Challenging Medication Stigma in Long Term Recovery from OUD

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Study Sites: Fairbanks Addiction Treatment Center & Life Spring Health System

Funded by the Indiana University

"Responding to the Addictions Crisis" Grand Challenge

Objectives

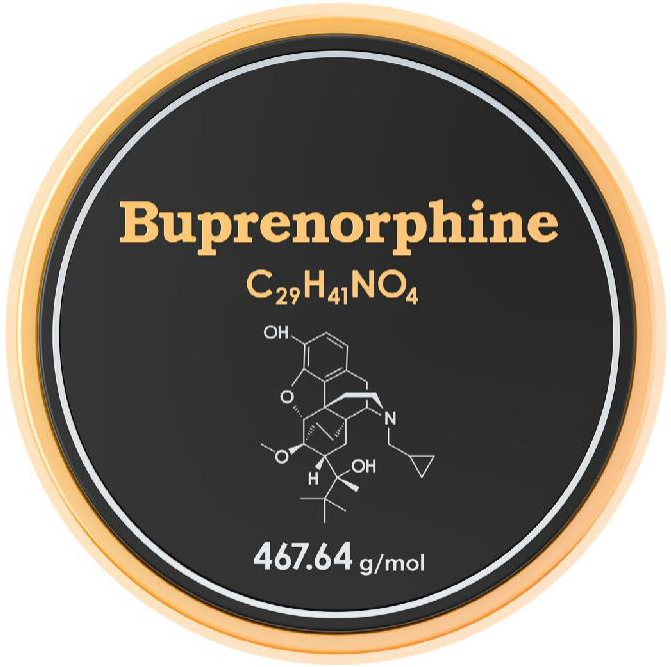
*Understand what the scientific research says about the role and effectiveness of MOUD in long-term recovery from Opioid Use Disorder.

*Obtain a brief history of our ideas about opioid use disorder as a moral failing versus a disease to place our ideas in the context from which they emerged.

*Understand how opioids affect the brain and why those impacts make medication an important part of recovery.

*Identify stigmatizing perceptions of MOUD and how they affect treatment decisions and can affect outcomes.

*Consider how this research, history, and awareness of stigmatizing beliefs can help us reframe both OUD and use of MOUD in long term recovery.



Medication Assisted Recovery

Most who choose to stop or taper Methadone treatment relapse during or after completing the taper.[1,2]

Continued buprenorphine is superior to buprenorphine dose taper in reducing illicit opioid use.[3]

Long-term studies confirm its effectiveness outside of clinical research protocols.[4,5]

A study of justice-involved adults who received Naltrexone along with brief counseling and referrals found that at 6 months, those who received the medication demonstrated longer time to return to substance use, a lower rate of return to use, and a higher percentage of negative urine screens.[6]

Despite abundant information to support MOUD as effective:

- Only 36% of all organizations for individuals with SUD and 33% of publicly funded organizations offer MOUD.[7]
- Only 10% of individuals with OUD are receiving any form of treatment.[8]

Substance Use Disorder is a Brain Disease

1

Binge/intoxication stage: Addictive substance produces rewarding or pleasurable effects, "hijacking" the brain and forming habits

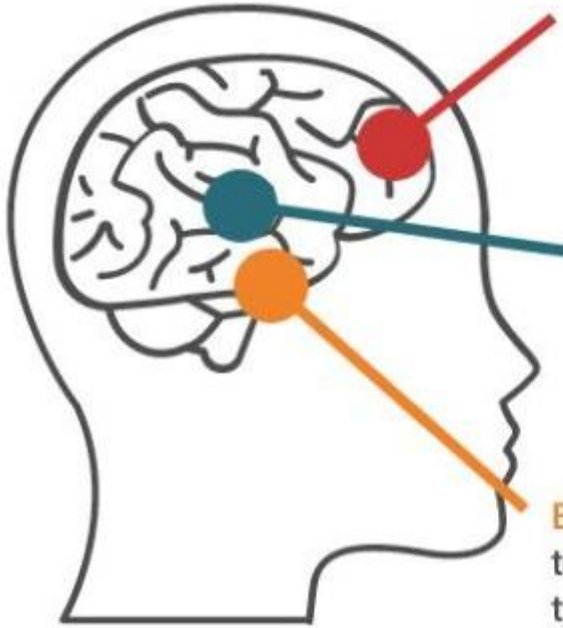
2

Withdrawal/negative affect stage: Absence of substance leads to withdrawal symptoms, including negative emotions and physical symptoms like pain

3

Preoccupation/ anticipation stage: Executive function overruled by cravings leading to substance-seeking and a preoccupation with use

The prefrontal cortex, basal ganglia and extended amygdala are the main areas of the brain involved in substance use disorders, and associated with the three stages of the addiction cycle.



Prefrontal cortex: Involved in executive function, like organizing thoughts, managing time, making decisions and exerting control over substance use

Basal ganglia: Control the rewarding or pleasurable effects of substance use; responsible for habitual substance use

Extended amygdala: Regulates reactions to stress, anxiety and irritability, which typically accompany withdrawal

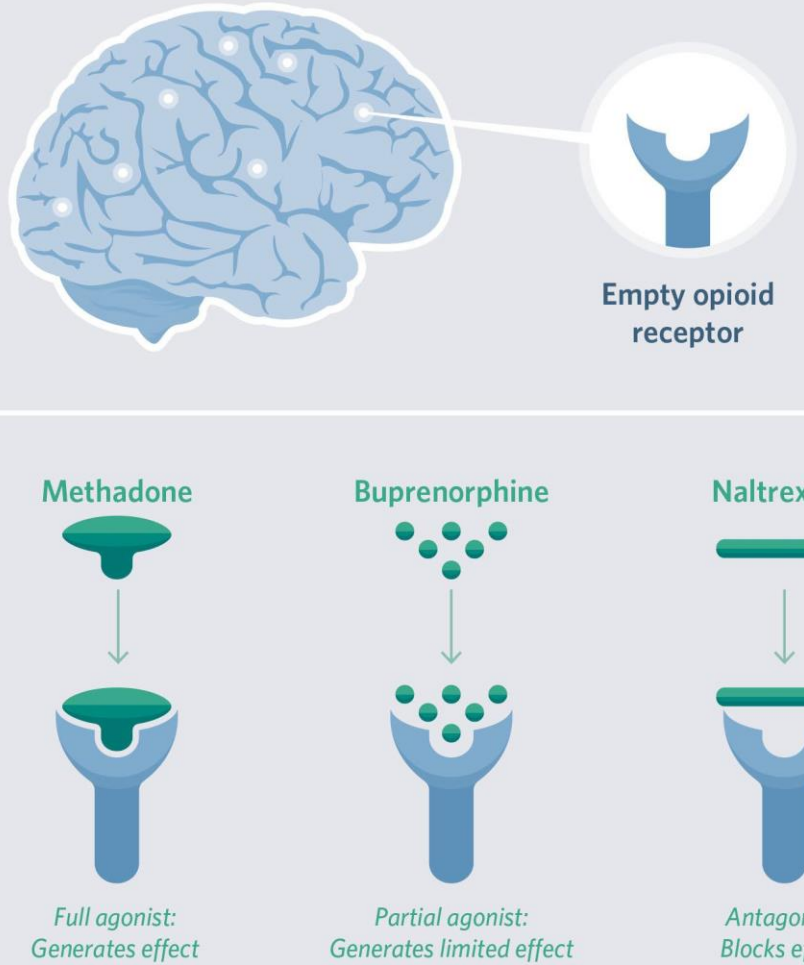
U.S. Surgeon General's Report on Alcohol, Drugs, and Health, 2016

Medications for OUD

- Normalize brain chemistry
- Gradually regulate and increase dopamine levels, allowing patients to preform normal daily functions
- Block euphoric effects of opioids
- Relieve psychological cravings
- Increase treatment retention and decrease substance use symptoms and negative consequences

Figure 1

How OUD Medications Work in the Brain

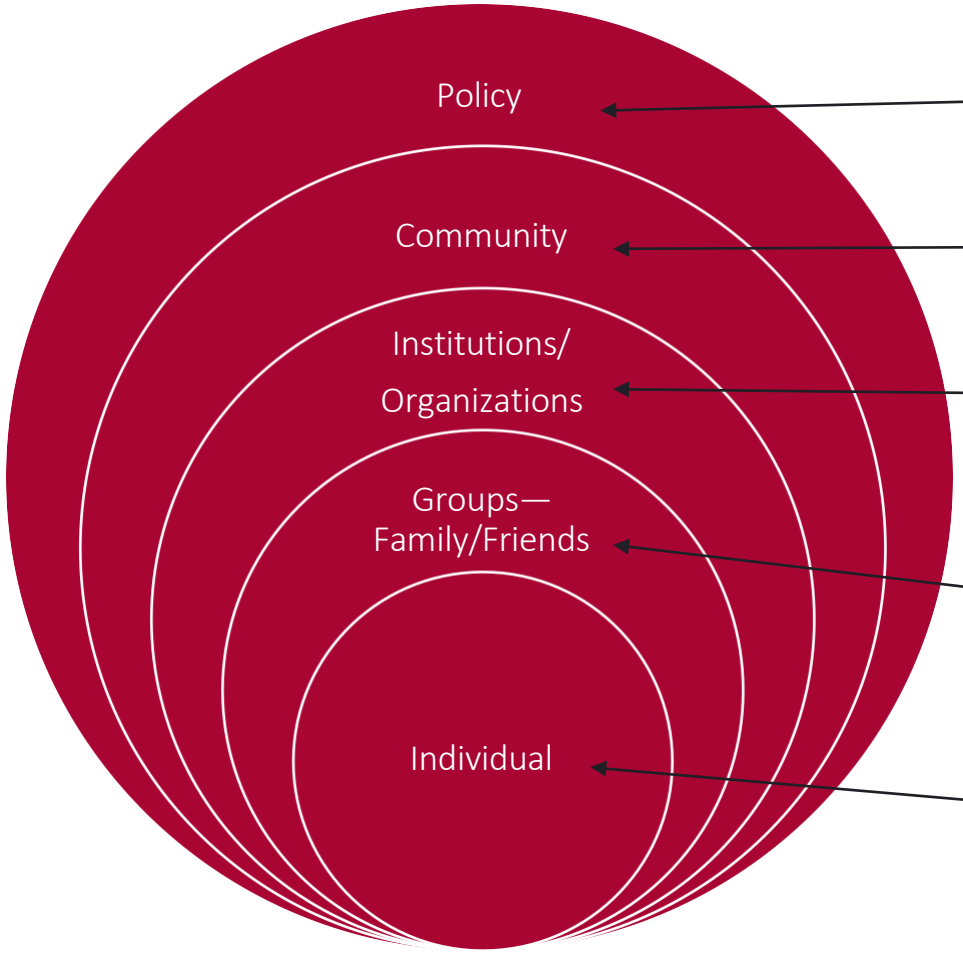


Medication	Mechanism of Action	Route	Dosing frequency	Available through	Reduces opioid cravings	Reduces illicit opioid use	Reduces risk of opioid overdose	Increases rate of treatment retention
Methadone	Full agonist	Pill, liquid, and water forms	Daily	Opioid treatment program	Yes	Yes	Yes	Yes
Buprenorphine	Partial Agonist	Pill or film (placed inside cheek or under tongue)	Daily	Any prescriber with the appropriate waiver	Yes	Yes	Yes	Yes
		Implant (inserted beneath the skin)	Every six months					
		Oral	Daily					
Naltrexone	Antagonist	Extended-release injectable	Monthly	Any health care provider with prescribing authority	Yes	Yes	Inconclusive	Yes, if initiation is possible

ASAM, 2015; The Pew Charitable Trusts, 2020

Stigma

"A deeply discrediting attribute; 'mark of shame'; 'mark of oppression': or 'devalued social identity'"[9]



Structural Stigma: Prejudice and discrimination by policies, laws, and constitutional practice; also called institutionalized stigma.

Public Stigma: Stereotypes, prejudice, and discrimination endorsed by the general population.

Provider-based stigma: Prejudice and discrimination voiced or exercised, consciously or unconsciously, by occupational groups designated to provide assistance to stigmatized groups.

Courtesy Stigma: Stereotypes, prejudice, and discrimination by association with marked groups.

Self-Stigma: Internalized acceptance of stereotypes and prejudice.

The Stigma Complex

The Social Ecology of Stigma

Stigmatizing Perceptions

Abstinence Dominates Culture of Recovery in the U.S.

- MAR trades one drug for another and those who use MAR are not in "recovery."
  - Sober = full abstinence from substances other than nicotine and caffeine.
  - Abstinence = "Clean."
- MAR is acceptable as a stepping-stone to sobriety.
- Long-term use of MAR indicates treatment failure or ineffectiveness

Shared Perceptions Create a Barrier to Effective Use of MOUD for Long Term Recovery

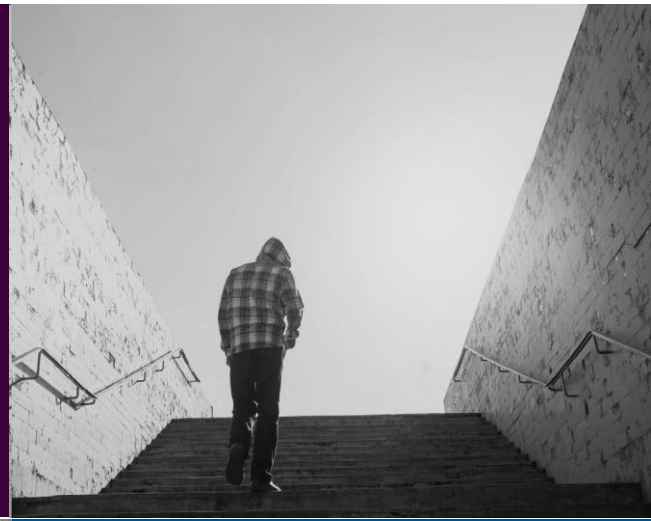
Community Members

You're talking about using one drug to cure another drug...No, no, no, no. It ain't right. Period. Because drugs ain't nothing to play with. Either way that's the same thing. You're still doing the wrong thing.

— Ray, Community Member

Friends & Family

My wish for everyone is to be clean. But that's not reality. So, you know if you stay on it maybe a year or so maybe yeah. Then I feel like you're being recovered, but if you are on it for 10 or 15 years then that's not really helping you. It's not beneficial to you. —Susan, Friends and Family



Service Providers

None of it should be longer than 30 to 60 days, period. It should not be a long term after 90 days situation.

— Kilee, Service Provider

Individuals in Recovery

I don't think it works. The vast majority of people are trapped there for a lifetime. –Bennett, Short-term Recovery

I don't think I know anybody that's successfully weaned off Suboxone. —Trevor, Short-term Recovery

Awareness of Personal Beliefs and their Consequences

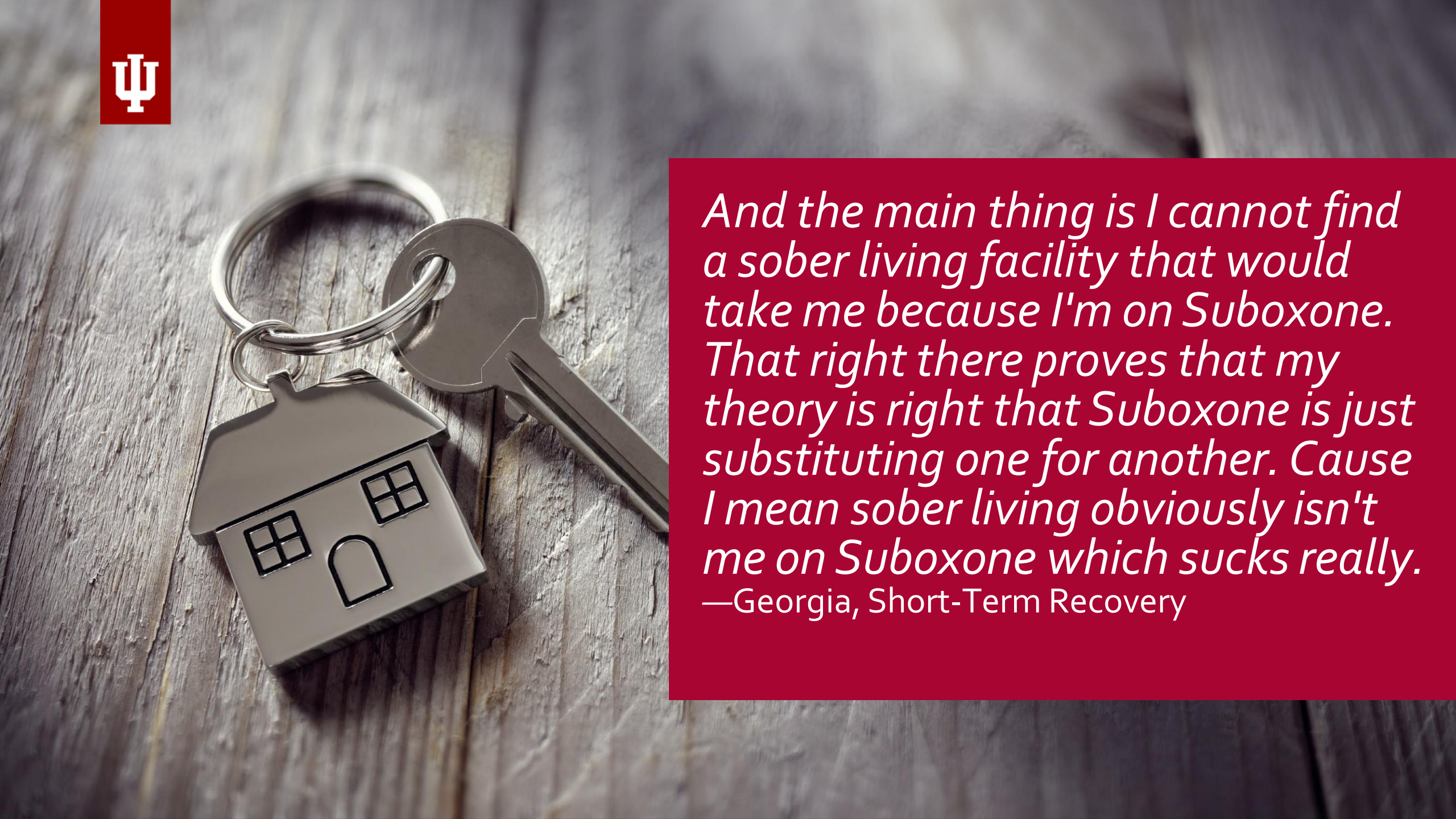
- See MAR as a last resort strategy.
- Set expectations that medication will be a short-term stepping-stone.
- Discourage use of medication as part of long-term recovery.
- Uphold strong expectations for abstinence-based recovery.
- Reduce community support for access to effective treatment.

If someone has already tried to go cold turkey and it hasn't worked, then maybe the medication assisted treatment would work. — Sadie, Community Member

I've had patients who come in and at first…. They're motivated to change, and their family is supportive. But, as the journey goes on, they're supposed to be out, their family is turning, as three or four years happen. Even though that patient has continued progressing and is doing good in their recovery program and working appropriately.— Kelly, Service Provider

I have also known a person that had been on methadone for years. I'm thinking, how long can they keep that? That's where I think the doctors in the clinic should say "okay, you know it's time you're off…14-15 years is a long time". — Susan, Family and Friends

My community has been approached with the idea of bringing a Recovery Clinic, a methadone clinic, and the outrage in that community is just you know, and I don't know what the answer is. If I could be shown yes, this scientifically assists them, and I believe fully any of those who have a need for medical assisted recovery in a variety of areas should have it. But the negative connotation is so overwhelming. Nobody wants to be in the neighborhood. —Jamie, Community Member



And the main thing is I cannot find a sober living facility that would take me because I'm on Suboxone. That right there proves that my theory is right that Suboxone is just substituting one for another. Cause I mean sober living obviously isn't me on Suboxone which sucks really.

—Georgia, Short-Term Recovery

Next Steps

Using what we've learned to make change.

Training: Support informed approach to client care[9]

- Assess stigmatizing views and actions.
- Use avatar-based simulation “game” to educate and train.
- Assess stigmatizing views and actions following intervention

Purpose:

- Reduce fears.
- Increase knowledge.
- Reduce stigma.
- Understand the positive effect providers can have on client experience.

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