DECREASING STIGMA & INCREASING ACCESS: TREATING OPIOID USE DISORDER IN RURAL COMMUNITIES

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Opioid Response Network

OBJECTIVES

Participants will learn:

- The 3 FDA approved medications for opioid use disorder (MOUD)
- Best practices for the initiation and maintenance of MOUD
- Key components of a successful MOUD program in a rural community clinic and treatment facility
- Strategies to decrease stigma associated with MOUD

- Opioid Use Disorder (OUD)
- Medications for OUD (MOUD)
- Stigma

SUBSTANCE USE DISORDER (SUD)

- DSM 5 redefined substance use disorders as a spectrum of pathology and impairment
- Previously termed Abuse and Dependence
- Biological, Psychological and Social Criteria
- Problematic pattern of substance use leading to clinically significant impairment or distress

MOUD

Methadone – full agonist

Buprenorphine – partial agonist

Naltrexone – full antagonist

MOUD

- Has been shown to :
  - Improve survival
  - Increase retention in treatment
  - Decrease illicit opioid use
  - Decrease hepatitis and HIV seroconversion
  - Decrease criminal activities
  - Increase employment
  - Improve birth outcomes with perinatal drug users

MOUD

- Methadone
  - Long-acting synthetic opioid so can be dosed once daily
  - Higher doses are more effective at reducing opioid use
  - Good outcomes are contingent on length of treatment

METHADONE

- Methadone is only available through an Opioid Treatment Program (OTP)
- Wyoming is the only state that doesn't have an OTP
- Clients are required by federal law to see a licensed addiction professional monthly
- 8 urine drug screens are required annually
- Dosed daily out of an OTP – take home doses are earned based on compliance with the OTP as well as 8 federal rules

OPIOID TREATMENT PROGRAMS

Take-Home Methadone 8 Criteria

1. Absence of recent drug and alcohol abuse
2. Regular OTP attendance
3. Absence of behavioral problems at the OTP
4. Absence of recent criminal activity
5. Stable home environment and social relationships
6. Acceptable length of time in comprehensive maintenance treatment
7. Assurance of safe storage of take-home medication
8. Determination that rehabilitative benefits of decreased OTP attendance outweigh the potential risk of diversion

HEARTVIEW FOUNDATION OTP

Heartview Foundation Methadone Patient Outcomes
February 10, 2022

Baseline data (n=305):

- 13.7% (n=42) self-reported having ever tested positive for HIV
- 57% (n=174) self-reported having ever tested positive for Hepatitis C
- 65% (n=198) reported having ever experienced violence or trauma

	Baseline (n=305)	**6 Month Follow-up** (n=190)	**1-year Follow-Up** (n=122)
Employed	32.5% (99)	56% (106)	70.5% (86)
Mean days worked past month	5.88	11.61	12.2
Mean Monthly Income	$452	$886	$863
Fair or Poor mental health	47%	31%	24%
Arrested	90% (lifetime) Ave 10	8% (past month)	4% (past month)
Injected drugs	84% (lifetime)	13% (past month)	9% (past month
Overdose	61% (lifetime)	3.5% (past month)	<.8% (past month)
Treated ED for Alcohol or Drugs	47% (lifetime) Ave 4	4% (past month)	3% (past month)

- Subutex – buprenorphine alone
  - Previously considered to be safer in pregnancy
- Suboxone – combination of buprenorphine and naloxone (antagonist of opioid receptor)
  - Available in tablets or strips
- Zubsolv – combination of buprenorphine and naloxone (theoretically tastes better than suboxone)
- Sublocade – subcutaneous monthly injection
- Brixadi – subcutaneous weekly or monthly injection

MOUD

- Buprenorphine
  - Approved by FDA for treatment of opioid use disorder in October 2002
  - Opioid partial agonist – able to suppress withdrawal symptoms and less likely to cause euphoric high or lead to death by overdose
  - Lower risk of abuse, addiction and side effects
  - Administered sublingually, intradermally, subcutaneously
  - No evidence of organ damage

MOUD

- Buprenorphine
  - Previously heavily regulated by FDA
  - Only recently the rules changed so that any provider can prescribe and there are no limits on the number of patients

NALTREXONE

- Oral Naltrexone (Revia)
  - Opioid antagonist
  - Daily dose of 50-100 mg – hepatotoxicity was seen in obese patients taking 300 mg daily
  - If opioids are in the patient's system, Naltrexone will produce opioid withdrawal.
  - Compliance is an issue

NALTREXONE

- IM Naltrexone (Vivitrol)
  - Intramuscular shot given every 28 days
  - 380 mg
  - Available through specialty pharmacies
  - Well tolerated
  - Patient must be through their withdrawal before administration

MOUD

- Buprenorphine and Methadone both raise dopamine to normal levels of 40-60 ng/dL in the brain
- Patients with low dopamine levels have extremely low retention rates for treatment (less than 10%)
- Mortality rate for patients with OUD who pursue abstinence-based recovery is 10 times higher than individuals who receive MAT
- MOUD combined with psychosocial treatment is superior to drug or psychosocial treatment alone

National Institute on Drug Abuse

BENEFITS OF MOUD

- Opioid Use Disorder increases the risk of premature death 10-fold compared to the general population
  - 1 in 20 people who survive an opioid OD die within a year – 20% die within the first month
- MOUD is associated with decreased overall mortality by at least 50%

BENEFITS OF MOUD

- During the first 4 weeks of treatment, buprenorphine is associated with 90% lower mortality rates, Methadone is associated with 80% lower mortality rates and both are associated with 40% lower mortality rates after the first 4 weeks.
- Reduced mortality rates associated with buprenorphine hold up when individuals stop receiving pharmacotherapy prescription
- The mean duration of a single treatment episode was 363 days for methadone as compared with 173 days for buprenorphine

recoveryanswers.org

STIGMA TOWARDS MOUD

- “It’s trading one drug for another”
- “It keeps people sick”
- “People on MOUD aren’t in recovery”
- “People on MOUD aren’t sober”

People judge one another, interpret and evaluate each other's behavior and find ways to inevitably group each other into ready-made normative categories

Based on simplistic generalizations

This can be harmless and useful but it becomes corrupted when those stereotypes become negative

STEREOTYPING

FLORIDA

VIKINGS

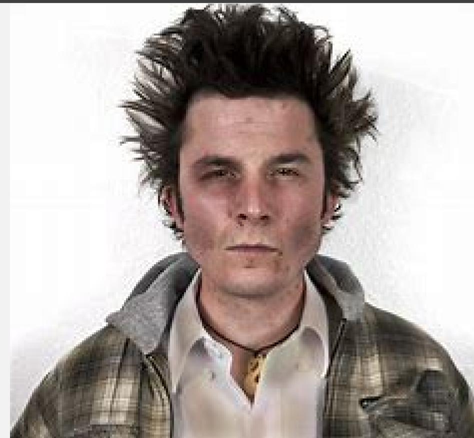
PACKERS

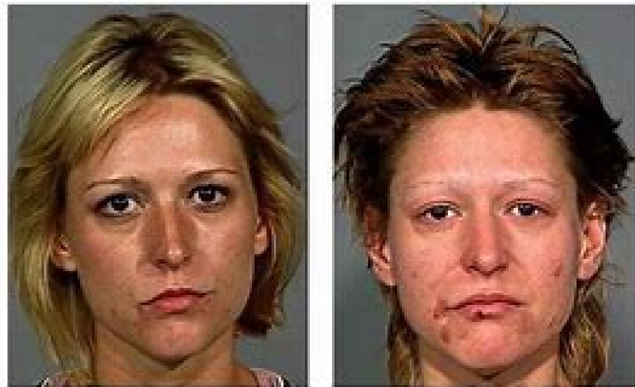
NDSU
POWERED BY

22
23
22

84

“JUNKIE”, “TWEAKER”, “METHHEAD”, “DOPE FIEND”





STEREOTYPICAL BELIEFS ABOUT ADDICTION

- “It’s a choice”
- “If you wanted to stop, you could”
- “Drug addicts are criminals. They should all be locked up”
- “Let them suffer. They deserve it”
- “Treatment doesn’t work anyway. No one gets better”

Origin comes from the ancient Greek word meaning tattoo or puncture mark from the practice of branding slaves with a pointed stick

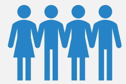
Goffman 1963 – stigma reduces a stigmatized individual "from a whole and usual person to a tainted discounted one"

Oxford English Dictionary - A mark of disgrace or infamy; a sign of severe censure or condemnation, regarding as impressed on a person or thing; a "brand"

STIGMA

NAZI GERMANY

PUBLIC STIGMA



Occurs when the general public endorses negative stereotypes and discriminates against a group of people

Excludes affected individuals from public engagement by seeing them as unreliable and untrustworthy

Mattews et al. "Stigma and Self-Stigma in Addiction", J Bioeth Inq (2017)

PUBLIC STIGMA

Public stigma toward individuals who use drugs found that public perceptions of dangerousness, unpredictability, irresponsibility and blame for their condition were commonly endorsed

Core stereotypes were endorsed including dangerousness, criminality, hopelessness, worthlessness and blameworthiness

Yang, et al. "A New Brief Opioid Stigma Scale to Assess Perceived Public Attitudes and Internalized Stigma: Evidence for Construct Validity", J Subst Abuse Treat (2019)

SELF STIGMA

Occurs when people internalize the negative stereotypes and believe them to be true

Leads to shame, reduced self-esteem, social withdrawal, hopelessness and demoralization

May motivate people to continue to use in order to forget or reduce the negative feelings arising from their shame

Pronounced in addiction

EFFECTS OF STIGMA

Can be a barrier to help-seeking

Increased acting-out behaviors

Reduced public funding for services

May contribute to suicidality

Shame

SHAME

A painful emotion caused by consciousness of guilt, shortcoming, or impropriety

- Merriam-Webster dictionary

Directed towards oneself

Can be compounded by aggregation of guilt

SHAME

- Counterproductive
- Can lead to a quality of life that undermines the motivation needed to heal
- Compounded feelings of guilt can reinforce drug use in order to blunt or eradicate the negative feelings and attitudes of one's prior use

CONSEQUENCES OF STIGMA IN HEALTHCARE

- Widely documented
- Range from outright denial of care, provision of sub-standard care, physical and verbal abuse, to more subtle forms, such as making certain people wait longer or passing their care off to junior colleagues
- Barrier to care for people seeking services for disease prevention, treatment of acute or chronic conditions, or support to maintain a healthy quality of life

Nyblade L, Stockton MA, Giger K, Bond V, Ekstrand ML, Lean RM, Mitchell EMH, Nelson RE, Sapag JC, Siraprapasiri T, Turan J, Wouters E. Stigma in health facilities: why it matters and how we can change it. BMC Med. 2019 Feb 15;17(1):25. doi: 10.1186/s12916-019-1256-2. PMID: 30764806; PMCID: PMC6376713.

STIGMA DRIVERS

- Factors considered to produce or cause stigma
  - Negative attitudes
  - Fear (infection, behaviors, etc)
  - Beliefs
  - Lack of awareness about both the condition itself and stigma
  - Inability to clinically manage the condition
  - Institutionalized procedures or practices
  - Moral distress based on their personal disapproval of behaviors

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STIGMA REDUCTION STRATEGIES

- "Contact with stigmatized group" - relies on involving members of the stigmatized group in the delivery of the interventions to develop empathy, humanize the stigmatized individual, and break down stereotypes.
- An "empowerment" approach was used to improve client coping mechanisms to overcome stigma at the facility level.
- "Structural" or "policy change" - changing policies, providing clinical materials, and facility restructuring.

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CHANGING STEREOTYPES

Most effective strategy is to increase personal contact between mainstream citizens and members of the stigmatized group

- Corrigan, et al. "Testing social cognitive models of mental illness stigma The prairie state stigma studios" Psychiatric Rehabilitation Skills. 2002

Most effective when the contact is between people of equal status, is voluntary and cooperative and is mutually judged to be a positive experience

- Couture et al. Interpersonal contact and the stigma of mental illness. A review of the literature. Journal of Mental Health. 2003

TAKE HOME POINTS

- There are treatment options available for MOUD
- Don’t overthink this
- MOUD is a lifesaving intervention
- Reducing stigma will improve access to MOUD
- All of us have a role in reducing stigma
- The Opioid Response Network is a terrific resource for SUD education and support