WEBINAR VIDEO TRANSCRIPT

Opioid Addiction Treatment ECHO

Overview of opioid use disorder (OUD)

28 July 2017

BRANT: Thanks, Adam. This is just an opioid addiction treatment 101 so this is introduction to opioid use disorder. This will be review for most of you and so I'd like, if you could, for you just to bring up questions or comments all throughout the presentation to try to make it as interactive as possible. I don't have any disclosures and what we're gonna do basically is define opioids, we're gonna review opioid intoxication, understand a little bit of the parameters of the opioid epidemic, we'll learn about some harms from opioids, we'll review the criteria for opioid use disorder, and we'll understand the role of primary care teams in addressing opioid use disorder, and then lastly we'll spend a little bit of time confronting stigma.

So basically, opioids refers to agents that bind to the body's opioid receptors. There's three opioid types of receptors in the body that have various effects. The natural opioids are derived from the opioid poppy include morphine and codeine and opium. Hydrocodone will also be metabolized into opiate metabolites. And there are synthetic, either partially or completely synthetic, and these are called opioids. So opioids is the blanket term that includes natural and synthetic members of the drug class. So the opioids, or the semisynthetic ones or the fully synthetic ones that you can see listed here.

Now all of these medications have a potential for causing an addiction. They also have these common effects that can be quite useful. For example, pain relief like post-surgically or during surgery, cough suppression, constipation, sedation. These ones are not so useful effects, respiratory suppression, respiration arrest and death. These are some of the things that end up causing accidental overdose deaths. So here is our splash screen of what's an opioid and what's not an opioid.

So a sort of thumbs up kind of thing if it's an opioid. So tramadol: opioid or not an opioid? Thumbs up. Thumbs down. Thumbs up. There's another thumbs down. So technically speaking, tramadol is an opioid because it acts on the opioid receptors. It is an opioid receptor partial agonist. So you would still call it an opioid since it's an interaction with opioid receptors. Let's see here. Methamphetamine: opioid, not opioid? Ah, thumbs down. Thumbs down, yes. This feels like a gladiatorial match where you're like thumbs up or thumbs down. This is good. Okay, methamphetamine. Not an opioid. Uh, let's see. Percocet, how about that one? Opioid, not an opioid? Thumbs up. Some very enthusiastic thumbs up. There's some percocet lovers out there. Mushrooms: opioids, not opioids? Yeah, negative. Right. You all pretty clearly recognize the opioids versus not opioids.

So they're very effective for acute pain so they're great for inducing anesthesia, for maintaining anesthesia, for pain management after an acute injury while healing is taking place. You want to ensure functionality, respiratory functionality or functionality of the body area that was operated on. They're

pretty limited in their effectiveness for chronic pain conditions. The absolute drop in sort of the pain amounts with the chronic opioid for many chronic pain conditions is very, very, very, very modest. And then there doesn't seem to be much of an improvement in functionality. So judicious use of opioids in an acute setting is a really helpful thing. Interestingly, when we look at sort of more long-term treatments, what we find is that healthcare personnel who are of a different cultural, racial background than their patients consistently underrate those patients' pain experiences versus subjective experiences whereas when the cultural and racial orientation are in alignment, there is more accurate representation. And so this is an important part of opioid prescribing and treatment of pain is to keep in mind that cultural barriers can create barriers in communication, accurate reception of communication, about pain.

So opioid intoxication. What does somebody look like when they are intoxicated with opioids? Just go ahead and unmute and speak up. What does somebody look like when they're intoxicated? Whoa, whoa, whoa. Oh Scott, we're catching a lot of background noise there. Go ahead, Casey.

CASEY: I'd say they look very sleepy. They have very small pupils. I've seen people like start nodding out or they're trying to keep awake kind of thing.

BRANT: Yep, yep, yep. They're nodding. It's the nodding. We'll take charades as well. Anybody else? Any other experiences with people who are intoxicated with opioids?

AUDIENCE MEMBER: Well respiratory depression, of course.

BRANT: Right, they may stop breathing.

AUDIENCE MEMBER: They're very slow and shallow.

BRANT: Yeah, they may even start to look acyanotic or blue.

AUDIENCE MEMBER: Right.

BRANT: Yeah. Yep. And then sometimes you see people when they are intoxicated on opioids, they get euphoric. We did a suboxone induction on a patient in our clinic this past week and the patient took their first dose of suboxone and started singing I am woman, hear me roar. We guessed that this is

probably an adequate dose of suboxone for this patient and that she probably was not taking as much opioids outside the clinic as she was reporting. Alright, yeah. So drowsiness, slow speech, confusion, so this euphoric high, and then pinpoint pupils. Okay, what major problems do opioids cause? Anybody? Just go ahead and unmute and speak to the major problems.

AUDIENCE MEMBER: Constipation is a big one. Huge.

BRANT: Yes, and it gets bigger with time.

AUDIENCE MEMBER: Yes, it does.

BRANT: Who else?

AUDIENCE MEMBER: Physical dependence and tolerance.

BRANT: Yep, yep. Tolerance and withdrawal, so what they call physical dependence. Casey?

CASEY: A decreased ability to tolerate pain so there's this strong drive, that craving that they have to get it, and if they're in pain, it's even stronger.

BRANT: Sure, yeah so pain can interact with the withdrawal symptoms to drive their craving or drive their use and there is such a thing as opioid induced hyperalgia so where their pain gets worse over time despite escalating doses of opioids. What else? What other problems do opioids cause? Go ahead, Merviana.

MERVIANA: Eventual loss of jobs.

BRANT: Yeah, as people start to replace their normal activities with activities that are necessary for them to acquire, use, and recover for the substance. And so this could not only be a reduction of their social behaviors but an introduction of some behaviors that could be potentially harmful for them. For example, theft or sex work in order to support the opioid use habit. Other harms, major problems?

CASEY: I've seen people, or at least they've talked about increase in mental health symptoms or anxiety depression or because of how they get their opioid that they're going out and putting themselves in situations that may lead to traumatic situations or consequences.

BRANT: Yeah, use in dangerous situations or yeah. Use around dangerous situations. So obviously the worst outcome is overdose and death from opioids. Addiction and opioid use disorder. Opioid use disorder can be used interchangeably. And then we talked about some of the other problems. Some of the other problems that come are blood borne infections, Hepatitis C, HIV, endocarditis, abscesses, bone infections, and so on that can occur with injection use of opioids in particular. So why have opioids become such a big problem in the United States? Well, the United States consumes much more opioids than any other country. There's like an insatiable appetite for opioids in the United States.

In the 1990s, the drug commission designated pain as the fifth vital sign and was pushing providers to eliminate pain as part of effective treatment. Now, I think this is a useful thing, pain being the fifth vital sign. It's a very useful thing in terms of picking up on acute injuries, picking up on things that may require additional intervention, and also it's a very, very helpful thing when you have somebody with say for example cancer and your goal still in cancer care is to minimize pain as much as possible. Now however, this push to eliminate pain in everybody was sort of dove-tailed with pharmaceutical company promotion of opioids as a means in which to do this which led to some overprescribing behaviors and even some maladaptive prescribing behaviors such as some of the pill bills, for example like the ones that existed in Florida, and then increased diversion, widespread non-medical use, and then once somebody starts the use of opioids, it can get quite expensive and then if they can't get it medically, then heroin becomes a less expensive alternative for them.

This is a chart showing kilograms of opioids sold commercially in the United States from 1999 to 2010. You can see this increase. This is for 10,000 people so seven kilograms of opioids for 10,000 people in 2010. And this dove tails, it correlates with deaths due to opioid overdose and also admissions for opioid abuse treatment. Here, the age-adjusted opioid overdose death rates related to both prescription opioids and heroin and you can see these sharp increases over the course of the past 15 years.

These are trends in non-medical use of pain relievers. So this is by age. This brown one here is 18 to 25. The red one here is 12 to 17. Black one here is 12 or older, and then the little pentagon-shaped one is 26 or older. And you can see, there's some decrease in non-medical use of pain relievers over time so that's a lucky trend. Now, drug overdose deaths cause more deaths in the United States than motor vehicle accident deaths or firearms deaths. So it is estimated that 91 people in the United States die everyday from an opioid overdose. So this is one of the reasons why they call it an epidemic, opioid overdose epidemic.

Now part of this epidemic in terms of opioid overdose deaths is due to some of the synthetic opioids that have started making their way into opioids that are found on the street. So fentanyl, highly potent synthetic opioid. You all who are prescribers know that the dosing of fentanyl is in the microgram range

versus dosing of opioids is usually in the milligram range. So this tells you that it's quite a bit more potent than other opioids so estimated to be 100 times more potent than heroin. It's easy to manufacture. It can be cut into heroin and sold as heroin and there's been a rise of overdoses. For example, fentanyl accounts for two-thirds of overdoses in Massachusetts now. I've just started seeing in my patients here in New Mexico, an increase in fentanyl positive urines amongst my patients who inject opioids. And it can be difficult to reverse fentanyl because of potency.

Now interestingly, things like fentanyl and the synthetic opioids like oxycodone, methadone, these won't be picked up on a normal drug screen. Normal drug screens typically only test for opiates. So that would pick up like morphine and codeine, heroin, and oxycodone metabolites. So if you're curious about whether or not somebody is using fentanyl, you have to test independently for fentanyl metabolites. So it would be under the opioid stream or sometimes there are some urine drug screens that include fentanyl separately. Methadone always has to be tested separately. Alright so what is opioid use disorder? Put simply, it's opioid addiction.

The American Society of Addiction Medicine describes addiction as a primary, chronic, and relapsing brain disease characterized by an individual pathologically pursuing reward and/or relief by substance use and other behaviors. So it's interesting because addiction is a brain disease that's developed in the context of a use behavior. Once somebody has the addictive disorder, it implies that their brain has shifted into these sort of addictive or addiction-related functionality. It's not to say that people who develop an addiction disorder have abnormal brains before they develop their addiction disorder. They develop it as a result of the addiction but then the changes in brain functionality persist beyond the addiction disorder itself. Physical dependence on opioids is not the same as opioid use disorder. Somebody explain what they're trying to get at by this, somebody on the network. What do they mean by this?

CASEY: Patients can be using prescribed opiate medications and become physically dependent. They get the withdrawal and tolerance built up but they're not using it in an addictive way to get that relief or euphoria from it.

BRANT: Exactly, and this is why tolerance and withdrawal, if they're the only two criteria, it doesn't count towards opioid use disorder if you're considering prescribed opioid treatment. So this is the diagnostic criteria for opioid use disorder from the DSM 5 and two or more of these criteria equals an opioid use disorder and so all of the things that we were talking about before in terms of problems from opioids, people using larger amounts or longer than intended, this much time spent using actually includes a lot of time being spent either acquiring, using, or recovering from the effects of the opioid. So it's not just a lot of time spent using. It's all the lead up and the tail end afterwards. Activities are given up in order to use and then furthermore, there can be hazardous use so activities given up and then hazardous use like using in dangerous situations or engaging in dangerous activities in order to support the use. Things get neglected. People start to have physical or psychological problems, start to have

erosion in their social interpersonal lives and then craving was something that was added newly to the DSM 5.

So any two of these will equal opioid use disorder except if you're thinking about it in terms of prescribed opioid treatment. If there's only withdrawal and tolerance, then it doesn't count. Alright here's some examples and we're gonna see how will we decide whether or not someone has opioid use disorder. So this is an example of a 37-year-old guy who had been prescribed opioids for pain control after a motorcycle accident, multiple surgeries, receiving prescriptions for opioids for many months, he tells you that the opioid analgesic doses that he has been prescribed are no longer controlling his pain. He is asking for a higher dose or a more potent formulation. Does this person have opioid use disorder from what we see here? We see somebody being prescribed opioids and it looks like he's building a, what do you call this when somebody, the same amount is not getting the same effect? What's that called, Merman?

MERMAN: Tolerance.

BRANT: Yeah, Merman and Laura tied for tolerance. Yep, that's tolerance. And so what else would we need to know to know whether or not he has an opioid use disorder?

CASEY: Has he been taking his medication as prescribed or has he been taking more than he was prescribed?

BRANT: Right, is he like taking more amounts say to not only to relieve pain but to feel a sense of euphoria and then running out. Yeah, what else would we need to know? Or what else present in this context would say this is probably and opioid use disorder? What if the urine drug stream came up, go ahead Merviana.

MERVIANA: Well I was just going to say is he going to other providers for the medication?

BRANT: Yeah, say he's doing something illegal in order to require more opioids. What about if he says that he's starting to crave the opioids? Would that sort of be indicative of a mild opioid use disorder? Really start to crave these opioids. They make my life feel rosy for the next four hours after I take them. Hmm? Maybe?

AUDIENCE MEMBER: Yeah, absolutely. I mean that's one of the things when people tell me, that's one of my first cues and in fact, I'll even write it in one of my sticky notes in my EMR that patients don't have access to is when they say yeah, you know, I take that, it really makes me feel good. It's like warning, warning. Don't really think about whether or not opioids are a good choice when someone's in for an acute pain kind of syndrome for the future. That for me is a huge point.

BRANT: That's a good point, Laura, and certainly there's sort of a warning sign. I would also say that that sense of euphoria, it becomes craving when they say that made me feel really good and I'm really looking forward to my next one. And that sense of euphoria, there are some people who get a sense of euphoria and they're like I was disturbed by the sense of euphoria because it might mean I'm becoming addicted and I don't want to become addicted. So the euphoria itself doesn't necessarily imply that opioid use disorder but how they talk about the euphoria and how they relate to it could pertain to whether they have the disorder.

Alright this person. 52-year-old woman prescribed 180 morphine milli equivalents per day, that's what MME stands for, it's when you convert a dose to morphine equivalent doses. So prescribed 180 morphine milli equivalents per day for chronic pain for inflammatory bowel syndrome. The patient's former physician has left her practice and she is transferring to you for care. You note that the prescription monitoring program shows that she has received additional opioids in two different emergency department visits last month. The front desk and staff tell you that the patient has recently lost her job and is getting divorced. So how would you decide if she has an opioid use disorder?

CASEY: My first thing would be trying to figure out what was going on with those two emergency room visits. Was that because she ran out of the medication, because the tolerance was higher than the medication could address, or kind of what was going on there?

BRANT: Yeah what other things? Go ahead, Laura.

LAURA: As well with that, if you have a controlled substance agreement which we do, that would be a clear violation and then I'd think just going farther with more of the questions about so tell me more about kind of what's happening. If this is the first time you're meeting with them, now I'm not sure you want to set up an adversarial relationship but you certainly want to gather more information about what's going on and the use over time and all of that kind of information and all the stress in her life and how is she using the medication, how she's managing her stress and all of that.

BRANT: Sure, yeah. Yeah and she sent a text just indicating that she would just go through the criteria of opioid use disorder and that's frequently a really good way of doing it and if you show curiosity and

empathy when you're asking those questions and say for example if you utilize a normalizing stance like many people who take opioids for a long period of time for pain, they can start noticing themselves like craving their next dose or they can start noticing that they're starting to have problems because of the opioids and are those things happening to you? That can go over pretty. Merviana, you were going to say something? You're muted, Merviana.

MERVIANA: Sorry, it's along the same vain of what you were saying using that checklist. Now she's lost her job and has having some social problems because she's getting divorced and trying to evaluate that further with her.

BRANT: Right, and you have to wonder are these things a result of her opioid use or is the opioid increased use as a result of these stressors? Alright, next person. A 19-year-old woman comes in with a large abscess on her arm. She track marks on both her arms and hands and acknowledges injecting heroin several times per day. She has been trading sex for drugs and was recently released from jail. What's the diagnosis and what kind of physical and emotional care may be needed and how would you talk with her about her drug use? What's her diagnosis here? Ryan?

RYAN: She needs an incision and drainage of the abscess on her arm as one of the diagnoses. I think the heroin several times a day would fall under opioid dependence or opioid use disorder. She needs a bunch of blood tests and then finding out more about the physical and emotional problems that are kind of going on with her. But I would put the priority on the abscess, I guess.

BRANT: Sure, sure yeah. And this criteria here of trading sex for drugs. So this falls under use in dangerous situations and these track marks and large abscess, this falls under the category of continued use despite adverse consequences for the opioids. Now interestingly enough, the injecting heroin several times per day just in and of itself would not be criteria for opioid use disorder. If was just somebody injecting heroin multiple times per day. Now if somebody injecting heroin multiple times per day because they've built dependence and they have withdrawal, that would meet the criteria for the use disorder.

AUDIENCE MEMBER: Would that also count for the spending a lot of time on activities related to the opioid use? Like I have to go get it, I have to shoot up, then I'm high, withdrawal, then shoot up again.

BRANT: Well interestingly, there are some European countries, I think Switzerland in particular, that will actually use heroin to treat heroin dependence and people will come into the shooting galleries and will shoot multiple times per day. So under that circumstance like if they're just doing it, it's like kind of

taking their lunch break, their breakfast break, their lunch break, and their dinner break but they're not having any problematic behaviors related to it, it wouldn't be necessarily an opioid use disorder. But in our context since we don't use heroin to treat heroin it would probably imply that she's spending a lot of time acquiring and recovering. So how would you talk with her about her drug use? You would say your drug use means you're a really bad person and you need to stop that right now and stop all that bad behavior. How would you even introduce the diagnosis to her?

AUDIENCE MEMBER: Make sure you call it drug abuse so she feels worse about it.

BRANT: Oh right, sure yeah.

AUDIENCE MEMBER: Just kidding. I would just acknowledge that that's what you're seeing in your exam room tells a little bit of her story and that you want to know the story from her perspective 'cause I think that person came for help most likely so you've got to start there.

BRANT: Would you ever use this sort of like, you know, I'm really worried about your health. I'm really concerned about you. Use that approach or the approach of... Misty says it looks like your substance use is causing you some issues. Can I help you with this? Yes, very solicitous, Misty. Yeah, so a really gentle kind of approach. Oh there's more. Oh, smiley face. Okay so this is the slide that's getting an ounce of prevention being worth a pound of cure. So this is a slide that's suggesting to primary care teams to approach the treatment of pain in more conservative fashions. And this is based off of CDC guidelines in 2016.

So the three principles of opioid describing per the CDC are number one, try to use non-opioid therapies so for example, non-pharmacologic therapies whenever that's relevant and non-opioid pharmacologic therapies whenever that's relevant. Try to establish and measure goals for pain and function and don't routinely use opioids to treat chronic pain. There are a number of treatments that are non-pharmacologic that can improve function that don't have much of an impact on the pain but people's functioning improve and they start to actually feel better about themselves and their lives. So for example, one is called acceptance and commitment therapy that can improve functionality. If you're going to prescribe an opioid, start low and dose low. Start with the lowest possible effective dose. Start with immediate release. Only prescribe the amount needed for the expected duration of pain. So for example, post-surgically, however long you expect the healing process to take place and then track the effects of it and taper and discontinue if there are no improvements or risks of harms outweigh the benefits.

One of the things that happens here is that care providers are busy, patients can be quite attached to their opioids, and this can lead to a situation in which there's a potential for conflict and then also a potential for a provider to want to avoid that conflict either because they want to maintain the

therapeutical reliance or they've already seen 25 patients that day and this is their 26th and they're just really tired. And so it's important to be able to structure these discussions about harms and benefits and tapering and discontinuation based on the tracking of pain and functionality. How many folks have seen patients who say they come in every time and their chronic pain is the same amount despite the opioid dose and they're not functioning any better but you said okay, we need to discontinue or we need to taper off and they say but wait, the opioids are helping? Right, right. And so there's a disconnect there.

And then lastly, close followup, checking prescription monitoring program and drug tests. So for example, you're prescribing somebody oxycodone and you're checking the prescription monitoring program and all of a sudden they're picking up clonazepam at a high dose from another provider, that's a red flag or if some fentanyl starts showing up in their urine, you have to sort of take a step back and scratch your head a little bit. Avoiding concurrent benzos and opioids. This is because the risk of overdose death increases with the combination. And then arrange treatment for opioid use disorder if needed and that's why we're all here, so we can treat opioid use disorder wherever you're at.

Alright, what can primary care teams do besides prevention to address opioid use disorder? First off, screening. Having those sort of things that you keep in mind as your red flags and asking sensitively about the criteria for opioid use disorder and then trying to intervene early on in the case of risky use. So that person who's prescribed oxycodone and they sort of embarrassedly admit that they started buying a couple oxycodone, extra oxycodone pills, because they like how it makes them relax at the end of a day and they don't want to run out early, that's a really good place for intervention for risky use.

Preventing diversion usually means close monitoring of patients, a use of the prescription monitoring program, urine drug screens, you want to confirm that the substance you're prescribing is present and you want to see the absence of other opioids or other potentially dangerous substances. What do people do in the instance where somebody, you're prescribing somebody say oxycodone for treatment of some chronic pain or morphine and then there's cannabis that shows up in the urine? What do you do? What's the stance that you take in your individual settings?

AUDIENCE MEMBER: I ask that they need to tell me about it and give them my opinion that it might not be in their best interest but given that it's legal here, I don't really pass a large amount of judgment or change treatment based on it.

BRANT: There's the California perspective there. Thanks, yeah. Yeah, it really dependents a lot upon the legal context. Merviana, you were going to say?

MERVIANA: I was just gonna make note that it's so common in our practice that if it wasn't present, then that's the red flag.

BRANT: Oh I see. Gotcha.

MERVIANA: And I wonder if it's someone else's urine.

BRANT: Well yeah, that's a good point, yeah. Anybody else, Laura?

LAURA: I guess I don't worry about marijuana. If I were to worry about that, I'd have an ulcer. No honestly. I worry about it, it's so common in my practice and it is not legal in the state of Ohio at least at this point. The medical marijuana is supposedly coming around but I just, I don't worry about.

BRANT: Laura, so marijuana could help with that ulcer that you have.

LAURA: Yeah, I know. I'm sure it would help with lots of things.

BRANT: And then what about if you see some amphetamines in the urine? The thing you're prescribing is still there but there are amphetamines there.

LAURA: For me, I would look to see if they, well first of all I ask them if they've taken any over-the-counter substances before I even start and 'cause if they've taken sudafed or something like that, that would of course show up as amphetamine. But if they tell me no, then that would definitely be a concern for me because meth is pretty big around here. I'm in southeastern Ohio so for me, that would be a dirty screen and we would have a discussion.

BRANT: Yeah. What are the highest risk things, combinations that you would see in urine drug screening?

AUDIENCE MEMBER: Opioids mixed with the benzos. Those are pretty.

BRANT: Yep. Or if you see like yeah, like Casey's saying, opioids with benzos or opioids with Z drugs like zolpidem or something like that. Good. Harm reduction is the approach, it's an approach that is humanistic, recognizing that people have choice and supporting them in trying to reduce as much harm

as you can while also supporting their freedom of choice. So harm reduction in the context of opioid use disorder involves overdose prevention, provision of naloxone, infection prevention through syringe exchange, vaccination, making sure people are having clean injection techniques and often times, as a temporizing measure, until or before they are ready to engage in medication assisted therapy for opioid use disorder.

Now medication treatment for opioid use disorder is highly effective in reducing relapse, overdose, other harms. Behavioral health treatments and peer support can help to prevent relapse. So the backbone of treatment for opioid use disorder is medication treatment. And then addressing comorbid conditions are also a backbone of treatment.

Alright so this is our slide about reducing stigma and stigma is kind of sneaky. It can kind of sneak into our language. A soft example of stigma that I see every day, has anybody heard the phrase the patient has failed the medication? Yeah, right. So that's a soft example of stigma. We're saying it's kind of the patient's fault that this medicine didn't work for them, right? And then the slipper slope as it continues are sort of judgmental ways that we use to describe things. So although addiction is a brain disease, people with substance use disorders are often regarded as simply needing more will power rather than treatment. And then language use perpetuates stigma. And stigma prevents people from seeking care. What are some stigmatizing forms of language you've seen with regard to substance use disorders?

CASEY: I think that we've got like some old school clinicians who still call each other addicts and alcoholics and sometimes that word can really put off somebody.

BRANT: Yeah, the adjectives are problematic. So instead of addict or alcoholic, you might say what?

CASEY: A patient with a substance use disorder.

BRANT: A person with a disorder, yeah. What are some other ways that stigmatized language can bleed into our vocabulary? Go ahead, Laura.

LAURA: Well in our practice, it's interesting because there's only three of the six clinicians that will treat people with substance abuse disorders so people that even have a primary provider in our practice, they have to see one of us in order to get treated for a substance abuse disorder so I look at that and I think that person who's already established a relationship with this other person is told well now you need to see somebody else. And maybe in some ways that's an okay thing, but in another way, I think I don't know, it's just potentially.

BRANT: With as common as substance use disorders are, it would be kind of like a primary care provider saying I'm sorry, I don't treat hypertension. I need you to see this hypertension person. What do you all think about the language of clean and dirty? What do you think of that language? Clean and dirty? That urine was dirty. Your urine was dirty.

AUDIENCE MEMBER: No bueno.

BRANT: No bueno, right. What do you mean my urine was dirty, what? Yeah, so how do you phrase that differently in a way that's non-stigmatized.

AUDIENCE MEMBER: Positive or negative.

BRANT: Yeah, there was this substance or this substance that we found in your urine and there was this substance or this substance we didn't find in your urine. Yeah, it sends a message to our patients and often times, we will see our own patients using stigmatizing language to describe themselves and that is a great opportunity to help them to educate themselves about how to treat themselves with more kindness. If somebody comes in and they've had a lapse and they come in and they say I really screwed up. Well, think about how long your lapse was this time which was, you know, you used for five days versus your last use was for five months. You're doing a lot better. Alright, we're in the questions phase of things.