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Consideration of Social Determinants Risks in Substance Use Disorder Assessment and Treatment Plan Formulation

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Abstract

Substance use disorders continue to trend as an increasingly pervasive public health problem in the United States. Substance use disorders are recognized as a global health problem by the World Health Organization. It is imperative to explore all opportunities to improve outcomes of substance use disorder treatment. Consideration of social determinant risks in assessment, treatment planning, and treatment implementation is one such opportunity. Social determinant conditions can be conceptualized along a continuum of primary categories. Developing methods to help clinicians understand and incorporate social determinants into assessment and treatment plan formulation processes may help improve outcomes for those who are experiencing one or more substance use disorders. This column includes a proposal for a framework of primary categories of social determinants and offers a definition for each. The categories are identified as basic needs insecurity, past trauma, historical oppression, current/ongoing severe distress and layered/compounded risks. These categories and definitions are developed in the context of practical application for clinical assessment and treatment plan formulation.

Keyword: Social Determinants of Health

INTRODUCTION

There are two recent population health reports, released by the Centers for Disease Control and Prevention (CDC), that serve as good place for which to introduce this column. The most recent is a 2021 report confirming a 1.8-year reduction in life expectancy in the calendar year of 2020. This represents the largest decline in life expectancy since World War II. Although the leading contributors to this decline were reported to be heart disease, cancer, and COVID-19, drug overdose was

identified as a contributor to all deaths that were categorized as “mortality from unintentional injury” (Adamy, 2021). Approximately 1 month before the release of final data on life expectancy, the CDC released a report on preliminary data that indicated the United States had incurred the grim milestone of 100,000 drug overdose fatalities over the course of the first year of the pandemic. This period is defined as the time between April 2020 and April 2021 and represents a 28.5% increase from the prior 12-month period (Santhanam, 2021). Although the phenomena of overdose fatalities from synthetic opioid drugs garner most of the attention by the media, policy makers, and the public, it remains only one facet of the totality of the scourge of substance use disorder on the United States. The consequences of substance use disorder are far reaching, beyond just physical and psychological public health. Substance use disorder adversely impacts economic stability, safety of communities, national security, global competitiveness, and, most recently, pandemic response (Berman, 2003; National Institute on Drug Abuse, 2021; U.S. Department of Agriculture, 2021). Substance use disorder is long known to, like COVID-19, disproportionately impact those most historically disenfranchised along minority lines of race, ethnicity, gender and sexual identification, status of residency, and access to financial means. The recent milestones noted above are only two recent data points reflecting these long-standing, broad, and profound impacts of substance use disorder. Therefore, it is imperative to explore all opportunities to improve outcomes of substance use disorder treatment. Consideration of social determinant risks in assessment, treatment planning, and treatment implementation is one such opportunity.

IDENTIFYING SOCIAL DETERMINANT RISKS

Most clinicians, across all health profession disciplines or medical specialties, have historically been trained to focus on signs and symptoms in the formulation of both diagnoses and treatment plans. Outcomes are thusly evaluated based on perception of improvement in these signs and symptoms, in both quantifiable metrics as well as interpretation of patient report and clinical observation. For many clinicians, it may be a novel challenge to conceptualize how to incorporate inquiry and assessment of social determinant risks in the

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evaluation of substance use disorder. To assist clinicians in this challenge, social determinant risks could be organized into some primary categories:

- *Basic needs insecurity*: includes (but is not necessarily limited to) access to basic needs, such as food/nutrition, heating and cooling, climate-appropriate clothing, stable and/or safe housing, drinkable water, Internet and Internet-connected devices, transportation, health insurance, and enough financial means to access these and other basic needs. Many of these basic needs directly relate to an individual's ability to access any form of follow-up care even if they are able to obtain an assessment.
- *Past trauma*: includes (but is not necessarily limited to) abuse or neglect as a child; this includes emotional abuse or neglect that can potentially be more easily overlooked, including a range of adverse childhood experiences (CDC, 2021), significant loss, or lingering grief. Such past trauma may have been experienced as chronic, such as physical or sexual abuse, or it might be experienced as a singular event such as a severe car accident or witnessing the death of a loved one. This singular event could also be victimization, which could include enduring a physical or sexual assault. It might also be important to note that these can be experiences that occur during childhood or adolescence, or anytime during adulthood. Traumatic experiences can continue to have a significant individual impact, even if that trauma has not occurred in years or even decades.
- *Historical oppression*: Some individuals who exist and identify as a minority (including, but not limited to, minority identification by race, ethnicity, gender, sexuality, and/or residency status) may have experienced (and may continue to experience, as described in the next category) trauma or adverse event(s) that are directly related to their minority status as well as sanctioned oppression associated with that status. These could include, for example, chronic bullying in upbringing, a persistent sense of lack of safety in their community, and the observation of a parent or other loved one experiencing economic impacts of discrimination.
- *Current/ongoing severe distress*: Individuals might have a wide range of psychosocial circumstances that are inflicting a direct toll on their health and a powerful negative influence on substance use behavior. This can include current victimization from a violent intimate relationship, recent significant interpersonal loss or physical and/or psychological injury, recent change in financial means or health status, or loss of employment. Individuals may experience distress from ongoing historically based oppression, and/or they may experience distress individually that is a direct derivative of macro-level policy. Such examples might be continued fear of physical safety because of their racial, gender, sexual, or residential identity, or inability to access recently outlawed reproductive healthcare. Increasingly, individuals may be experiencing

ing significant distress from overexposure to pernicious news media, social media content, or interpersonal discord over increasingly divided sociopolitical belief systems and associated rhetoric.

- *Layered/compounded risks*: Another phenomenon that may be present is that individuals may experience a combination of all risk types at once. Furthermore, they may experience one, a combination, or all risk types in conjunction with one or many comorbid, physiological, or behavioral health medical conditions. These may be acute or chronic and may bidirectionally exacerbate one another as well as impact the individual's ability to effectively navigate social determinant risks.

CLINICAL IMPACT RELATED TO SUBSTANCE USE DISORDER

Perhaps what is most immediate in terms of understanding clinical impact in the context of substance use disorder is that any combination of social determinant risks outlined above can fuel motivation to continue to use substances and suppress motivation for treatment or positive supports, such as engaging in a 12-step peer support group or sponsor. This is not limited to the impact of social determinant risks on treatment and clinical improvement from substance use disorder. There are other impacts that can be immediately relevant in assessment and treatment planning. The impact of social determinant risks can sharply impact an individual's sense of self-worth. The challenge of trying to inspire motivation for positive change can be insurmountable if the individual believes they are not worthy of better health and better quality of life. This sense of worthlessness can instead serve as a cognitive template to resignation of suffering and rationalization of self-destruction. Such cognitions are likely to be manifested by ongoing and increased intensity of substance use as well as engagement in risky behaviors associated with obtaining and consuming the substance(s) of abuse. Oftentimes, clinical assessment of suicidality is limited to the clinician asking, "Are you suicidal?" Perhaps further inquiry includes questions regarding thoughts, cognitions of intent, and/or access to lethal means. What might not be asked is "Do you care what happens to you?" Although an individual may not be experiencing suicidal ideation or intent in the generally understood definition of the concept, an individual may be experiencing a level of apathy about their own life that governs their emotional and behavioral response in a way that places them at a significant risk of harm and even death. The connection proposed here is that social determinant risk influences a sense of worthlessness, which in turn begets a level of apathy for one's own well-being that places them at an immediate risk in a way that might be similar, but importantly distinct, from suicidal ideation or intent. In addition to clinical impacts on motivation for engagement in treatment, self-care, and pursuit of better health, social determinant risk can also render even a highly motivated individual unable to access the healthcare resources needed to sufficiently support them in their pursuit of healing and recovery from their substance

use disorder condition. Even someone with access to basic needs and modest income may be hindered by underinsurance that, for example, might not cover expensive medical detoxification treatment. In some circumstances, that may leave them facing extensive physical and psychological suffering from withdrawal if they decide to pursue recovery without that care. For some, they face a direct, life-threatening risk if they discontinue use without that medical detoxification treatment.

INCORPORATION INTO ASSESSMENT AND TREATMENT PLANNING

Despite the daunting challenges of social determinant risk in substance use disorder clinical care, clinicians can incorporate social determinant screening into assessments and social determinant risk mitigation strategies into treatment planning relatively quickly and easily. Although the type of care coordination needed to address some risks associated with basic needs insecurity and the clinical expertise needed to address other risks like trauma and historical oppression can be more involved, clinicians can take immediate and simple steps to capture these risks in the assessment phase and begin to incorporate them into the treatment phase. Perhaps the initial challenge is getting oneself (as the clinician) comfortable with inquiring about potential social determinant risks and being mindful of engaging the patient in an empathetic way. It can be thought of as expanding the assessment from collecting signs and symptoms data to trying to understand who the individual is (e.g., come to know not only their narrative but also their narrative through their perspective). In the assessment, the patient may present with social determinant risks that are beyond the assessing clinician's expertise, such as a history of trauma because of child abuse or neglect or victimization in the context of currently occurring intimate partner violence. The clinician can acknowledge this, along with voicing commitment to make sure someone with trauma-informed care expertise is a part of the treatment team and plan. Likewise, the patient may present with basic needs insecurity that might require a case management type of support that includes assessing for and connecting to social welfare resources. In addition, in the assessment, patients may clearly present and/or identify as a member of a minority group of which the clinician is not. For the clinician, there can be an opportunity to inquire about their experience as a member of that minority group and how that has impacted their life or even their health. If there is a known opportunity to pair that patient with an identity-congruent clinician, the clinician might consider offering that, stressing that it is only offered as an option for that patient and not a reflection of the clinician's reluctance to provide the care (or part of the care) themselves. If there is no such availability, the clinician may consider having a conversation with the patient that acknowledges those differences can significantly shape environmental experiences and one's perception of those experiences. The clinician might convey that they will strive to make sure they are seeing the perspective of that patient as well as strive to foster trust building and open communication between themselves so that the patient feels understood in the context of their identity and

life experience. It is understood that some settings will have multidisciplinary and diverse specialty staff resources to fully address any combination of social determinant risks and other settings may not. It is also understood that cooperative interdisciplinary and diverse specialty care coordination is not always easily accessible and in fact may often seem inaccessible. Despite this, there can still be opportunities for a sole clinician to factor in social determinant risks to assessment, treatment planning, and treatment implementation and, by doing so, generate at least some level of positive impact on the treatment goal pursuits and a better healthcare encounter experience for the individual patient.

OPPORTUNITY FOR POSITIVE IMPACT

At the end of 2021, there were and (continue to be) news reports associated with emerging data on the impact of the ongoing pandemic on the U.S. healthcare workforce (Levine, 2021). These reports might prompt the thought that it is currently counterintuitive to discuss ways in which clinicians can expand their clinical skill set. The concept of collaborative care and enhanced assessment plans when healthcare worker resources are stretched so thin may seem overwhelming. The purpose of this article is to provide a high-level overview of social determinant risk detection and at least some preliminary, but hopefully simple and straightforward, steps to incorporate the concepts. Perhaps more importantly, the purpose of this article is to offer this as an opportunity—an opportunity to make a positive impact immediately with minimal additional burden of effort or cost. In relation to the plight of healthcare worker burnout, there is also an opportunity to make a deeper human connection with a patient, to foster a perception by the patient of being truly heard, and to possibly inspire (even in only a very small way) a sense of worth, dignity, and hope in those who present to us for help. If nothing else, the intention is that a clinician able to obtain sense of making such connection may slightly ease the psychological strain on that clinician as well as the patient. Thus, we create an opportunity for hope, better health, and a better quality of life in ourselves as well as those in our care.

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