Stigma and MAT

ANTHC Addiction ECHO Series

2/11/2020

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ANTHC Clinical ECHO Series

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ANTHC is approved as a provider of nursing continuing professional development by the Montana Nurses Association, an accredited approver with distinction by the American Nurses Credentialing Center's Commission on Accreditation.

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Contact Hours:

ANTHC designates this Live Activity for a maximum of 1 *AMA PRA Category 1 Credit(s)* ™ per session. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

ANTHC designates this activity as meeting the criteria for one nursing contact hour credit for each hour of participation up to a maximum of 1 hour(s)/session.

The Alaska Pharmacists Association (AKPhA) is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. Through a Joint Providership, ANTHC and AKPhA designates this pharmacist activity for a maximum of 1 hours(s) per session. To receive CE credit, participants must be included in attendance record of facilitator/virtual format moderator with the NABP e-profile number including MM/DD birthdate, and complete the evaluation or post session survey. CPE credit will be posted to the online CPE Monitor System within 60 days of activity completion. CPE credit is offered at no charge to ANTHC/SCF employees and AKPhA members. Fees may apply to participants not affiliated with either organization.

Approved for 1 CHAP CE

Conflict of Interest Disclosures:

All Presenters and Conference Planners for this activity do not have any relevant relationships or conflict of interests to disclose.

Requirements for Successful Completion:

To receive CE credit be sure you are included in attendance record as directed by the facilitator/session moderator, and complete the course evaluation or post session survey.

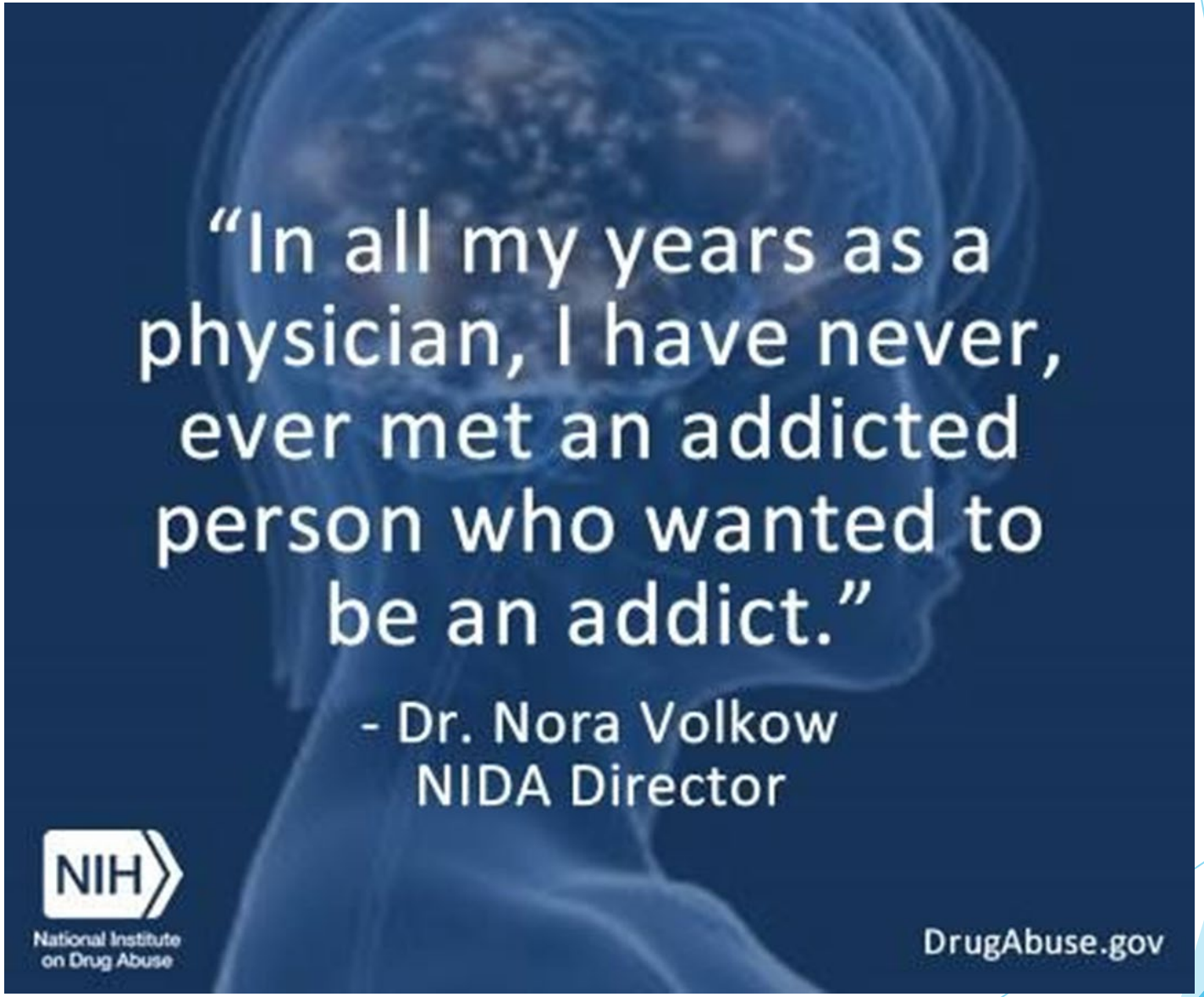
For more information contact Jennifer Fielder at jlfielder@anthc.org or (907) 729-1387

Conflict of Interest Disclosure

- Nothing to disclose

Objectives

- Participants will understand the need to de-stigmatize addiction medicine.
- Participants will learn how to talk with patients about MAT.


"In all my years as a physician, I have never, ever met an addicted person who wanted to be an addict."
- Dr. Nora Volkow
NIDA Director
NIH
National Institute on Drug Abuse
DrugAbuse.gov

Prevalence of Trauma
Substance Abuse Population

- Up to two-thirds of men and women in SA treatment report childhood abuse & neglect
  (SAMSHA CSAT, 2000)
- Study of male veterans in SA inpatient unit
  - 77% exposed to severe childhood trauma
  - 58% history of lifetime PTSD

  (Triffleman et al, 1995)

- 55-99% of women with substance use disorders have a lifetime history of trauma; 50% of women in treatment have history of rape or incest

(Najavits et. al., 1997; Gov. Commission on Sexual and Domestic Violence, Commonwealth of MA, 2006)

SAMHSA

acestoohigh.com

He says: Addiction shouldn't be called "addiction". It should be called "ritualized compulsive comfort-seeking".

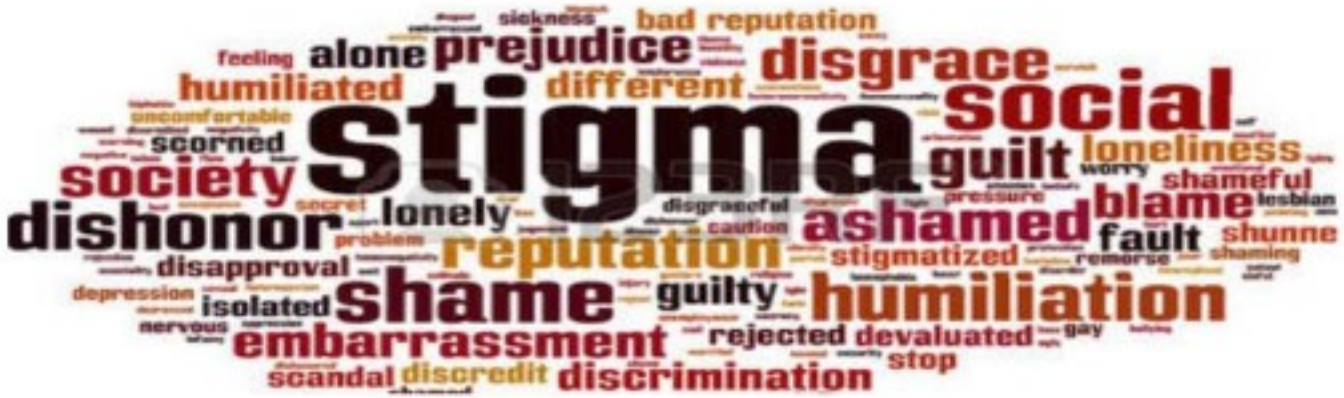
He says: Ritualized compulsive comfort-seeking (what traditionalists call addiction) is a *normal* response to the adversity experienced in childhood, just like bleeding is a normal response to being stabbed.

All too often healthcare settings re-traumatize patients when they seek care for their SUD by exposing them to stigma and ineffective or inappropriate treatments


Non-stigmatized Conditions
Low perceived fault
Low perceived control
High perceived fault
High perceived control
Stigmatized Conditions

What is Stigma?

- Stigma is defined as a mark of disgrace or infamy, a stain of reproach, as on one's reputation (SAMHSA, 2018)
- Stigma remains the biggest barrier to addiction treatment faced by patients/clients (naabt.org)



FACTS

- Substance Use Disorder (SUD) is among the most stigmatized conditions in the U.S. and around the world
- Healthcare providers might treat patients/clients with substance use disorders differently due to stigma
- People with a substance use disorder who expect or experience stigma have poorer healthcare outcomes

(SAMHSA, 2018)

Negative Consequences of Stigma

Drug addiction is viewed more negatively than mental illness.

(Johns Hopkins HUB, October 1, 2014)

People who experience stigma are less likely to seek treatment.

(*SAMHSA's Center For The Application Of Prevention Technologies*, 2017)

Trickle Down Effect:

Less willing to access healthcare →

Harm reduction is impaired →

Negative effect on self-esteem and mental health

The Real Stigma of Substance Use Disorders

In a study by the Recovery Research Institute, participants were asked how they felt about two people *"actively using drugs and alcohol."*

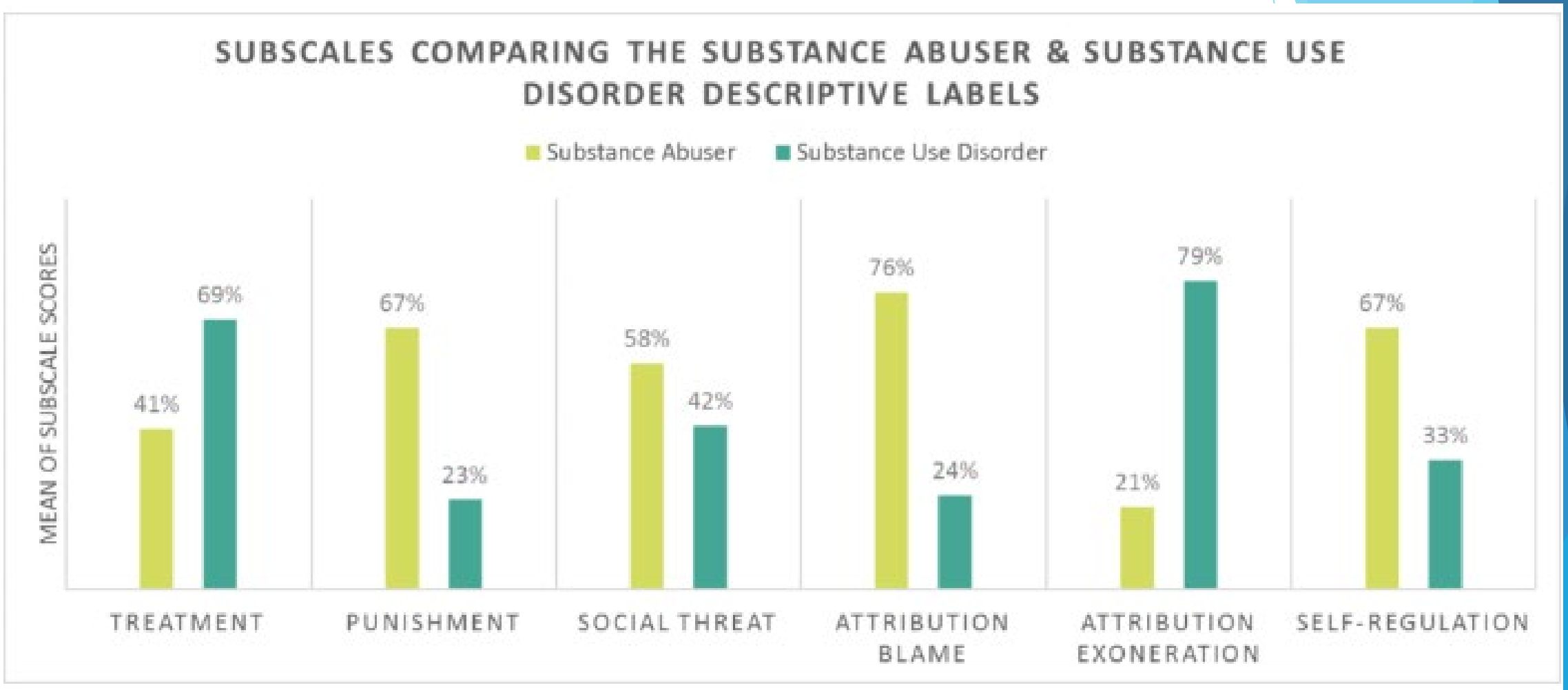
One person was referred to as a "substance abuser"

The other person as "having a substance use disorder"

No further information was given about these hypothetical individuals.

THE STUDY DISCOVERED THAT PARTICIPANTS FELT THE "SUBSTANCE ABUSER" WAS:

- less likely to benefit from treatment
- more likely to benefit from punishment
- more likely to be socially threatening
- more likely to be blamed for their substance related difficulties and less likely that their problem was the result of an innate dysfunction over which they had no control
- they were more able to control their substance use without help


SUBSCALES COMPARING THE SUBSTANCE ABUSER & SUBSTANCE USE DISORDER DESCRIPTIVE LABELS
Substance Abuser
Substance Use Disorder
MEAN OF SUBSCALE SCORES
41%
69%
67%
23%
58%
42%
76%
24%
21%
79%
67%
33%
TREATMENT
PUNISHMENT
SOCIAL THREAT
ATTRIBUTION BLAME
ATTRIBUTION EXONERATION
SELF-REGULATION

MAT = "MEDICATION FOR ADDICTION TREATMENT"

Words Matter:
How Language Choice Can Reduce Stigma

> *Protest any labels that turn people into things. Words are important. If you want to care for something, you call it a 'flower;' if you want to kill something, you call it a 'weed.'"* [i]

Avoid These Terms:	Use These Instead:
Addict, user, drug abuser, junkie	Person with opioid use disorder or person with opioid addiction, patient
Addicted baby	Baby born with neonatal abstinence syndrome
Opioid abuse or opioid dependence	Opioid use disorder
Problem	Disease
Habit	Drug addiction
Clean or dirty urine test	Negative or positive urine drug test
Opioid substitution or replacement therapy	Opioid agonist treatment
Relapse	Return to use
Treatment failure	Treatment attempt
Being clean	Being in remission or recovery

Myth

- Buprenorphine/methadone is among the most abused street drugs, It just replaces one addiction with another

JUST BECAUSE A MEDICATION HAS VALUE ON THE STREET DOES NOT MEAN THAT IT IS BEING USED TO “GET HIGH”

If you woke up tomorrow morning with the worse flu you've ever had…

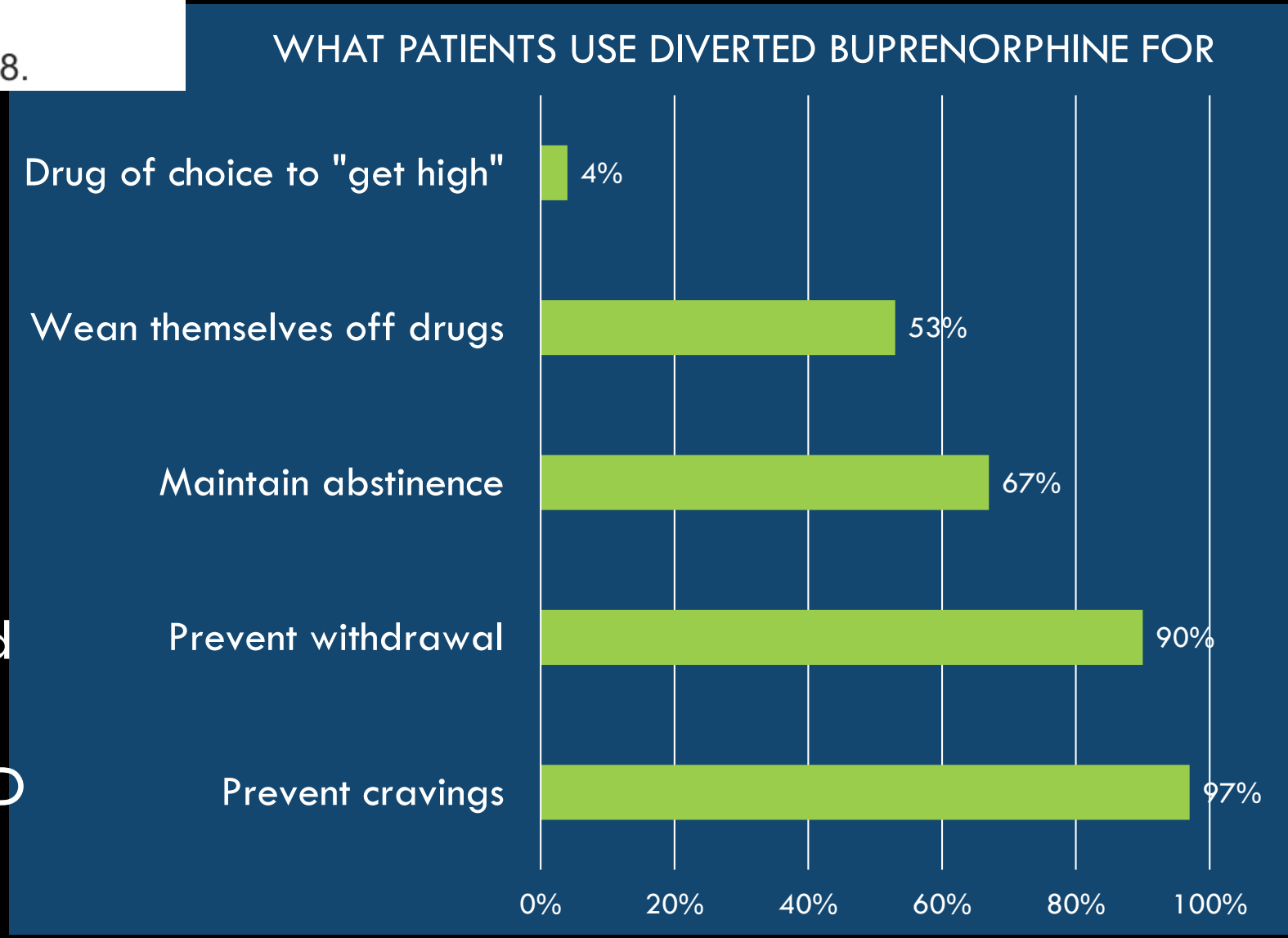
- Shaking chills and profuse sweating
- Vomiting, diarrhea and abdominal cramping
- Severe pain in every muscle and joint of your body
- A feeling of restlessness so severe that you wanted to tear your skin off
- An overwhelming feeling of despair and hopelessness

How much money would you pay for a single dose prescription medication that would relieve your symptoms for 24 hours?

Understanding the use of diverted buprenorphine.

Cicero TJ, et al. Drug Alcohol Depend. 2018.

"The minority proportion or people who use buprenorphine illicitly to get high has been shown to decrease over time, which could suggest that people abandon this goal after they experience the drugs blunted reward effects. Indeed, patients in treatment for OUD rarely endorse buprenorphine as the primary drug of misuse"



Some drug courts don't recommend methadone because of their personal biases against methadone as a valid treatment.

"Methadone always has this stigma associated with it…. People can't think of it as medicine"

The clinical implications of these biases can be grim. A judge in New York ordered a defendant taken off of methadone treatment, stating that it does not enable a person "to actually rid him or herself of the addiction." The man subsequently died from overdose

We tend to have a biased perception:

Patients who improve, leave and are forgotten

Patients who do *not* improve return frequently and are remembered

Leads us to think that most patients do not improve

…contrary to scientific data.

Drug vs Medication

Drugs are what people use to get high.

Medications are what people use to get well under a physician's care.

Because people taking them will not feel or act high on appropriate doses, medications do not compromise people's recovery.

Philedelphia dept Behav Health, adapted from
Narcotics Anonymous and the pharmacotherapeutic treatment of opioid addiction by William White

Methadone and buprenorphine DO NOT substitute one addiction for another

Addiction is defined by the American Society of Addiction Medicine as compulsive drug use despite harmful consequences. Taking a daily prescribed medication that improves functioning, health, and quality of life, while reducing other drug use and death, does not meet this definition.

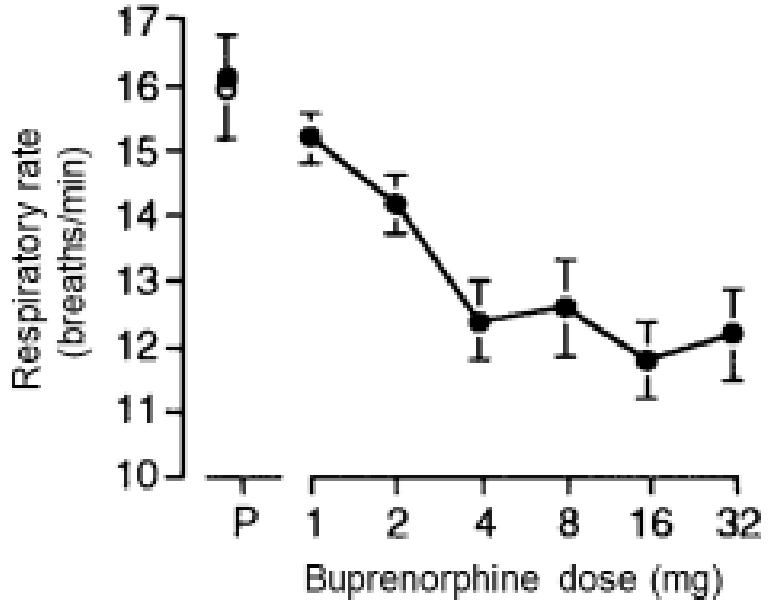
People taking opioid agonist therapy depend on a daily medication to keep their disease in remission, the same way that people with diabetes, hypertension, hyperlipidemia, hypothyroidism, and nearly every chronic medical condition do

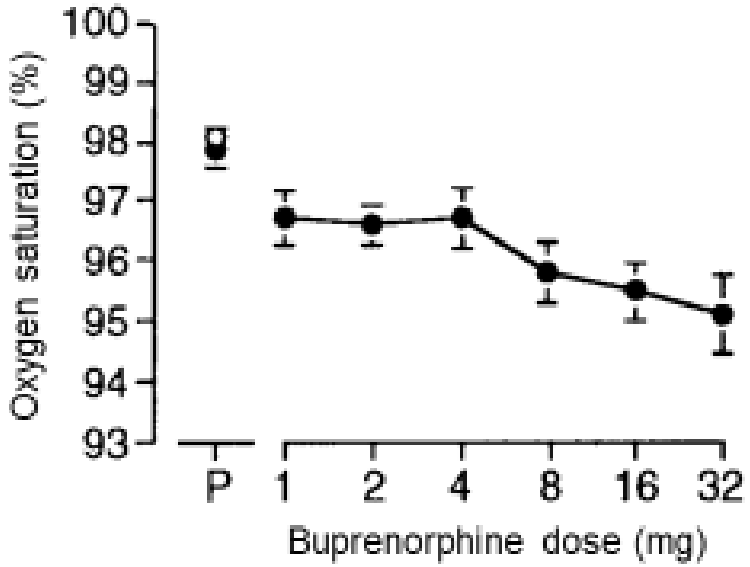
Myth

- Patients who take buprenorphine or methadone feel high and are not safe to work/drive/take care of their children

Buprenorphine Dosing: Safety

- Cognitive and psychomotor effects appear to be negligible





- Nearly all fatal poisonings involve multiple substances

Hakkinen et al., 2012
Walsh et al., 1994

PCSS Providers Clinical Support System

Does Opioid Agonist Therapy (OAT) cause impairment of psychomotor function?

Generally, once a patients OAT medication dose is stabilized for a few weeks, they should experience negligible psychomotor or cognitive effects

Most stable patients are able to safely work, drive, parent and perform cognitive tasks.

(Not allowed for Commercial License holders/CDL)

Impairment may occur with dose increases, the addition of new sedating medications, or use of alcohol or sedating drugs.

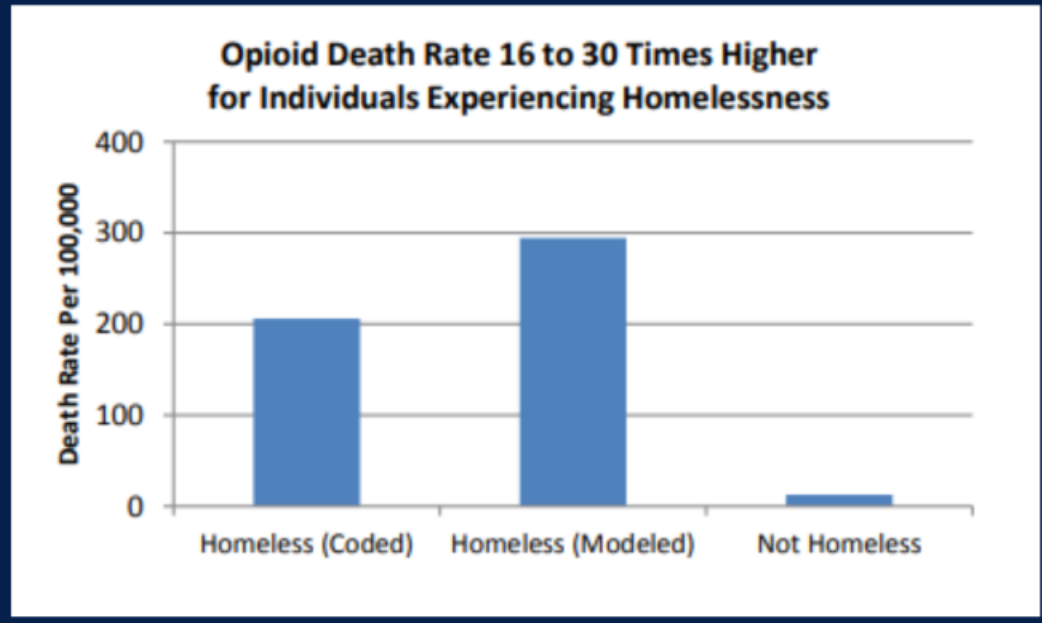
Patients who are stable on their medication should NOT exhibit daytime sleepiness (nodding out), and this symptom without recent medication changes should prompt evaluation for relapse.

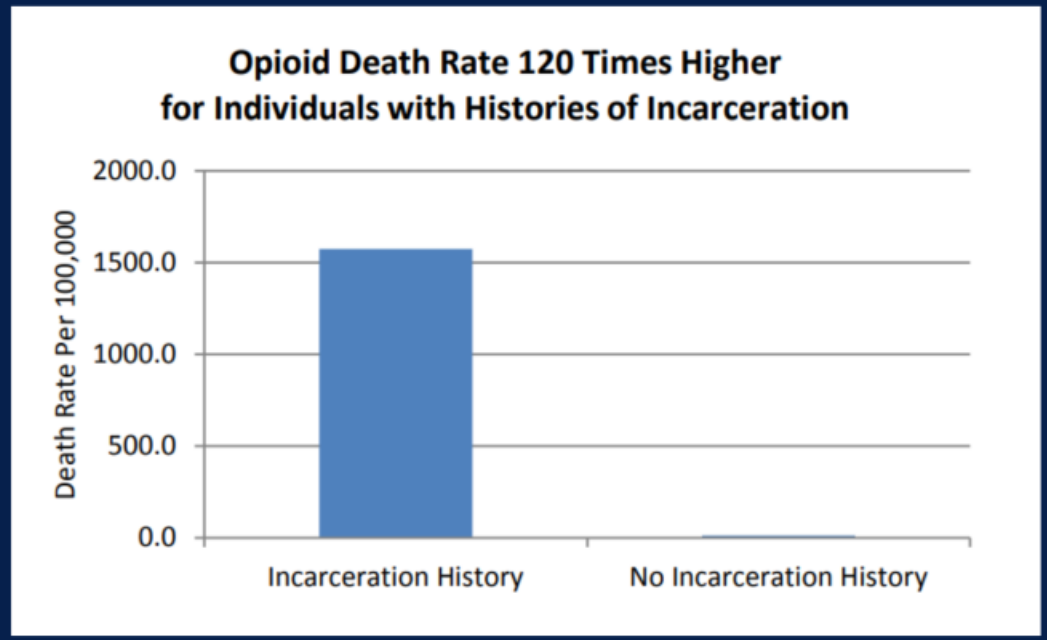
Myth

- Patients who take buprenorphine or methadone are at increase risk of overdose. These medications should not be used in patients who use sedatives or drink alcohol

Overdose *Does* Discriminate

- Those at greatest risk of death often most marginalized
- People experiencing incarceration, homelessness, serious mental illness have markedly higher rates of overdose death
- Treatment models not designed with these populations in mind





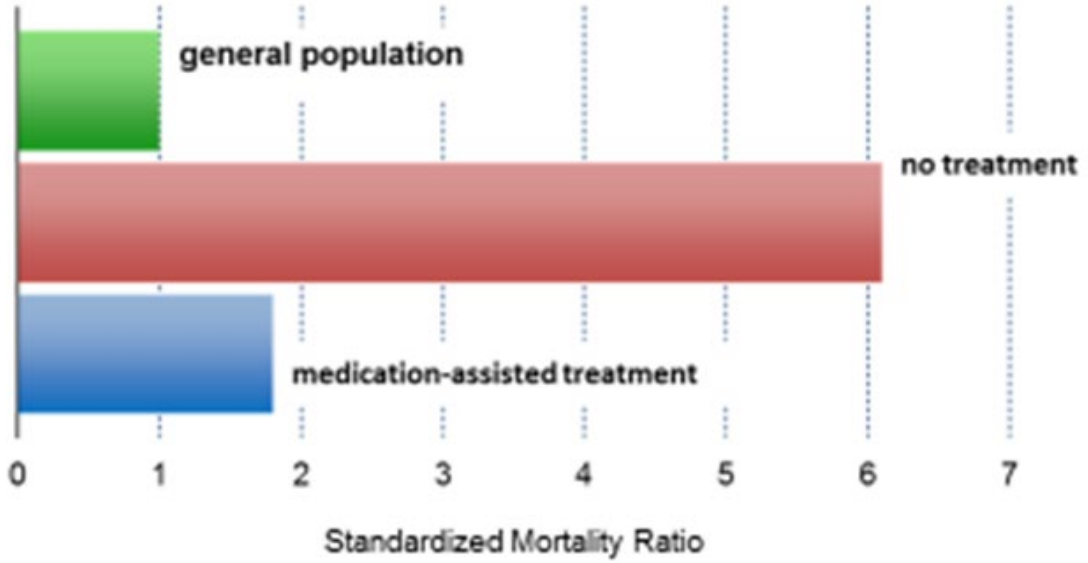
MA DPH. https://www.mass.gov/files/documents/2017/08/31/legislative-report-chapter-55-aug-2017.pdf

ASAM American Society of Addiction Medicine

Benefits of MAT: Decreased Mortality

MAT can reduce death rates by 80%

Death rates:



Overdose risk the first 2 weeks after leaving treatment is 10-30 times higher

Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017

Evidence Based Treatment

"Access to medication – assisted treatment can mean [the] difference between life or death."

Michael Botticelli, October 23, 2014
Director, White House Office of National Drug Control Policy

Risk vs. Benefit

"Based on our additional review, the U.S. Food and Drug Administration (FDA) is advising that the opioid addiction medications ***buprenorphine and methadone should not be withheld from patients taking benzodiazepines*** or other drugs that depress the central nervous system (CNS). The combined use of these drugs increases the risk of serious side effects; however, ***the harm caused by untreated opioid addiction can outweigh these risks.***"

FDA Drug Safety Communication, 9/20/17

Myth

- MAT is only meant to be used for a short period of time and the goal should be to taper the patient off as soon as possible

RECOVERY RESEARCH INSTITUTE

Even 3 years into treatment, patients that stay on their medication have 2/3 less relapse
5 years in have ½ the relapse rate

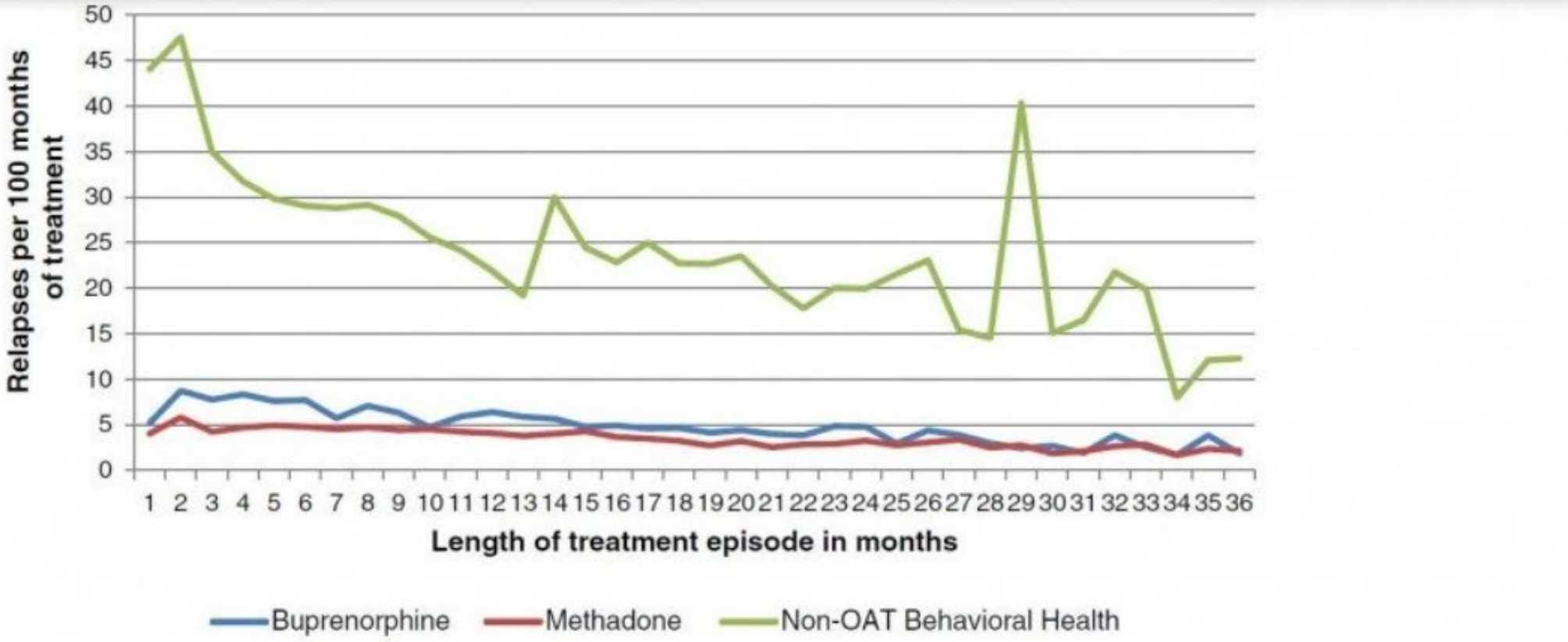


Fig. 1. Relapses during treatment among MassHealth members who received treatment for opioid addiction between 2003 and 2010[1]. [1] N = 18,866 episodes of buprenorphine treatment, 24,309 episodes of methadone treatment and 31,220 episodes of non-OAT behavioral health treatment in month 1. 33% of buprenorphine episodes, 52% of methadone episodes, and 12% of non-OAT treatment episodes lasted 12 months or more. 13% of buprenorphine treatment episodes, 27% of methadone episodes, and 1% of non-OAT treatment episodes lasted 24 months or longer.

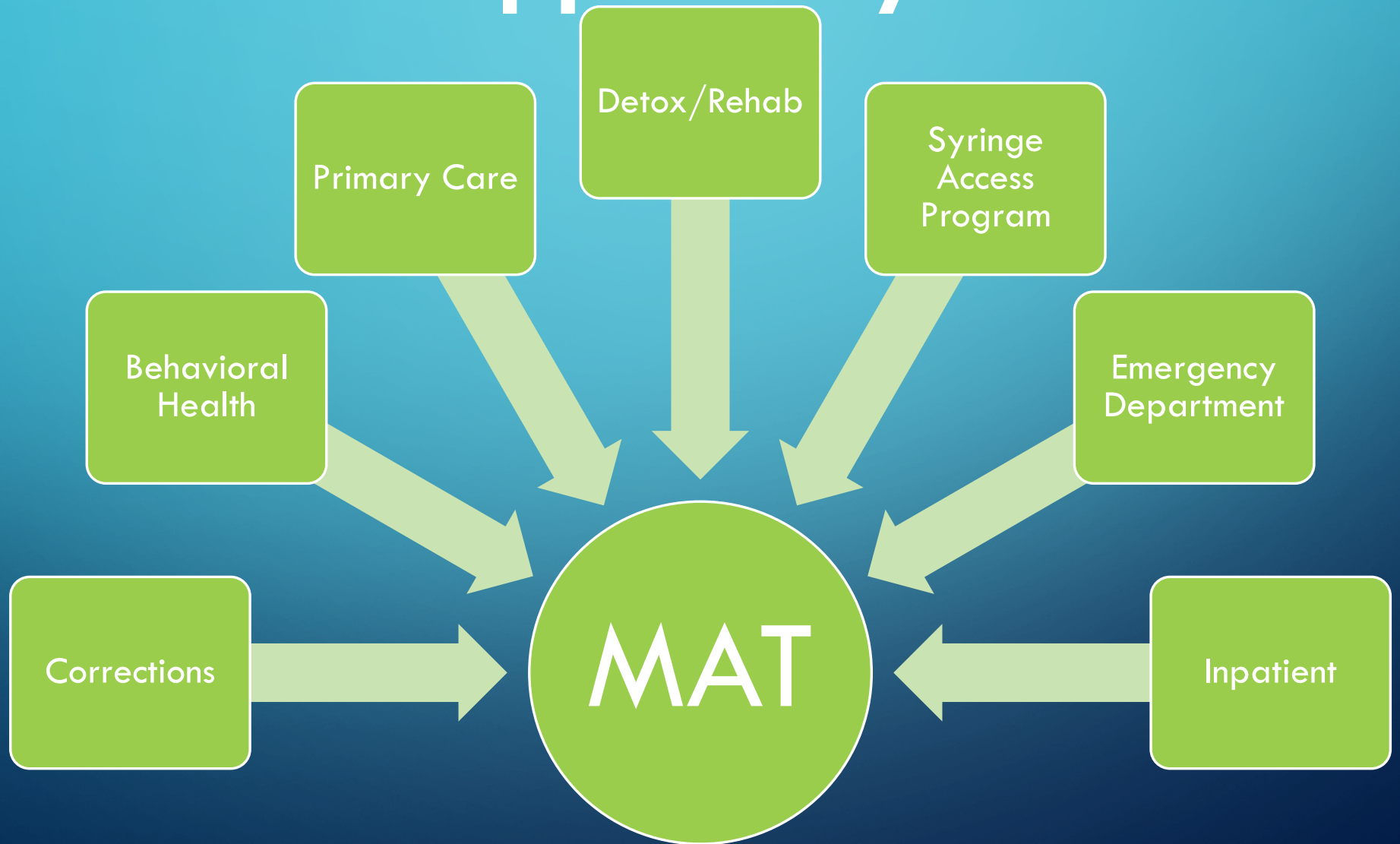
Medication Duration and Tapering

Evidence is clear that long-term or indefinite treatment with medications for OUDs is often required for effective and sustained outcomes.[48] In practice, successful tapers from methadone or buprenorphine typically occur in only about 15 percent of cases, the likely result of premature or unwarranted discontinuation of the medication regimens.[51, 68] Administering MAT for 90 days or less, which is common practice in many jails and prisons, offers no beneficial effects.[51] According to the U.S. Surgeon General, successful tapers typically occur, if at all, when individuals have been treated with MAT for at least 3 years.[69]

We work to counsel patient AGAINST discontinuation:

- During Pregnancy/postpartum
- During high stress times
- During surgery/hospitalization
- Due pressure from family/friends
- Because they “don’t need it anymore”

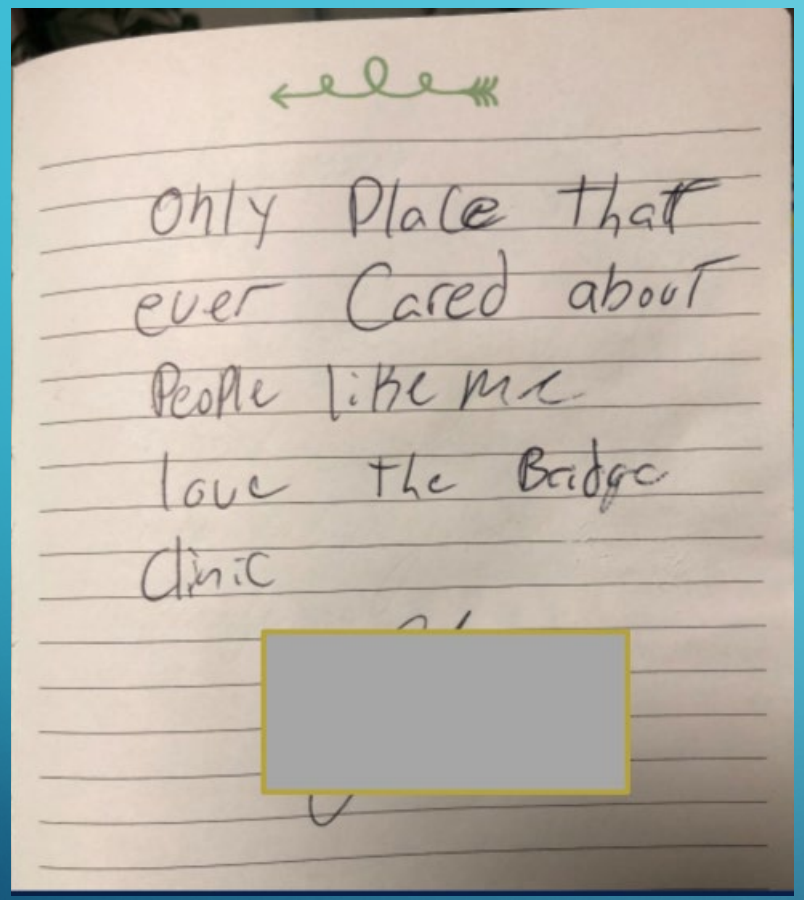
Meeting people where they are can happen anywhere



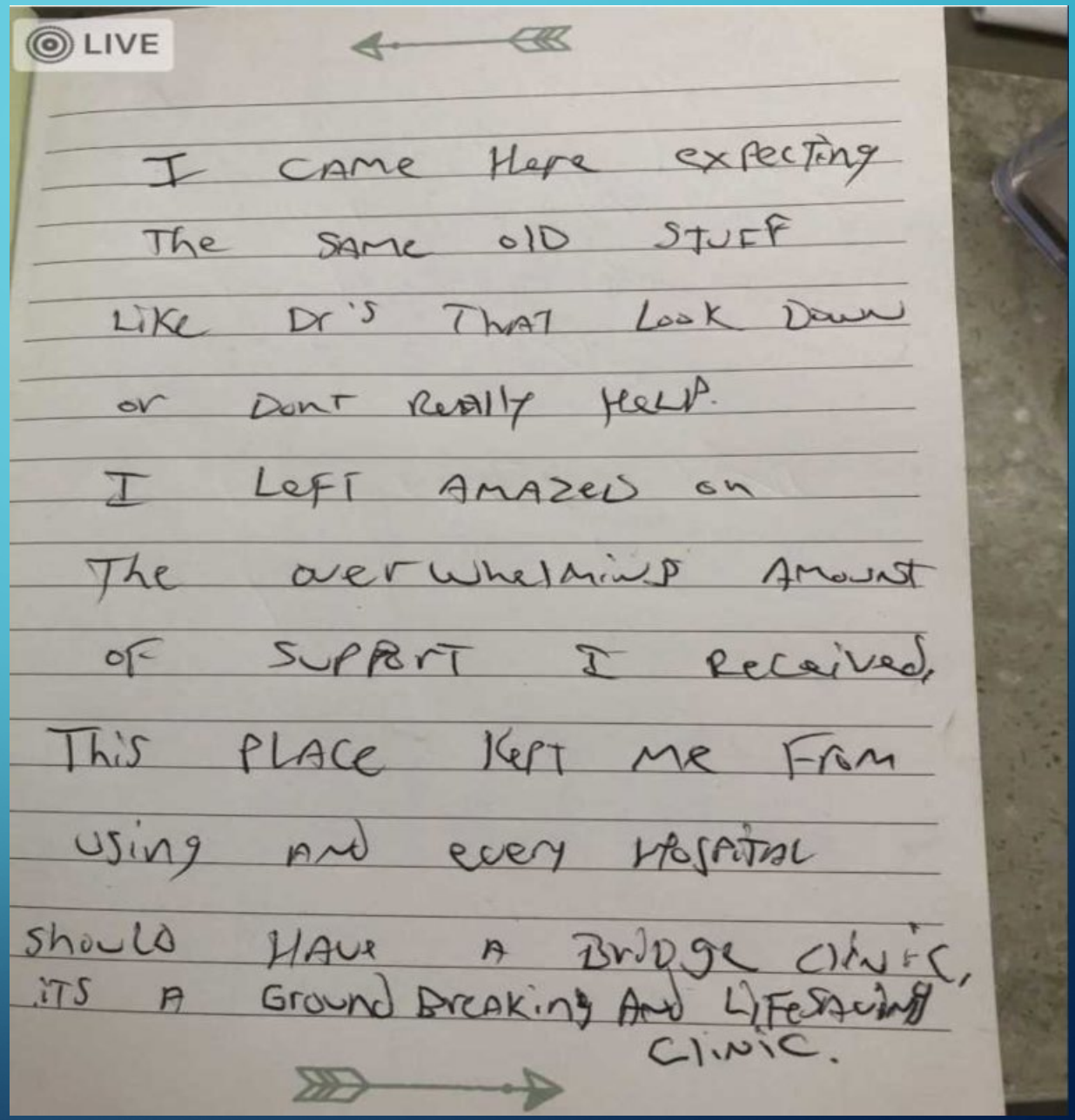
Dignity, Value and No Barriers

"The guiding vision of our work must be to create a city and a world in which people with a history of alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity, and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated."

-William White



From Mass General Bridge Clinic



References
PCSS training videos

- https://pcssnow.org/education-training/training-courses/stigma-and-oud/
- https://pcssnow.org/education-training/training-courses/role-shame-opioid-use-disorders/
- https://pcssnow.org/education-training/training-courses/respect-and-dignity-key-in-treating-substance-use-disorders/
- https://pcssnow.org/education-training/training-courses/sherri-kindness-and-support-was-key-in-her-recovery/

Case Presentation

Project ECHO's goal is to protect patient privacy

- To help Project ECHO accomplish that goal, please only display or say information that doesn't identify a patient or that cannot be linked to a patient.
- **References: For a complete list of protected information under HIPAA, please visit www.hipaa.com**

Thank you for joining us today.
We appreciate your participation and hope to see you at the **NEXT ECHO Session:**

February 25th, 2021 from 12pm -1 PM

You will be receiving a follow up survey that we hope you will complete to help us improve. If you are requesting continuing education credits, you will be required to complete the survey to receive your CEs.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