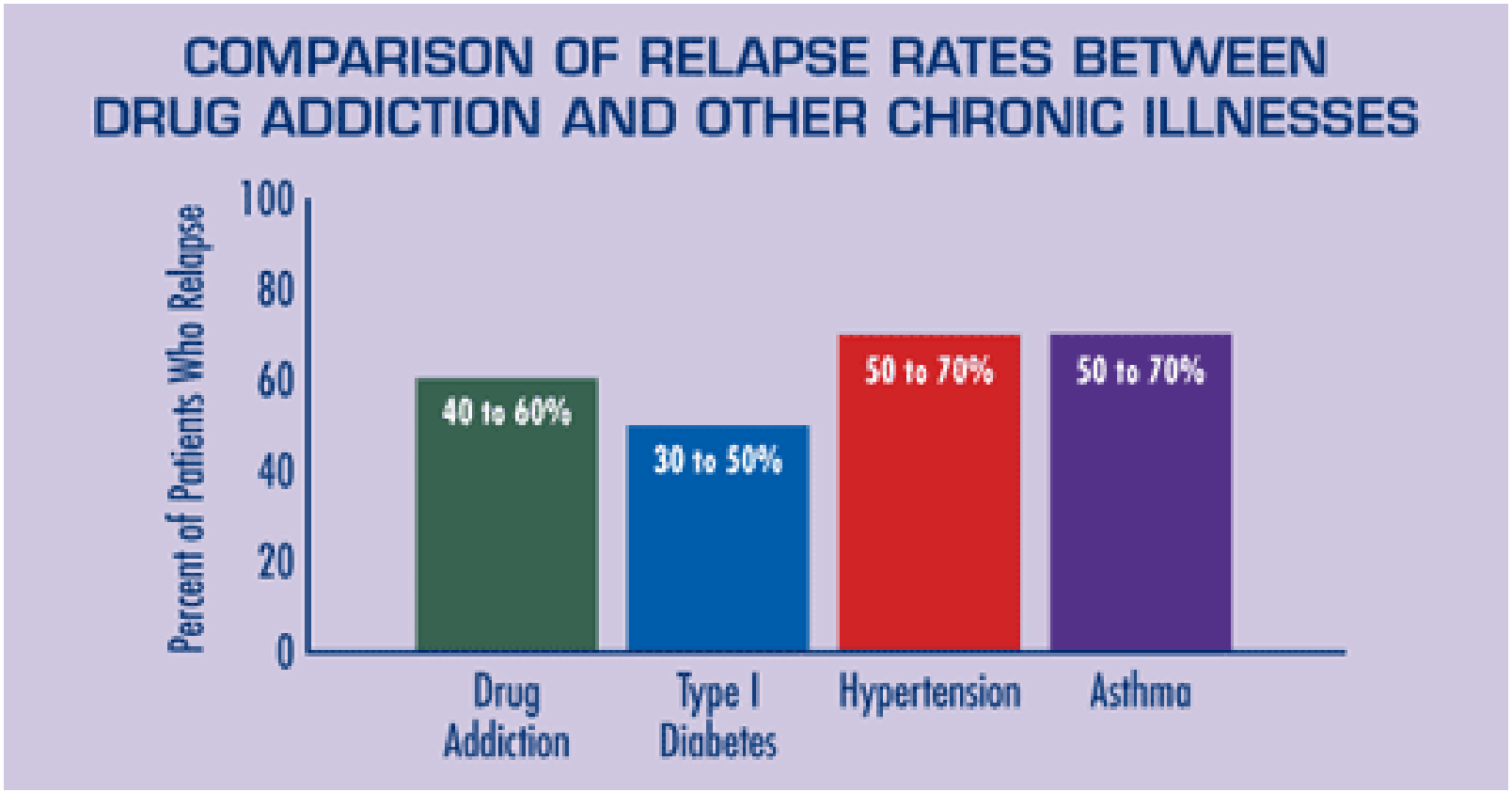
https://medicine.yale.edu/news-article/racial-inequities-in-treatments-of-addictive-disorders/

Populations known to be more at risk

- People with existing mental health or substance use conditions, may experience increased distress and trauma symptoms, treatment may be disrupted, and care providers and systems put under additional strain.
- Older adults and those with cognitive decline or problems with self-care.
- People at risk of sexual and gender-based violence.
- Children and adolescents with disrupted schedules, activities and socialization.

SUD is a chronic disease

SUD is often perceived and treated differently than other chronic diseases.



JAMA, 284:1689-1695, 2000

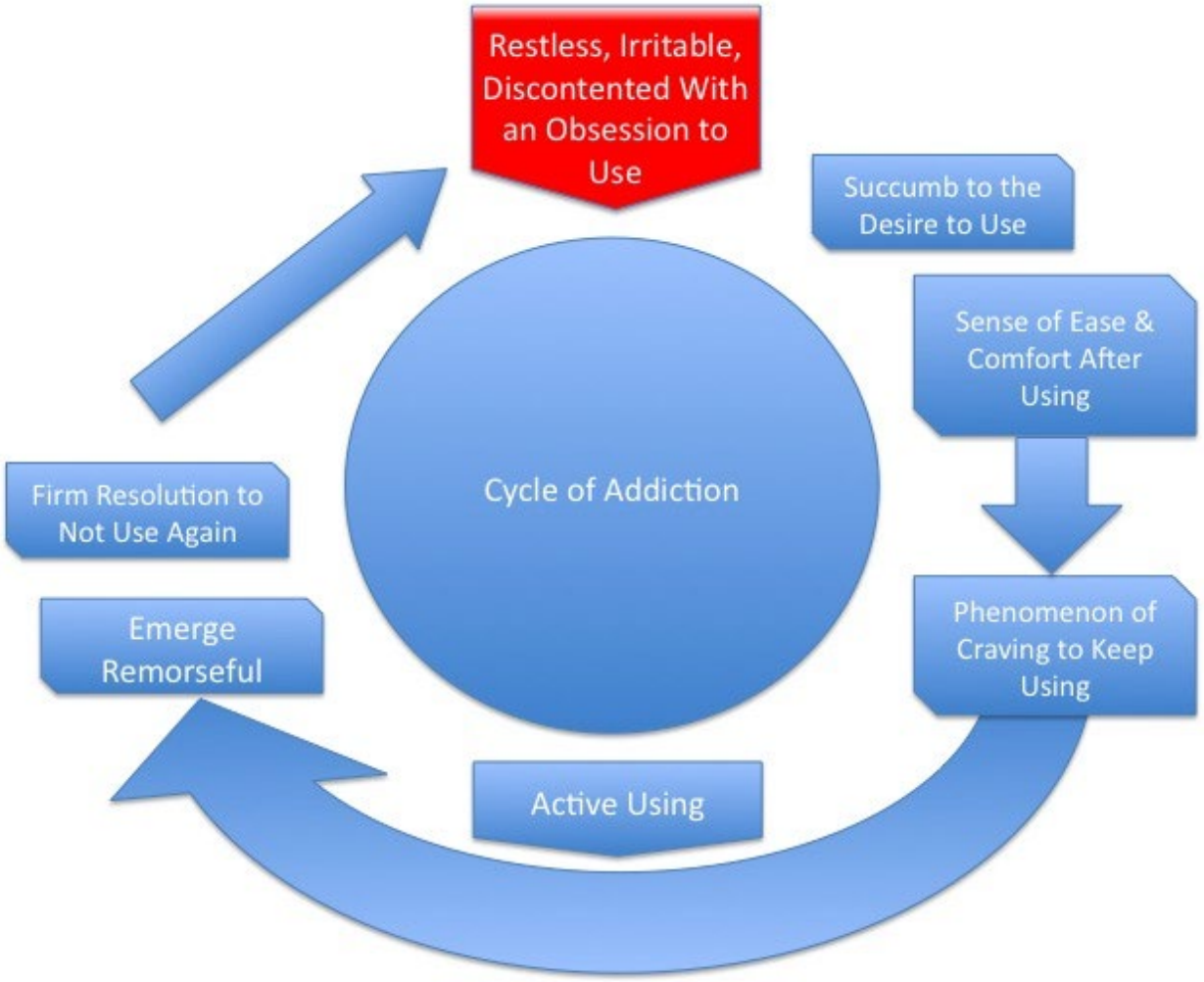
How can employers support employees with SUD?

- Reduce stigma and bias against substance use disorders and empower employees to seek help for themselves or a family member.
- Promote the availability of timely, accessible, relevant and engaging treatment options.
- Understand the power of language and modify to align with non-stigmatizing messaging, words matter.
- Examine culture as it relates to substance use as a norm of business or life stress relief. **Modify to infuse norms that improve health, wellness and accommodate an expanding workforce in remission from a SUD** (e.g., enable non-stigmatizing beverages at work events or host work events that do no revolve around alcohol).

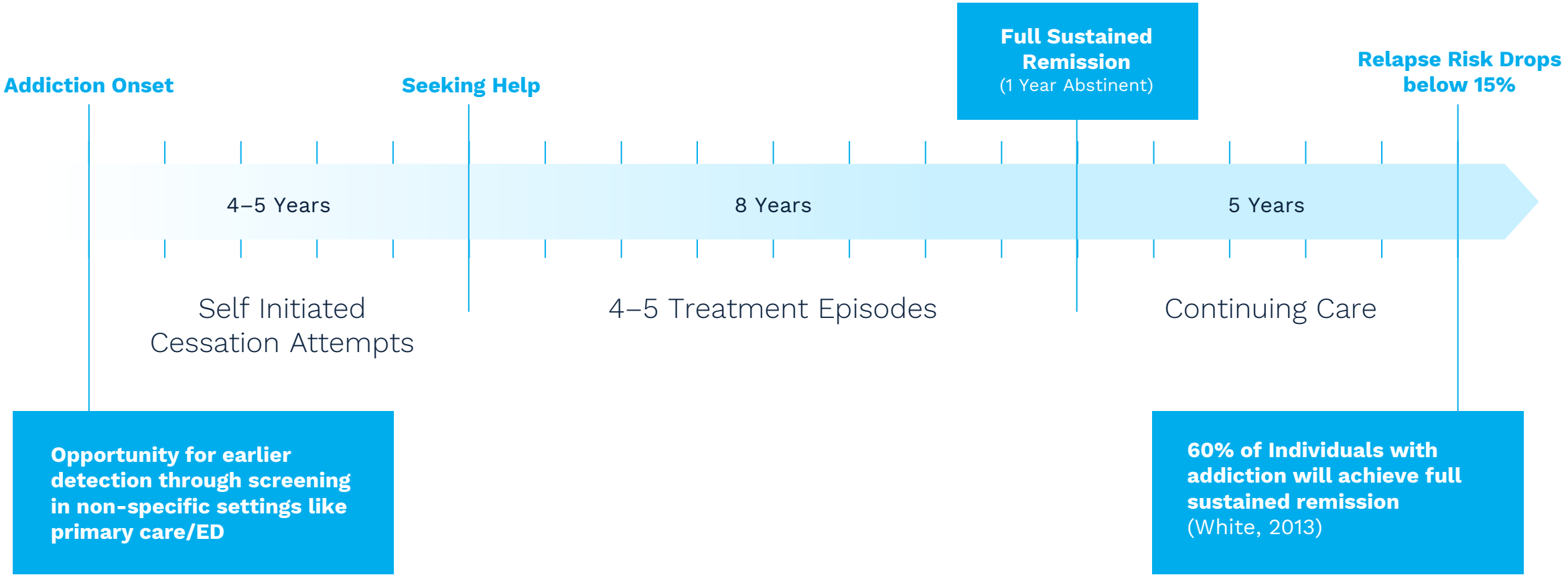
Resources for Employers

- "Changing the Narrative" Language Toolkit
- SAMHSA Employer Toolkits
- Peer Recovery Support in the Workplace Toolkit

SUD Cycle


Restless, Irritable, Discontented With an Obsession to Use
Succumb to the Desire to Use
Sense of Ease & Comfort After Using
Phenomenon of Craving to Keep Using
Active Using
Emerge Remorseful
Firm Resolution to Not Use Again
Cycle of Addiction

Substance Use Disorder Course of Recovery



https://www.recoveryanswers.org/media/addiction-course-of-recovery-timeline/

CA SB 221 – Patient follow up appt

- Existing California regulations require health plans to provide members access to an initial mental health or substance use disorder appointment no more than 10 days after requested.
- SB-221 further requires follow up appointments be offered no more than 10 days from the initial appointment. (July 2022)

https://geology.com/state-map/california.shtml

Access - Front End Processes and Patient Impact - Universal Truths

- The steps we take from first contact through the end of the 1st clinical encounter make or break a prospective patient's resolve to attend and return.
- No one aspires to attend an SUD evaluation or treatment.
- The many steps in the road to recovery are not palatable in the first contact or appointment.
- Rules and lists at initial points of contact are distracting from the intent of the contact.
- We rarely remember what we are asked in services access. We always remember how long we wait and if the people are nice.

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Desired Access Characteristics for Impact

- Real time, human answers first call for help, accepts walk-ins
- Multi-Cultural Competence, multi-lingual
- Clinical triage vs. financial
- Low (less than 3 days) or no wait times.
- Providing what is tolerable
- Availability to trouble shoot barriers- transportation, childcare, or medication assistance and technology
- MAT and Medication first processes.
- **Employers should look for these access characteristics in the SUD programs they purchase directly or indirectly.**

Current Evidence-Based Treatments

AUD

Assessment and treatment of withdrawal as medically indicate

FDA approved medications for the treatment of AUD

Cognitive behavioral treatments/motivational interviewing

Relapse prevention strategies that reduce stigma

JAMA. 2021;325(6):596. doi:10.1001/jama.2020.2012

OUD

Cognitive behavioral treatments/ motivational interviewing

Overdose prevention and medication first models

Relapse prevention strategies that reduce stigma

FDA approved medications that operate on the opioid receptors to relieve craving and preoccupation.

Publication No. PEP21-02-01-002 First released 2018. Revised 2019, 2020, and 2021

Stimulants

Motivational interviewing

Contingency management

Community reinforcement approach

Cognitive behavioral treatments

Publication No. PEP20-06-01-001

Environments of Care

Environments of Care	Level of Acuity
Digital (e.g., apps, nudges)	ASAM Level .5-2.1 (Early intervention – intensive outpatient)
Outpatient (in-person or virtual)	ASAM Level .5-1.0 (Early intervention - outpatient)
Intensive Outpatient (in-person or virtual)	ASAM Level 2.1
Short and Long-Term Residential Rehab (1-4 weeks to 18 months)	ASAM Level 3.1-3.3 (Residential services)
Clinically Managed Inpatient Care	ASAM Level 3.5 (Clinically Monitored/managed inpatient care)
Inpatient (e.g., detox)	ASAM Level 3.7-4.0 (Medically managed and monitored inpatient services)

Intensity of Service Across Continuum of Care

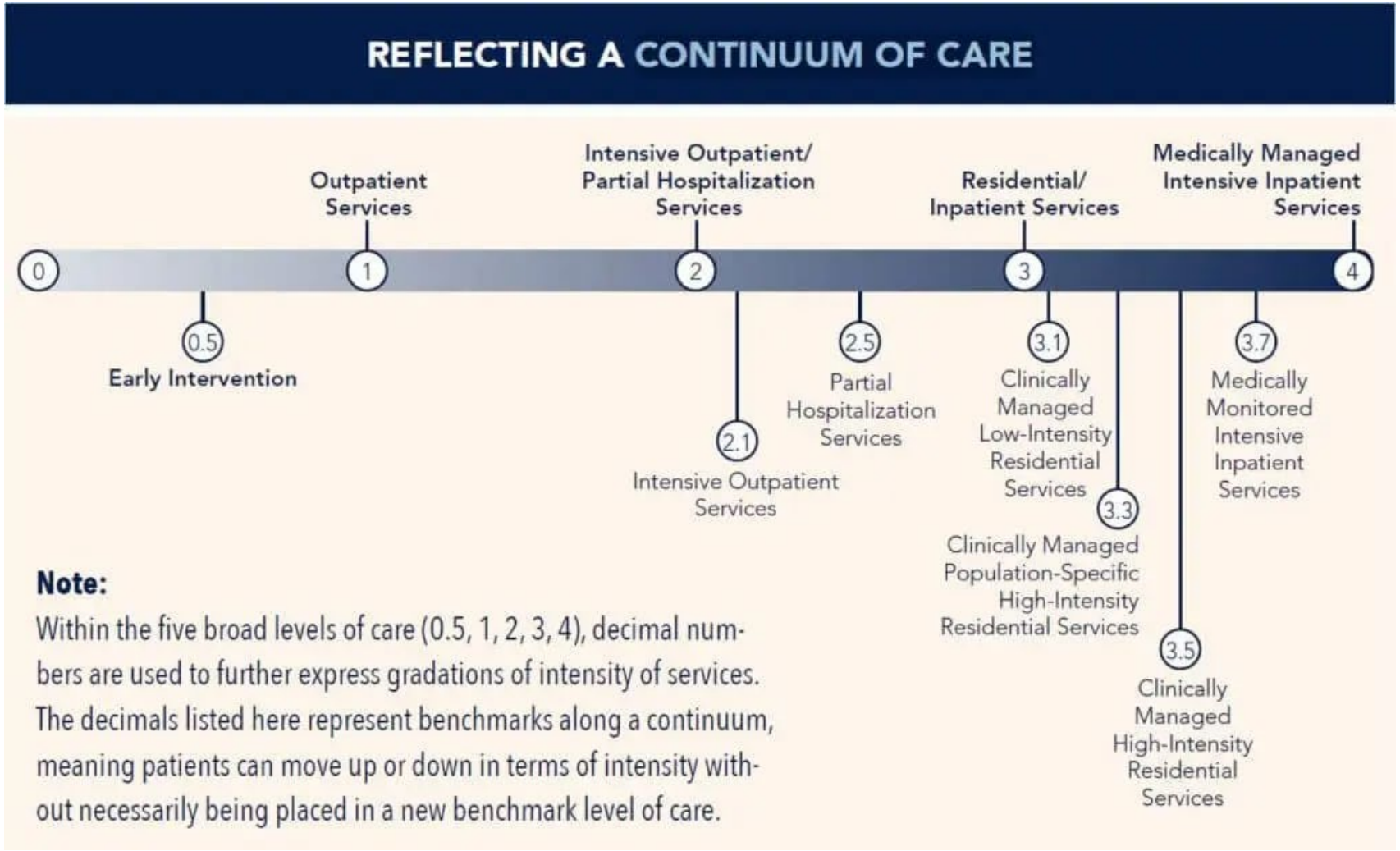

Image provided by ASAM

Level of Functioning, Intensity of Need

Criteria Dimensions	Severity Rating **LOW**	Severity Rating **MEDIUM**	Severity Rating **HIGH**
D1. Acute intoxication and/or withdrawal potential.			
D2. Biomedical conditions and complications.			
D3. Emotional, behavioral, or cognitive conditions and complications.			
D4. Readiness to change.			
D5. Relapse, continued use or continued problem potential.			
D6. Recovery environment.			

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The Rationale for Medications for Addiction Treatment

MAT as Standard of Care for Substance Use Disorder

- MAT is the integration of FDA approved medications to assist in stabilizing, treating and maintaining sustained remission from addiction disorders.
- Medications for Opioid Use Disorder (OUD) include Methadone, Buprenorphine and Naloxone/Vivitrol.
- Medications for Alcohol Use Disorder (AUD) include Naltrexone, Acamprosate and Disulfiram
- Methadone Maintenance (MMT) remains the most studied intervention for the treatment of opioid addiction.
- All FDA approved medications greatly improve mortality rates, treatment outcomes and sustained remission from opioid addiction and alcohol use disorder.

Goals of Recovery from a Substance Use Disorder

"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/#.V_knXvkrKCg

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What Employers Should Look for in a Substance Use Disorder Solution

High-Quality Substance Use Disorder Solutions

1. Use an evidence-based behavioral modification change approach (including medication assisted therapy) and engagement strategies.
2. Have a **welcoming** first contact and intake process designed to maximize engagement.
3. Provide timely access (**24 hours**) to first clinical appointment and have multiple referral channels for new clients
3. Directly address co-occurring mental health conditions.
4. Understand and strengthen client's environment and support system
5. Welcoming intake process and robust assessment with validated tools.

Think about key features

Substances treated (alcohol, opioids and/or stimulants*)

Continuum of care and **acuity**; high-quality **referrals** if acuity not addressed within the solution

Evidence-based **behavioral modification** approach

Medication Assisted Treatment (MAT) for alcohol and opioids

Treatment for **co-occurring mental health** conditions

Access: how **referred to the solution, intake** and **time to treatment**

Care coordination and integration with existing providers

Equitable access and culturally concordant care

Peer, family and community support

*Examples of stimulants are cocaine, methamphetamines, amphetamines, nicotine and ecstasy.

Key outcomes for selection and vendor reporting

Access

- Wait time for initial clinical appointment
- Patient experience of "getting treatment quickly"
- Intake conversion rate (=admissions/first contacts)

Engagement and Satisfaction

- Patient experience of overall rating of counseling and treatment
- Participants remain actively engaged at 30, 60, 90, and 180 days.
- For opioid use disorders: 30, 60, 90, 180 days of continuous medication for OUD

Patient Improvement

- Patient-perceived improvement (including functionality)
- Reductions in use (while understanding that relapses are to be expected)

Readmission rates or admissions to a higher level of care

Behavioral health improvement

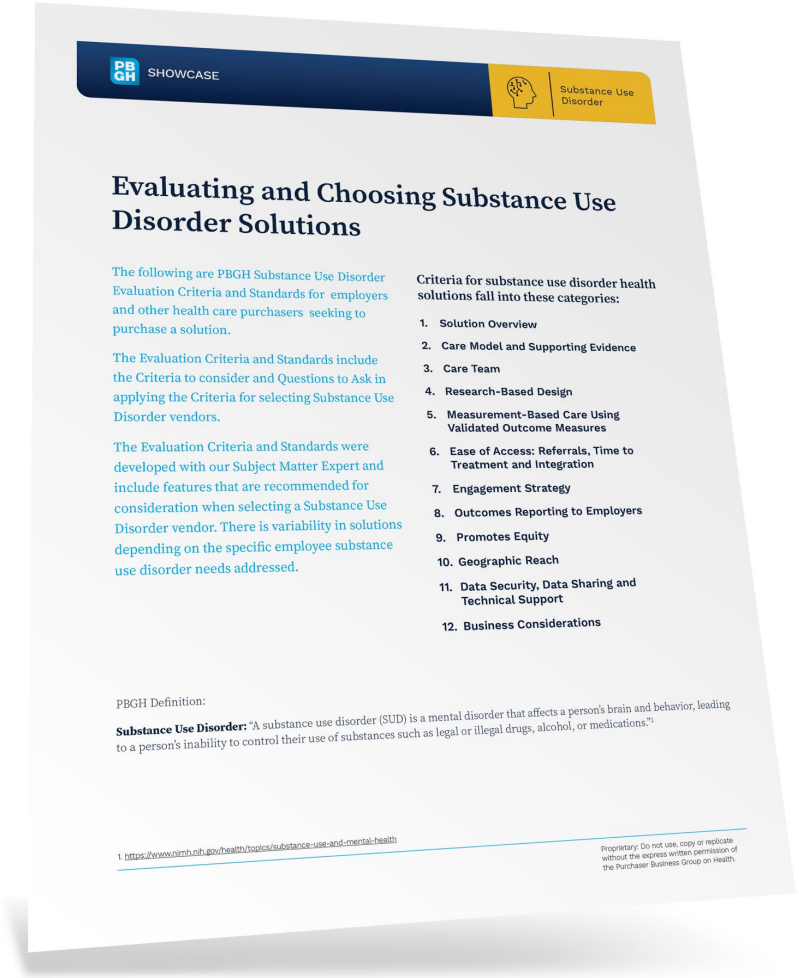
- PHQ-9 (depression)
- GAD-7 (anxiety)
- Basis 24

Behavioral health improvement

Joint Commission Accreditation for SUD or equivalent

Note: Specific measures and definitions can be found in the PBGH SUD evaluation criteria.

Use the PBGH Evaluation Criteria



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Appendix

Drug Use Among States

- Nearly 70% of law enforcement agencies in the western and midwestern areas of the United States view methamphetamine and fentanyl as the greatest threats to their populations.
- West Virginia has the nation's highest rate of overdose deaths at 51.5 deaths per 100,000 people.
- Delaware, with 43.8 deaths per 100,000 people.
- Maryland, with 37.2 deaths per 100,000 people.
- Pennsylvania, with 36.1 deaths per 100,000 people.
- Ohio, with 35.9 deaths per 100,000 people.

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Patient Assessment and Evaluation for Substance Use Disorders

- Patients requesting or are identified by the practice
- All drugs of use (long-acting verses short acting opioids, other drugs paying attention to alcohol, benzodiazepines)
  - Route of admin
  - Overdoses
  - Past treatment, pain management records
- Psychiatric history
  - ADHD, PTSD, bipolar disorder, hospitalizations, SI/SA
- Conduct a history and physical (or review if previously completed)
  - Birth control
  - PCP involvement (if in specialty setting)
  - Laboratory tests: LFTs, HIV, hepatitis, CMP, CBC, HCG if female pre-menopausal, UDS, others if indicated, i.e., TB, sexually transmitted diseases, etc. ETOH bio-markers as indicated.

Long-Term Patient Outcomes under MAT

- In a recent study of over 150,000 National Health Service patients treated for opioid dependence, followed for a total of 442,950 patient years, treatment of opioid dependence with buprenorphine was found to reduce risk for opioid overdose death by one half versus patients with no treatment or psychosocial treatment only. Importantly, survival benefit is not affected by cessation of injection drug use.
- In a study of 33,923 Medicaid patients diagnosed with opioid dependence in Massachusetts, mortality during the four-year study period (2003-2007) was double among patients receiving no treatment versus patients treated with buprenorphine. Additionally, patients treated with buprenorphine experienced a 75% reduced mortality versus patients treated with psychosocial interventions alone

Matthias Pierce et al., "Impact of Treatment for Opioid Dependence on Fatal Drug-Related Poisoning: A National Cohort Study in England," Addiction 111, no. 2 (January 14, 2016): 298-308, doi:10.1111/add.13193.

Robin E. Clark et al., "The Evidence Doesn't Justify Steps by State Medicaid Programs to Restrict Opioid Addiction Treatment with Buprenorphine," Health Affairs 30, no. 8 (2011): 1425-33, doi:10.1377/hlthaff.2010.0532

How Do We See This Revealed in Substance Use, Misuse and Dependence? Following 1 year of COVID-19 measures.

- In **adults** 30-59, men are reporting an increase of nearly 14% consumption and adult women an increase of 17%. In both cases this represents 1 more day per week of consumption over the average of 5.48 days per week for men and 4.58 days per week for women.

- For **adolescents**, the percentage of users has decreased during COVID-19, but the frequency of use for both cannabis and alcohol have increased for those already experimenting or using these substances.

- 49% of those using substances report using alone. Solitary use has increase substantially.
  - 31% report using with peers virtually on video-based apps and 26% report regular use with peers in face-to-face scenarios.

The Consequences of Drug Use

- In 2017, the cost of drug use in the US was nearly $272 billion, taking into account crime, healthcare needs, lost work productivity and other impacts on society.
- $193 billion was incurred in overall costs for illegal drugs in addition to $78.5 billion for prescription opioids.
- $11 billion was incurred in healthcare costs related to the use of illegal drugs and $26 billion for prescription opioids.
- 577,794 emergency room visits occurred for nonfatal drug poisonings or overdoses in 2016 with the most patients experiencing opioid poisoning. Increasing to over 800,00 visits in 2021.
- There are new psychoactive substances (NPS) entering the market every year. Between 2012 and 2016, the number of known psychoactive substances being sold increased from 269 to 479.
- Drug use often results in comorbidity- nearly 50% of persons who have substance use disorder also experience mental illness.

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Relapse Warning Signs

- Isolation
- Loss of interest in recovery activities and programs
- Developing a skeptical opinion of recovery and the potential for success in recovery
- Spending time with the people, places and things that were part of the substance use disorder
- Talking about one's ability to control and participate in that lifestyle without it becoming a problem again
- "Glorified" thinking
- Depression
- Changes in sleep and daily living patterns

What Does Treatment and Recovery Look Like?

- Matching patients to medically necessary treatment: balancing intensity and restrictiveness.
- Weighing the burden of treatment with the burden of the condition.
- Evidence based practices - modalities of care (peer reviewed consensus)
- Coordination of care, whole health care. Primary Care, specialists, family.
- Response monitoring (UDS, breathalyzer, diversion mitigation, show rates, retention over time, improved functionality)
- Integration of medications for addiction treatment - all FDA approved medication classes for the treatment of alcohol use disorder, and opioid use disorder.
- Rigorous process and outcome measurement/transparency

ASAM PPC - 2R What we will cover:

- What is “ASAM”? American Society of Addiction Medicine Standardized Patient Placement Criteria
- Review 6 dimensions/Low, Medium, High intensity
- Detox at what levels of care (LOC)?
- ASAM Patient Placement Criteria Crosswalk/LOC

ASAM PPC 2-R Dimensions & Focus

Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	Assessment for intoxication and/or withdrawal management. Detoxification in a variety of levels of care and preparation for continued addiction services
2. Biomedical Conditions and Complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services
3. Emotional, Behavioral or Cognitive Conditions and Complications	Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services
4. Readiness to Change Readiness to Change	Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change
5. Relapse, Continued Use or Continued Problem Potential	Assess readiness for relapse prevention services and teach where appropriate. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies.
6. Recovery Environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services

Detoxification Services

- ASAM PPC 2R identifies detoxification as an aspect of care in most levels of care.
  - Opioid Maintenance Therapy
  - Ambulatory Detoxification
  - Level II-D Ambulatory Detoxification with extended on-site monitoring. (23 hour-bed)
  - Social Detoxification-Medically monitored, nursing services available.
  - Medically Managed Intensive Inpatient Detoxification.

EBP's for SUD's: CBT Interventions- include Motivational Interviewing, Relapse Prevention and Contingency Management

Behavioral Interventions

- Identify triggers
- Make a behavioral plan
- Reward progress

Cognitive Interventions

- Recognize unhelpful thinking
- Invite gentle questioning
- Replace with helpful thinking

Courtesy of Martha Seabury, RN NCTTP

Behavioral Based Interventions: Parallels of Tobacco Tx. and other SUD's Tx.

Goal: Break the learned relationship between triggers and tobacco behavior.

- **Identify Triggers**
  - People, places, things, times of day, activities, emotional states, etc.

- **Make behavioral plans for triggering situations**
  - Distraction during craving
  - Replacement for hand/mouth
  - Delay decision to smoke
  - Deep breathing or visualization

- **Create incentives for not smoking**
  - Tracking money saved
  - Lists of reasons to quit; people who will be proud

Courtesy of Martha Seabury, RN NCTTP

Behavioral Plan

Coping Strategy	My Plan:
Replace behavior with:	Chew on toothpick, stress ball, doodle
Talk to or call:	Call my daughter, talk to wife, talk to coworker
Distract myself with:	Organize tools, work on puzzle, make to do list, walk around office
Use medication:	Use piece of gum
Change my mood by:	Play favorite music, watch funny video, look at pics of grandchildren
Delay smoking by:	Set timer for 15 mins
Food/Drink:	Have a glass of water and healthy snack
Exercise/Action:	Small walk, stretch, simple yoga poses
Write down reasons to quit:	List reasons to quit and who will be proud of me

Courtesy of Martha Seabury, RN NCTTP

Scripting for Improved Engagement

- Convey a genuine understanding of the employees' discomfort and distress.
- Convey an authentic, accessible plan for sustaining the relief/burden.
- How will I be Direct, Empathic and Hopeful?

MISTRUST OF PROVIDERS

- Mistrust of clinicians by minorities arises, in the broadest sense, from historical persecution and from present-day struggles with racism and discrimination. It also arises from documented misuse and perceived mistreatment, both in the past and more recently, by medical and mental health professionals. **Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General.**

- 43 percent of African Americans and 28 percent of Latinos, in comparison with 5 percent of whites, felt that a health care provider treated them badly because of their race or ethnic background. **Commonwealth Fund Minority Health Survey**

Neal-Barnett, A. M., & Smith, J. (1997) *Cultural issues in the treatment of anxiety* (pp. 154–174)., New York Guilford Press. [Reference list]
LaVeist, T. A., Diala, C., & Jarrett, N. C. (2000) *Minority health in America* (pp. 194–208)., Baltimore, MD. Johns Hopkins University Press.

Change Thinking to Cope with Craving

Thoughts about craving – or "self-statements" – are learned through experience and become patterned and automatic.

Examples:

"This anxiety is too much for me"

"I can't relax"

"I am so stressed and nothing but a cigarette will help"

Goals:

- Increase awareness of automatic thoughts
- Develop skills to manage the thoughts
- Practice new thoughts

Courtesy of Martha Seabury, RN NCTTP

Building Awareness: Labeling Internal Experience

- I am having the thought that …. smoking helps me relax
- I am having the feeling of …. craving, desire, agitation, irritability
- I am having the memory of …. how I feel after that first inhale
- I am feeling the bodily sensation of … restlessness, antsy
- I am noticing the tendency to … watch my coworker who smokes

Courtesy of Martha Seabury, RN NCTTP

Recognize and Replace

- **Recognize Tobacco Thought**: "Smoking helps me relax."
- **Replace**: "I do deserve to relax, but smoking is not the answer. If I smoke now I will just end up chasing the next cigarette and that is not very relaxing."
- **Coping Behavior**: "I am going to try one of the ideas from my behavioral plan like calling a friend."

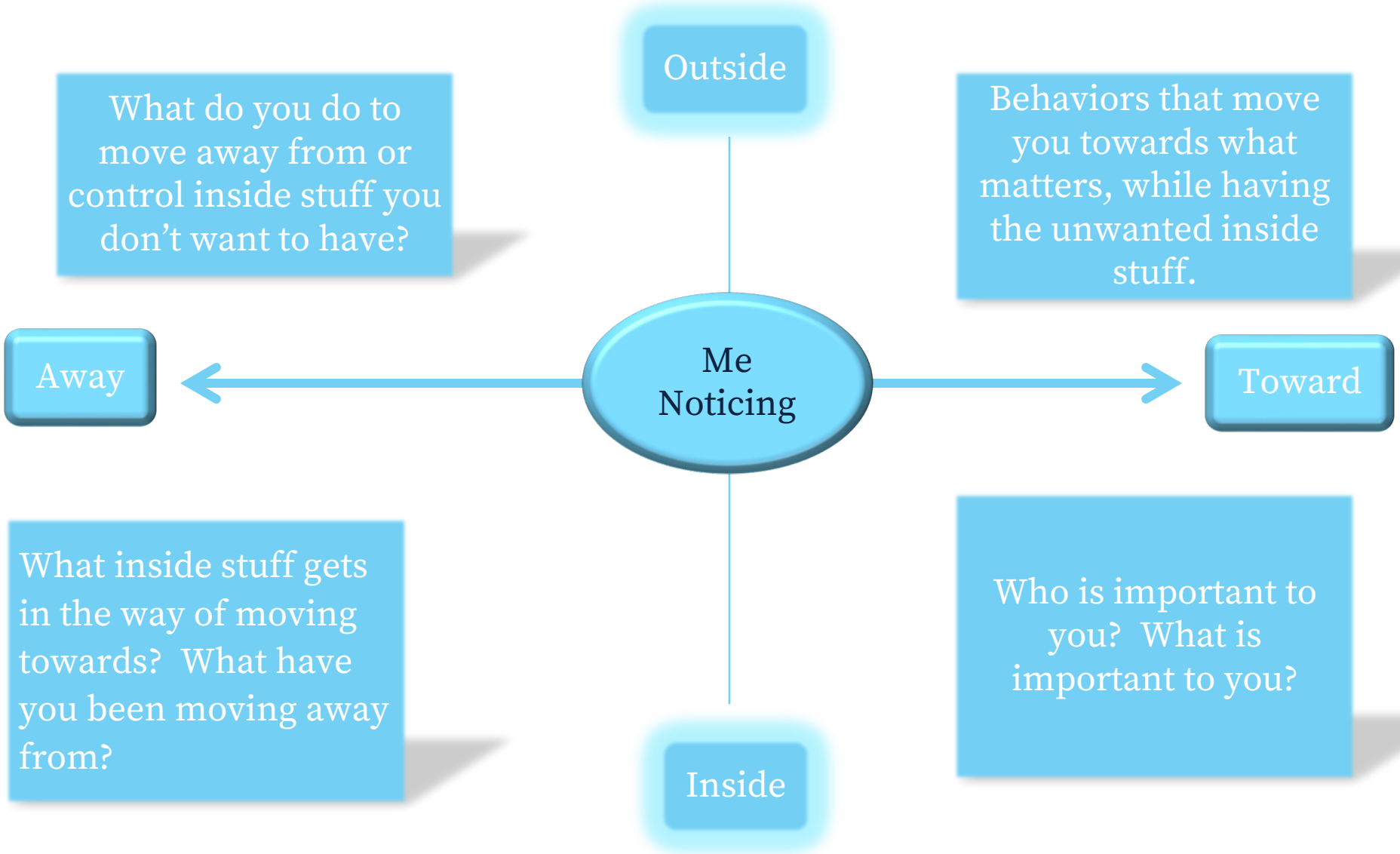
- **Recognize Tobacco Thought**: "I can't take the cravings."
- **Replace**: "I will do my best to take them one at a time and remember they will pass."
- **Coping Behavior**: "I am going to organize the hall closet to help me ride this out."

Courtesy of Martha Seabury, RN NCTTP

Acceptance and Commitment Therapy

- **Steven C. Hayes** developed Acceptance and Commitment Therapy in 1982 in order to create a mixed approach which integrates both cognitive and behavioral therapy. There are a variety of protocols for ACT, depending on the target behavior or setting.
- A form of mindfulness-based therapy, ACT looks at character traits and behaviors to assist in reducing avoidant coping styles. ACT also addresses commitment to making changes, and what to do when changes are not made.

Simple ACT Matrix



What percentage of drug users develop a SUD?

- Tobacco: 32%
- Heroin: 23%
- Cocaine17%
- Alcohol: 15%
- Marijuana: 9%

Institute of Medicine; National Academy of Science

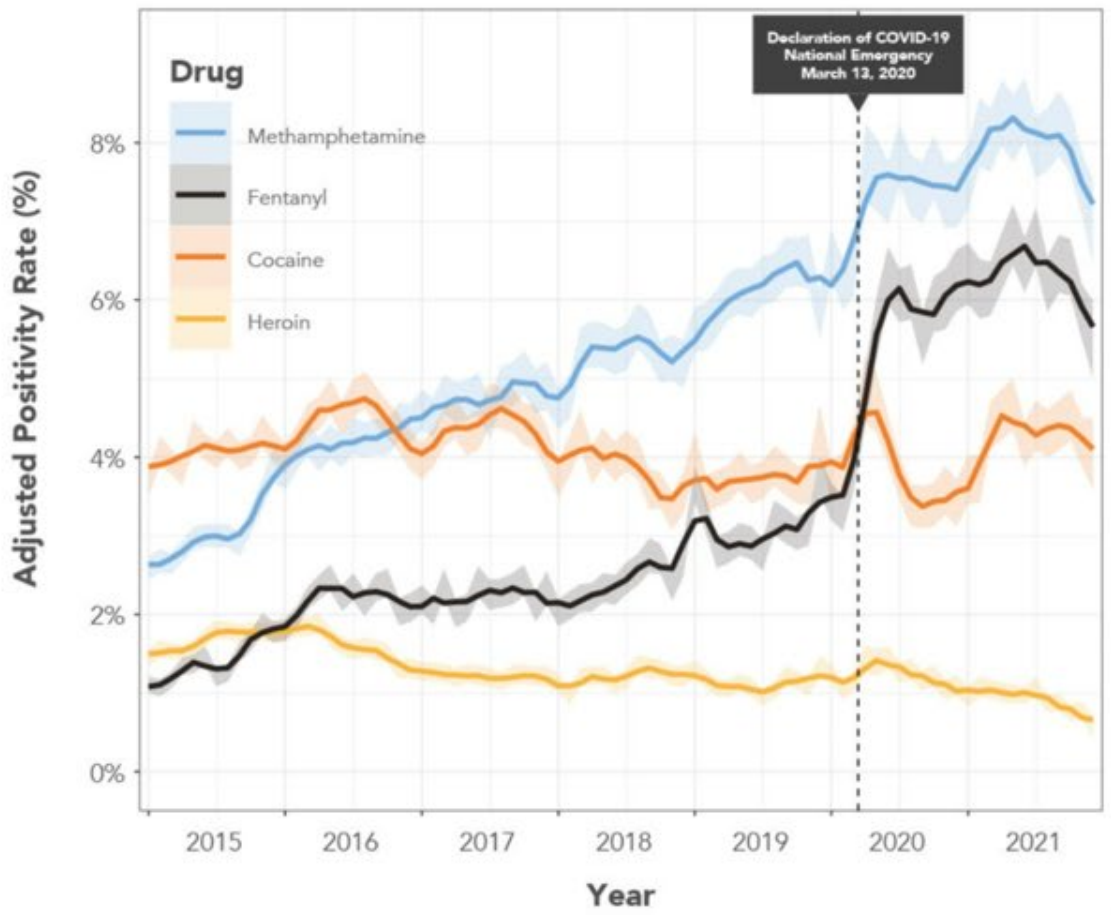
Principles of Harm Reduction

- Set of practical strategies and ideas aimed at reducing negative consequences associated with drug use
- Movement for social justice built on a belief in, and respect for, the rights of people who use drugs
- Incorporates spectrum of strategies from safer use, to managed use to abstinence to meet drug users "where they're at," addressing conditions of use along with use itself
- Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction

Examples of Strategies for Harm Reduction

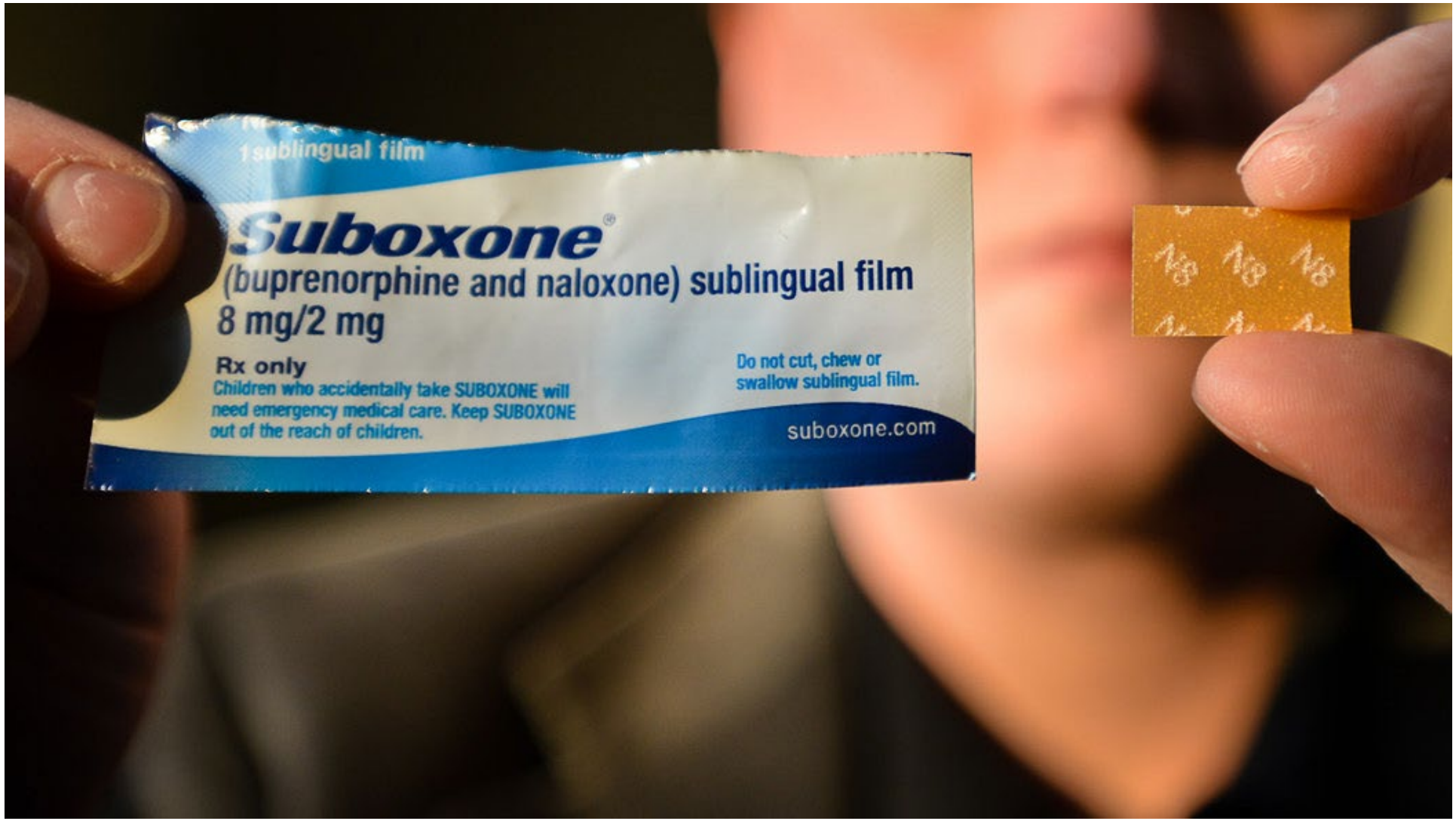
- Narcan and MAT availability (FDA Approved Medications that reduce overdose risk)
- Needle exchanges
- HIV/Hepatitis testing
- Reproductive planning
- Access to products for safer sex
- Primary, secondary prevention
- Universal SBIRT
- Low-Risk Drinking Guidelines

Urine Drug Test Positivity Rates



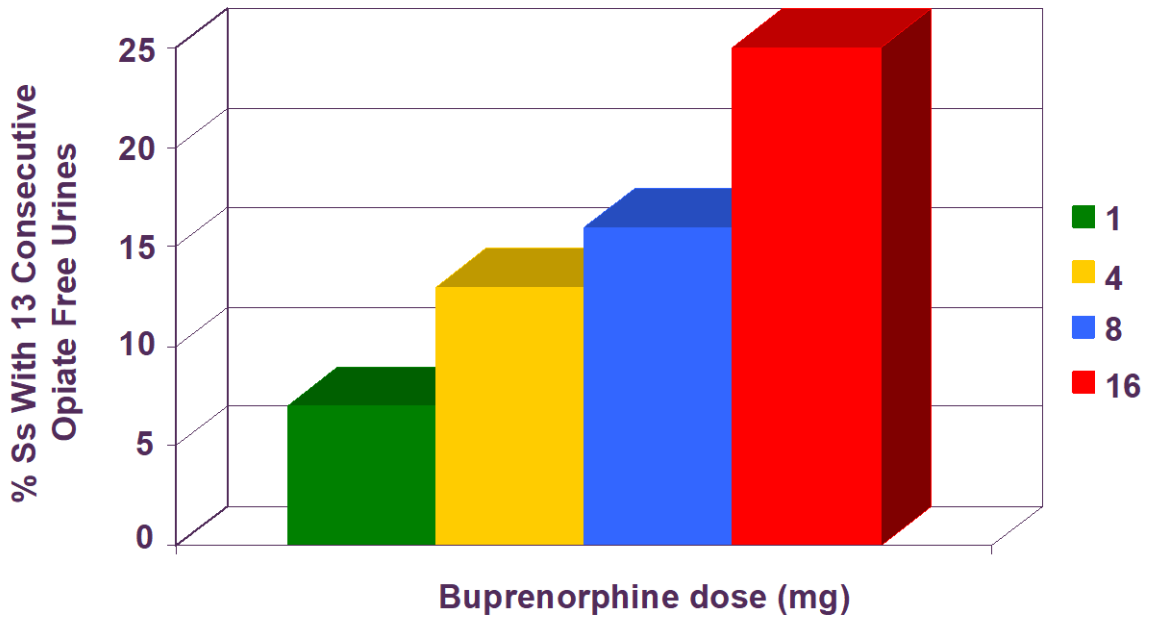
MILLENNIUM HEALTH

Suboxone: buprenorphine + naloxone



Opiate Use Decreases as Buprenorphine Dose Increases

Different Doses of Buprenorphine: Opiate Use Decreases with Increased Dose of Buprenorphine



(Ling et al., 1998)

PC MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

Naloxone (NARCAN)

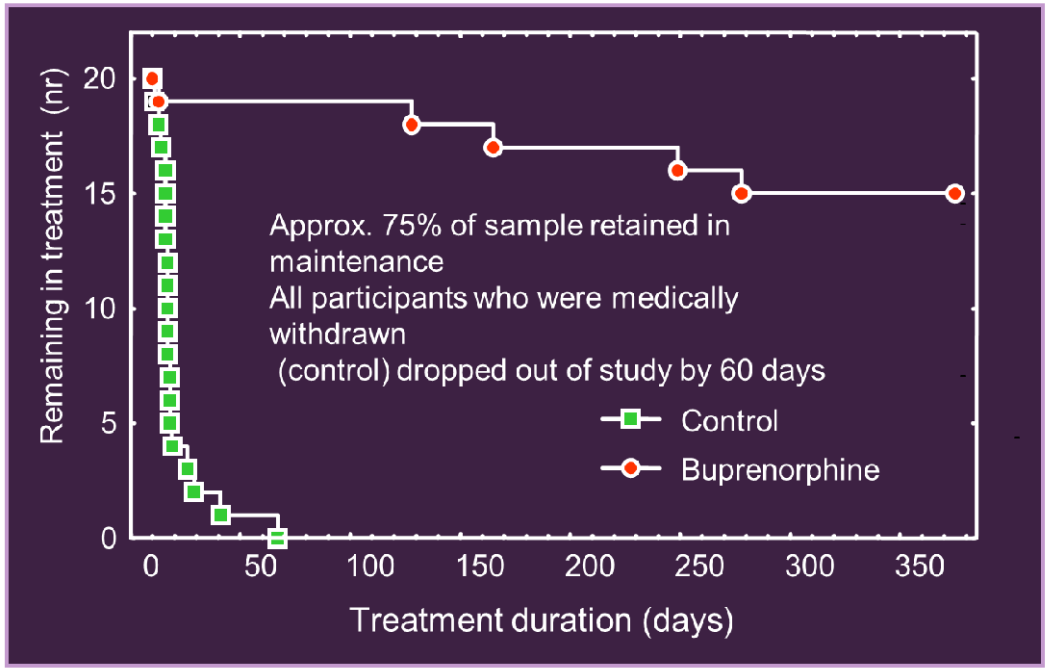
1. Saves Lives
2. Temporarily reverses the effects of opioids
3. No effect on people who are not using opioids
4. Can be administered by friends/family members/bystanders
5. Available through PCP office, walk in care, pharmacy (Rx not needed for many area pharmacies)
6. Where is the Naloxone kept in your place of business?

Antagonist Maintenance Treatment: Naltrexone/Vivitrol

- Patient must be free of all opioids including buprenorphine for 7-10 days
- Check LFTs before starting, and periodically thereafter
- Give PO x several days before starting IM to determine tolerability
- Side effects: nausea, sedation, dysphoria?

Maintenance is needed for success

Buprenorphine Maintenance/Withdrawal: Retention



(Kakko et al., 2003)

PCSS MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

20% of control group died

Summary of Evidence for MAT

Opioid-Abstinence Rates with Medication Compared to Nonmedication[a]			
Medication[b]	Percentage opioid free on medication	Percentage opioid free on placebo/detoxification	Study
Naltrexone ER	36	23	Krupitsky et al. (2011)[23]
Buprenorphine/naloxone	20–50	6	Fudala et al. (2003)[24] Weiss et al. (2011)[25,c]
Buprenorphine/naloxone	60	20	Woody et al. (2008)[26,d]
Methadone	60	30	Mattick et al. (2009)[27]

ER, extended release.

[a] The randomized, controlled clinical trials summarized here paired medication maintenance with evidence-based psychosocial treatments and opioid use self-report data that were confirmed with urine toxicology. Clinical settings for treatment delivery may affect the rates of opioid use in the nonmedication control groups. The trials predominantly used adult opioid use disorder populations, with the majority being heroin dependent or having mixed dependence on heroin and prescription opioids.

[b] All medications are FDA approved.

[c] Population was prescription opioid–dependent patients.

[d] Population was youth aged 14–21 years.

(Connery, Harvard Review of Psychiatry, 2015)

Comparison of MAT options

Table 1

Comparison of FDA-Approved Medications to Treat Opioid Use Disorder with Physiological Opioid Dependence

Medication	MOR intrinsic activity MOR binding	Differential pharmacology affecting MOR activation at therapeutic dose	Mechanism of relapse prevention
Buprenorphine	Partial agonist High affinity K_i* = 0.2 nM	Slow MOR dissociation allows thrice-weekly sublingual dosing and possibility of high-dose weekly formulations[13–15] Highest known MOR affinity makes rescue from overdose by naloxone less effective;[16] rapid precipitation of withdrawal if full agonists present	Reduces opioid craving, withdrawal, and stress reactivity Competitively blocks or reduces the reinforcing effects of other opioids
Methadone	Full agonist High affinity K_i* = 3.4 nM	Long terminal half-life (up to 120 hours) with delayed steady-state efficacy poses increased MOR toxicity risk during induction phase[17] Multiple drug-drug interactions pose both opioid-toxicity and withdrawal risks during treatment[18]	Reduces opioid craving, withdrawal, and stress reactivity Reduces the reinforcing effects of other opioids
Naltrexone ER	Antagonist High affinity $K_i^{\dagger}$ = 0.26–0.34 nM	Lack of MOR agonism associated with delayed stabilization of opioid craving[19] Safety concern based on rodent data demonstrating chronic naltrexone exposure increases respiratory-depression risk upon opioid agonist reexposure[20]	Competitively blocks reinforcing effects of opioid agonists Reductions in craving are psychologically mediated (reduced anticipatory expectancies)

(Connery, Harvard Review of Psychiatry, 2015)

Table 5.3A – Illicit Drug Use Disorder in Past Year: Among People Aged 12 or Older; by Age Group and Demographic Characteristics, Numbers in Thousands, 2019 and 2020

Demographic Characteristic	Aged 12+ (2019)	Aged 12+ (2020)	Aged 12-17 (2019)	Aged 12-17 (2020)	Aged 18+ (2019)	Aged 18+ (2020)	Aged 18-25 (2019)	Aged 18-25 (2020)	Aged 26+ (2019)	Aged 26+ (2020)
TOTAL	nc	18,394	nc	1,213	nc	17,181	nc	4,878	nc	12,304
GENDER										
Male	nc	10,315	nc	576	nc	9,739	nc	2,702	nc	7,037
Female	nc	8,080	nc	637	nc	7,442	nc	2,176	nc	5,266
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	nc	15,561	nc	884	nc	14,677	nc	4,112	nc	10,565
White	nc	11,913	nc	685	nc	11,228	nc	3,043	nc	8,185
Black or African American	nc	2,196	nc	94	nc	2,102	nc	676	nc	1,426
AIAN	nc	282	nc	*	nc	252	nc	*	nc	*
NHOPI	nc	13	nc	*	nc	9	nc	*	nc	*
Asian	nc	489	nc	27	nc	462	nc	126	nc	336
Two or More Races	nc	669	nc	44	nc	625	nc	231	nc	394
Hispanic or Latino	nc	2,833	nc	329	nc	2,504	nc	766	nc	1,738
EDUCATION LEVEL										
< High School	da	da	da	da	nc	2,000	nc	478	nc	1,522
High School Graduate	da	da	da	da	nc	4,798	nc	1,455	nc	3,343
Some College/Associate's Degree	da	da	da	da	nc	7,046	nc	2,262	nc	4,784
College Graduate	da	da	da	da	nc	3,336	nc	683	nc	2,654
EMPLOYMENT STATUS										
Full-Time	da	da	da	da	nc	7,680	nc	2,028	nc	5,652
Part-Time	da	da	da	da	nc	2,785	nc	1,237	nc	1,548
Unemployed	da	da	da	da	nc	1,893	nc	656	nc	1,237
Other[1]	da	da	da	da	nc	4,824	nc	957	nc	3,867

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Illicit drug use disorder (IDUD) estimates in 2020 are based on criteria from the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). IDUD and related estimates are not comparable between 2020 and prior years of NSDUH, because prior years' estimates were based on DSM-IV criteria. The 2020 estimates reflect additional methodological changes for the 2020 NSDUH. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details on these changes.
[1] Other Employment includes students, people keeping house or caring for children full time, retired or disabled people, or other people not in the labor force.
Definitions: Measures and terms are defined in Appendix A.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2019 and Quarters 1 and 4, 2020.

Table 5.4A – Alcohol Use Disorder in Past Year: Among People Aged 12 or Older; by Age Group and Demographic Characteristics, Numbers in Thousands, 2019 and 2020

Demographic Characteristic	Aged 12+ (2019)	Aged 12+ (2020)	Aged 12-17 (2019)	Aged 12-17 (2020)	Aged 18+ (2019)	Aged 18+ (2020)	Aged 18-25 (2019)	Aged 18-25 (2020)	Aged 26+ (2019)	Aged 26+ (2020)	Aged 12-20 (2019)	Aged 12-20 (2020)	Aged 21+ (2019)	Aged 21+ (2020)
TOTAL	nc	28,320	nc	712	nc	27,608	nc	5,215	nc	22,393	nc	1,826	nc	26,494
GENDER														
Male	nc	15,712	nc	290	nc	15,422	nc	2,443	nc	12,980	nc	794	nc	14,918
Female	nc	12,608	nc	422	nc	12,186	nc	2,772	nc	9,414	nc	1,032	nc	11,575
HISPANIC ORIGIN AND RACE														
Not Hispanic or Latino	nc	23,781	nc	433	nc	23,347	nc	4,210	nc	19,138	nc	1,339	nc	22,442
White	nc	18,317	nc	384	nc	17,933	nc	3,366	nc	14,567	nc	1,047	nc	17,270
Black or African American	nc	3,313	nc	19	nc	3,295	nc	444	nc	2,851	nc	128	nc	3,185
AIAN	nc	209	nc	*	nc	201	nc	*	nc	165	nc	*	nc	188
NHOPI	nc	48	nc	*	nc	46	nc	*	nc	*	nc	*	nc	43
Asian	nc	1,139	nc	9	nc	1,130	nc	181	nc	950	nc	73	nc	1,066
Two or More Races	nc	755	nc	13	nc	742	nc	180	nc	563	nc	66	nc	690
Hispanic or Latino	nc	4,539	nc	278	nc	4,261	nc	1,005	nc	3,256	nc	487	nc	4,052
EDUCATION LEVEL														
< High School	da	da	da	da	nc	2,876	nc	326	nc	2,550	da	da	nc	2,701
High School Graduate	da	da	da	da	nc	6,482	nc	1,192	nc	5,290	da	da	nc	6,185
Some College/Associate's Degree	da	da	da	da	nc	9,487	nc	2,554	nc	6,933	da	da	nc	8,845
College Graduate	da	da	da	da	nc	8,763	nc	1,143	nc	7,620	da	da	nc	8,762
EMPLOYMENT STATUS														
Full-Time	da	da	da	da	nc	15,675	nc	2,414	nc	13,261	da	da	nc	15,425
Part-Time	da	da	da	da	nc	3,809	nc	1,359	nc	2,451	da	da	nc	3,353
Unemployed	da	da	da	da	nc	1,630	nc	413	nc	1,217	da	da	nc	1,530
Other[1]	da	da	da	da	nc	6,494	nc	1,030	nc	5,464	da	da	nc	6,186

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Alcohol use disorder (AUD) estimates in 2020 are based on criteria from the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). AUD and related estimates are not comparable between 2020 and prior years of NSDUH, because prior years' estimates were based on DSM-IV criteria. The 2020 estimates reflect additional methodological changes for the 2020 NSDUH. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details on these changes.
[1] Other Employment includes students, people keeping house or caring for children full time, retired or disabled people, or other people not in the labor force.
Definitions: Measures and terms are defined in Appendix A.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2019 and Quarters 1 and 4, 2020.

Table 5.8A – Substance Use Disorder in Past Year: Among People Aged 12 or Older; by Age Group and Geographic and Socioeconomic Characteristics, Numbers in Thousands, 2019 and 2020

Geographic/Socioeconomic Characteristic	Aged 12+ (2019)	Aged 12+ (2020)	Aged 12-17 (2019)	Aged 12-17 (2020)	Aged 18+ (2019)	Aged 18+ (2020)	Aged 18-25 (2019)	Aged 18-25 (2020)	Aged 26+ (2019)	Aged 26+ (2020)
TOTAL	nc	40,263	nc	1,584	nc	38,679	nc	8,171	nc	30,508
GEOGRAPHIC REGION										
Northeast	nc	7,102	nc	273	nc	6,829	nc	1,453	nc	5,377
Midwest	nc	9,074	nc	322	nc	8,752	nc	1,890	nc	6,861
South	nc	12,985	nc	547	nc	12,438	nc	2,857	nc	9,581
West	nc	11,102	nc	443	nc	10,660	nc	1,972	nc	8,688
COUNTY TYPE										
Large Metro	nc	22,238	nc	845	nc	21,393	nc	4,315	nc	17,078
Small Metro	nc	12,791	nc	475	nc	12,317	nc	2,811	nc	9,506
Nonmetro	nc	5,234	nc	265	nc	4,969	nc	1,046	nc	3,923
Urbanized	nc	2,318	nc	93	nc	2,225	nc	471	nc	1,754
Less Urbanized	nc	2,572	nc	162	nc	2,410	nc	517	nc	1,892
Completely Rural	nc	344	nc	10	nc	334	nc	58	nc	276
POVERTY LEVEL[1]										
Less Than 100%	nc	6,850	nc	328	nc	6,522	nc	1,972	nc	4,550
100-199%	nc	7,741	nc	280	nc	7,461	nc	1,913	nc	5,547
200% or More	nc	25,579	nc	976	nc	24,604	nc	4,194	nc	20,410
HEALTH INSURANCE[2]										
Private	nc	24,048	nc	890	nc	23,158	nc	5,300	nc	17,858
Medicaid/CHIP	nc	8,721	nc	544	nc	8,177	nc	1,546	nc	6,630
Other[3]	nc	7,382	nc	90	nc	7,292	nc	571	nc	6,721
No Coverage	nc	5,425	nc	125	nc	5,300	nc	1,140	nc	4,160

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Substance use disorder (SUD) estimates in 2020 are based on criteria from the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). SUD and related estimates are not comparable between 2020 and prior years of NSDUH, because prior years' estimates were based on DSM-IV criteria. The 2020 estimates reflect additional methodological changes for the 2020 NSDUH. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details on these changes.
[1] Respondents aged 18 to 22 who were living in a college dormitory were excluded.
[2] Respondents could indicate multiple types of health insurance; thus, these response categories are not mutually exclusive.
[3] Other Health Insurance is defined as having Medicare, military-related health care, or any other type of health insurance.
Definitions: Measures and terms are defined in Appendix A.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2019 and Quarters 1 and 4, 2020.

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Table 5.8B – Substance Use Disorder in Past Year: Among People Aged 12 or Older; by Age Group and Geographic and Socioeconomic Characteristics, Percentages, 2019 and 2020

Geographic/Socioeconomic Characteristic	Aged 12+ (2019)	Aged 12+ (2020)	Aged 12-17 (2019)	Aged 12-17 (2020)	Aged 18+ (2019)	Aged 18+ (2020)	Aged 18-25 (2019)	Aged 18-25 (2020)	Aged 26+ (2019)	Aged 26+ (2020)
TOTAL	nc	14.5	nc	6.3	nc	15.4	nc	24.4	nc	14.0
GEOGRAPHIC REGION										
Northeast	nc	14.9	nc	6.9	nc	15.6	nc	25.6	nc	14.1
Midwest	nc	15.8	nc	6.1	nc	16.8	nc	26.7	nc	15.2
South	nc	12.3	nc	5.6	nc	13.0	nc	22.5	nc	11.5
West	nc	16.8	nc	7.3	nc	17.8	nc	24.6	nc	16.7
COUNTY TYPE										
Large Metro	nc	14.7	nc	6.0	nc	15.6	nc	24.3	nc	14.3
Small Metro	nc	15.1	nc	6.2	nc	16.0	nc	25.5	nc	14.4
Nonmetro	nc	12.7	nc	8.3	nc	13.0	nc	21.9	nc	11.8
Urbanized	nc	14.0	nc	7.0	nc	14.7	nc	21.4	nc	13.5
Less Urbanized	nc	13.0	nc	10.0	nc	13.3	nc	23.3	nc	11.9
Completely Rural	nc	6.8	nc	3.8	nc	6.9	nc	16.3	nc	6.2
POVERTY LEVEL[1]										
Less Than 100%	nc	16.3	nc	7.1	nc	17.5	nc	24.2	nc	15.6
100-199%	nc	15.3	nc	6.2	nc	16.2	nc	24.8	nc	14.5
200% or More	nc	13.9	nc	6.1	nc	14.6	nc	24.3	nc	13.5
HEALTH INSURANCE[2]										
Private	nc	13.8	nc	5.9	nc	14.6	nc	27.1	nc	12.8
Medicaid/CHIP	nc	17.9	nc	6.5	nc	20.3	nc	19.8	nc	20.4
Other[3]	nc	9.7	nc	5.4	nc	9.8	nc	23.5	nc	9.3
No Coverage	nc	19.1	nc	8.5	nc	19.6	nc	21.7	nc	19.1

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Substance use disorder (SUD) estimates in 2020 are based on criteria from the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). SUD and related estimates are not comparable between 2020 and prior years of NSDUH, because prior years' estimates were based on DSM-IV criteria. The 2020 estimates reflect additional methodological changes for the 2020 NSDUH. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details on these changes.
[1] Respondents aged 18 to 22 who were living in a college dormitory were excluded.
[2] Respondents could indicate multiple types of health insurance; thus, these response categories are not mutually exclusive.
[3] Other Health Insurance is defined as having Medicare, military-related health care, or any other type of health insurance.
Definitions: Measures and terms are defined in Appendix A.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2019 and Quarters 1 and 4, 2020.

210615

Table 5.9B – Received Substance Use Treatment in Past Year: Among People Aged 12 or Older; by Detailed Age Category, Percentages, 2019 and 2020

Age Category	Illicit Drugs (2019)	Illicit Drugs (2020)	Alcohol (2019)	Alcohol (2020)	Both Illicit Drugs and Alcohol (2019)	Both Illicit Drugs and Alcohol (2020)	Illicit Drugs or Alcohol[1] (2019)	Illicit Drugs or Alcohol[1] (2020)
TOTAL	0.8	*0.9*	0.9	*0.7*	0.4	*0.3*	1.5	*1.4*
12-20	0.7	*0.6*	0.5	*0.4*	0.4	*0.3*	0.9	*0.8*
21 or Older	0.9	*0.9*	1.0	*0.8*	0.4	*0.3*	1.6	*1.6*
12-17	0.5	*0.4*	0.3	*0.4*	0.2	*0.2*	0.7	*0.7*
12-13	0.1	*0.1*	0.1	*0.1*	0.1	*0.1*	0.3	*0.1*
14-15	0.4	*0.3*	0.2	*0.2*	0.2	*0.1*	0.6	*0.5*
16-17	0.9	*0.9*	0.5	*0.8*	0.5	*0.4*	1.2	*1.4*
18 or Older	0.9	*0.9*	1.0	*0.8*	0.4	*0.3*	1.6	*1.5*
18-25	1.1	*0.8*	1.0	*0.9*	0.6	*0.5*	1.7	*1.3*
18-20	1.1	*0.8*	0.8	*0.5*	0.6	*0.5*	1.4	*1.0*
21-25	1.1	*0.8*	1.1	*1.1*	0.6	*0.5*	1.9	*1.5*
26 or Older	0.8	*0.9*	1.0	*0.8*	0.4	*0.3*	1.6	*1.6*
26-49	1.4	*1.4*	1.3	*1.0*	0.6	*0.5*	2.2	*2.1*
26-29	1.4	*1.1*	1.3	*0.8*	0.7	*0.4*	2.2	*1.5*
30-34	1.8	*1.7*	1.5	*1.0*	0.6	*0.5*	2.9	*2.4*
35-39	1.3	*1.7*	1.2	*1.1*	0.6	*0.3*	2.1	*2.8*
40-44	1.5	*1.1*	1.2	*1.1*	0.7	*0.6*	2.1	*1.6*
45-49	0.8	*1.5*	1.2	*0.9*	0.5	*0.5*	1.7	*1.9*
50 or Older	0.4	*0.5*	0.7	*0.5*	0.2	*0.2*	1.0	*1.1*
50-54	0.6	*1.0*	1.0	*1.0*	0.4	*0.6*	1.5	*1.4*
55-59	0.7	*1.4*	1.2	*0.4*	0.4	*0.0*	1.6	*2.1*
60-64	0.4	*0.5*	0.9	*0.6*	0.2	*0.2*	1.2	*1.3*
65 or Older	0.1	*0.0*	0.3	*0.4*	0.1	*0.0*	0.5	*0.4*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Received Substance Use Treatment includes treatment received at any location, such as a hospital (inpatient), rehabilitation facility (inpatient or outpatient), mental health center, emergency room, private doctor's office, self-help group, or prison/jail.
[1] Estimates include people who received treatment specifically for illicit drugs or alcohol, as well as people who received treatment for unspecified substance(s).
Definitions: Measures and terms are defined in Appendix A.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2019 and Quarters 1 and 4, 2020.

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Table 5.42B – Received Substance Use Treatment in Past Year: Among People Aged 12 or Older; by Age Group and Demographic Characteristics, Percentages, 2019 and 2020

Demographic Characteristic	Aged 12+ (2019)	Aged 12+ (2020)	Aged 12-17 (2019)	Aged 12-17 (2020)	Aged 18+ (2019)	Aged 18+ (2020)	Aged 18-25 (2019)	Aged 18-25 (2020)	Aged 26+ (2019)	Aged 26+ (2020)
TOTAL	1.5	*1.4*	0.7	*0.7*	1.6	*1.5*	1.7	*1.3*	1.6	*1.6*
GENDER										
Male	2.0	*1.6*	0.9	*0.7*	2.1	*1.6*	2.0	*1.3*	2.1	*1.7*
Female	1.1	*1.3*	0.5	*0.6*	1.1	*1.4*	1.4	*1.3*	1.1	*1.4*
HISPANIC ORIGIN AND RACE										
Not Hispanic or Latino	1.6	*1.5*	0.6	*0.5*	1.7	*1.6*	1.8	*1.5*	1.7	*1.6*
White	1.7	*1.6*	0.7	*0.6*	1.8	*1.7*	2.0	*1.7*	1.8	*1.6*
Black or African American	1.5	*1.0*	0.5	*0.4*	1.6	*1.1*	1.3	*1.2*	1.6	*1.1*
AIAN	1.9	*7.2*	1.7	*	1.9	*8.3*	1.4	*	2.0	*9.5*
NHOPI	4.8	*	*	*	5.1	*	*	*	6.0	*
Asian	0.3	*0.1*	0.2	*0.2*	0.3	*0.1*	1.0	*0.0*	0.1	*0.1*
Two or More Races	3.2	*5.5*	0.6	*0.4*	3.7	*6.2*	2.4	*2.7*	4.1	*
Hispanic or Latino	1.1	*1.1*	0.9	*1.2*	1.1	*1.1*	1.4	*0.7*	1.0	*1.1*
EDUCATION LEVEL										
< High School	da	*da*	da	*da*	2.4	*1.8*	2.9	*0.9*	2.3	*1.9*
High School Graduate	da	*da*	da	*da*	2.0	*1.8*	1.9	*1.5*	2.0	*1.9*
Some College/Associate's Degree	da	*da*	da	*da*	1.8	*1.9*	1.4	*1.4*	1.8	*2.1*
College Graduate	da	*da*	da	*da*	0.9	*0.8*	1.0	*	0.9	*0.7*
EMPLOYMENT STATUS										
Full-Time	da	*da*	da	*da*	1.3	*1.2*	1.7	*1.4*	1.3	*1.2*
Part-Time	da	*da*	da	*da*	1.3	*2.0*	1.1	*1.3*	1.4	*2.2*
Unemployed	da	*da*	da	*da*	6.2	*2.8*	3.2	*2.0*	7.7	*3.1*
Other[1]	da	*da*	da	*da*	1.6	*1.6*	1.7	*0.9*	1.6	*1.7*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Received Substance Use Treatment includes treatment received at any location, such as a hospital (inpatient), rehabilitation facility (inpatient or outpatient), mental health center, emergency room, private doctor's office, self-help group, or prison/jail. Estimates include people who received treatment specifically for illicit drugs or alcohol, as well as people who received treatment for unspecified substance(s).
[1] Other Employment includes students, people keeping house or caring for children full time, retired or disabled people, or other people not in the labor force.
Definitions: Measures and terms are defined in Appendix A.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2019 and Quarters 1 and 4, 2020.

Table 5.17A – Locations of Substance Use Treatment in Past Year: Among People Aged 12 or Older Who Received Substance Use Treatment in Past Year; by Age Group, Numbers in Thousands, 2019 and 2020

Location of Treatment[1]	Aged 12+ (2019)	Aged 12+ (2020)	Aged 12-17 (2019)	Aged 12-17 (2020)	Aged 18+ (2019)	Aged 18+ (2020)	Aged 18-25 (2019)	Aged 18-25 (2020)	Aged 26+ (2019)	Aged 26+ (2020)
TOTAL POPULATION	4,184	*4,009*	172	*	4,012	*3,840*	578	*	3,434	*3,395*
Hospital - Inpatient	642	*801*	31	*	611	*767*	101	*	510	*668*
Rehabilitation Facility - Inpatient	1,004	*1,101*	46	*	958	*1,065*	147	*	812	*913*
Rehabilitation Facility - Outpatient	1,747	*1,788*	*	*	1,717	*1,744*	210	*	1,507	*1,602*
Mental Health Center - Outpatient	1,320	*1,422*	37	*	1,283	*1,403*	170	*	1,113	*1,266*
Emergency Room	514	*732*	19	*	495	*707*	81	*	413	*623*
Private Doctor's Office	948	*1,053*	20	*	928	*1,017*	115	*	813	*965*
Self-Help Group	2,065	*1,843*	*	*	2,031	*1,801*	243	*	1,788	*1,587*
Prison/Jail	254	*181*	16	*	238	*179*	59	*	179	*163*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Received Substance Use Treatment includes treatment received at any location, such as a hospital (inpatient), rehabilitation facility (inpatient or outpatient), mental health center, emergency room, private doctor's office, self-help group, or prison/jail.
[1] Respondents could indicate multiple locations for receiving substance use treatment; thus, these response categories are not mutually exclusive. Questions on virtual substance use treatment were added in Quarter 4 of 2020. Virtual substance use treatment is not included as a separate treatment location in this table. Data on virtual substance use treatment are included at the end of this section. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
Definitions: Measures and terms are defined in Appendix A.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2019 and Quarters 1 and 4, 2020.

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