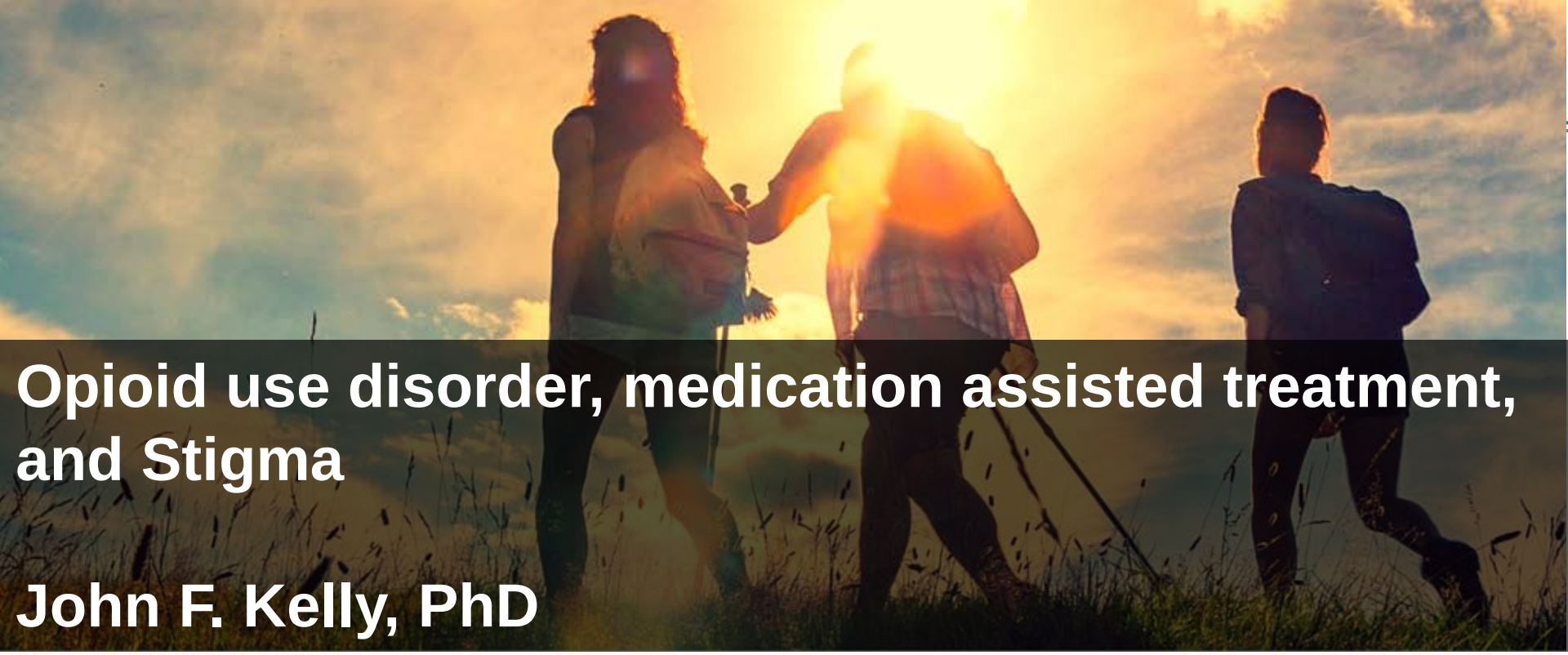

Opioid use disorder, medication assisted treatment, and Stigma

John F. Kelly, PhD

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What is stigma?

An attribute, behavior, or condition, that is socially discrediting

Addiction may be the most stigmatized condition in the US and around the world: Cross-cultural views on stigma

- **Sample**: Informants from 14 countries
- **Design**: Cross-sectional survey
- **Outcome**: Reaction to people with different health conditions

Stigma, social inequality and alcohol and drug use

ROBIN ROOM

Centre for Social Research on Alcohol and Drugs, Stockholm University, Stockholm, Sweden

Abstract

A heavy load of symbolism surrounds psychoactive substance use, for reasons which are discussed. Psychoactive substances can be prestige commodities, but one or another aspect of their use seems to attract near–universal stigma and marginalization. Processes of stigmatization include intimate process of social control among family and friends; decisions by social and health agencies; and governmental policy decisions. What is negatively moralized commonly includes incurring health, casualty or social problems, derogated even by other heavy users; intoxication itself; addiction or dependence, and the loss of control such terms describe; and in some circumstances use per se. Two independent literatures on stigma operate on different premises: studies oriented to mental illness and disability consider the negative effects of stigma on the stigmatized, and how stigma may be neutralized, while studies of crime generally view stigma more benignly, as a form of social control. The alcohol and drug literature overlap both topical areas, and includes examples of both orientations. Whole poverty and heavy substance use are not necessary related, poverty often increases the harm for a given level of use. Marginalization and stigma commonly add to this effect. Those in treatment for alcohol or drug problems are frequently and disproportionately marginalized. Studies of social inequality and substance use problems need to pay attention also to processes of stigmatization and marginalization and their effect on adverse outcomes. [Room R. Stigma, social inequality and alcohol and drug use. *Drug Alcohol Rev* 2005;24:143–155]

Key words: stigma, marginalization, social inequality, alcohol problems, drug problems, social control, moralization

Factors that influence stigma have language that is associated with them…

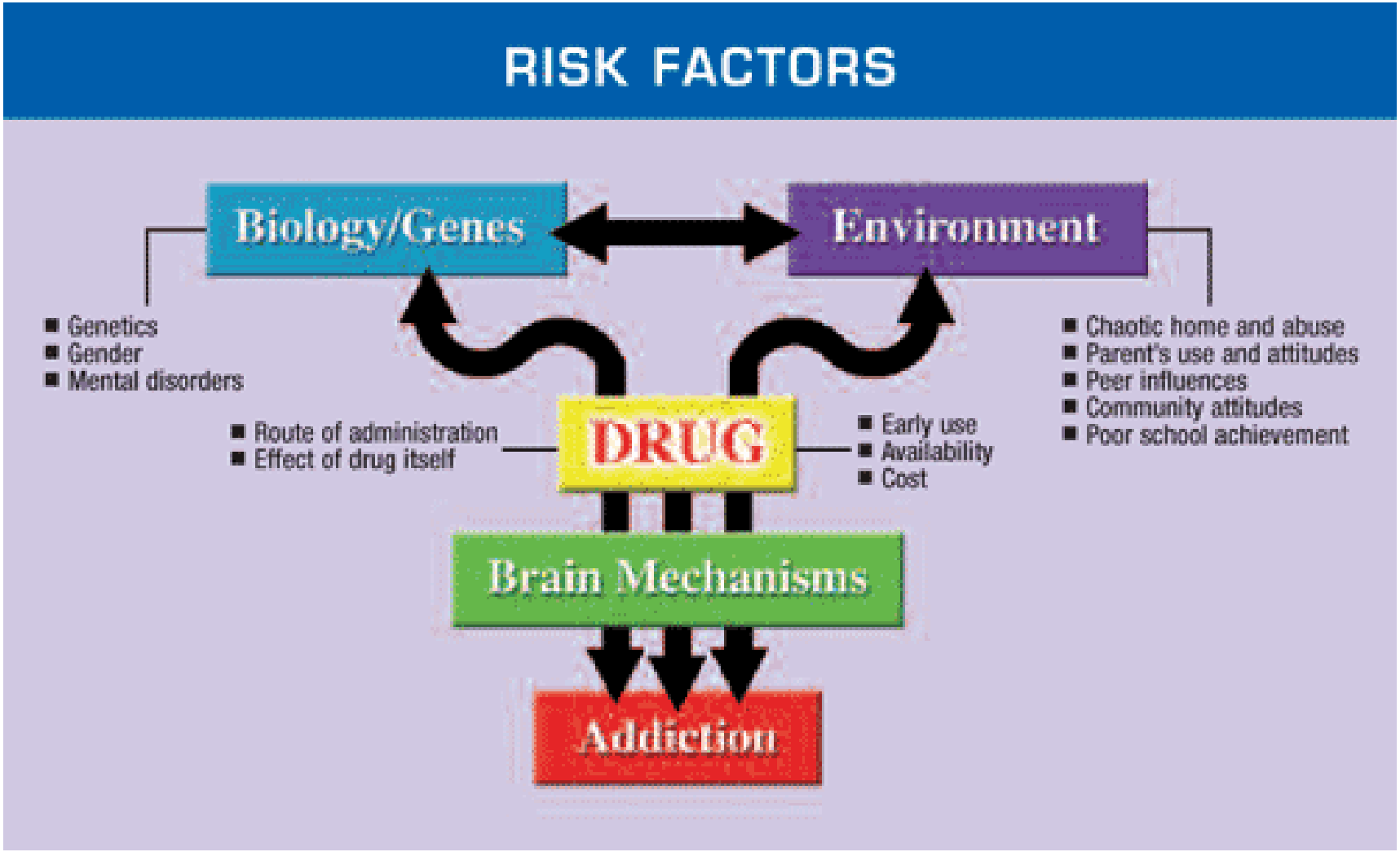
Cause	Controllability	Stigma
“It’s not their fault”	“They can’t help it”	Decreases
“It is their fault”	“They really can help it”	Increases

Addiction has strong genetic influence

If alcohol/drugs are so pleasurable, why aren't we all addicted?

MASSACHUSETTS GENERAL HOSPITAL

G x E Interactions: Risk Factors in Addiction



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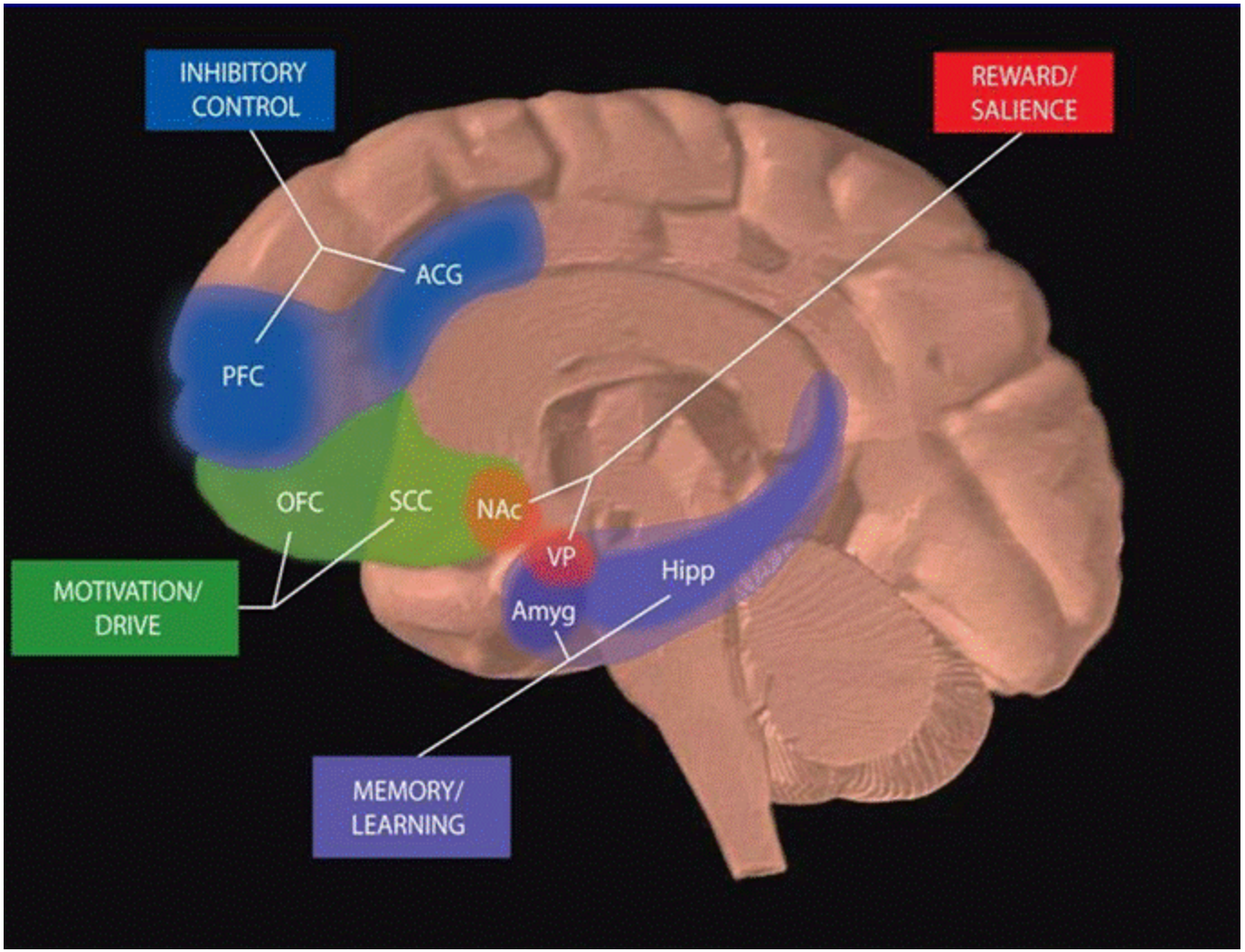
Circuits Involved In Drug use and Addiction



All of these brain regions must be considered in developing strategies to effectively treat addiction

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Addiction stigma; treatment and stigma

- Addiction very stigmatized
- Perverse that we would stigmatize a treatment that actually helps people recovery?
- Why?
- Lack of knowledge about/exposure to scientific findings?

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Agonist therapies - strong evidence supporting use

Opioid agonist treatment for pharmaceutical opioid dependent people (Review)

Nielsen S, Larance B, Degenhardt L, Gowing L, Kehler C, Lintzeris N

"… low to moderate quality evidence supporting the use of maintenance agonist pharmacotherapy for pharmaceutical opioid dependence. Methadone or buprenorphine appeared equally effective. Maintenance treatment with buprenorphine appeared more effective than detoxification or psychological treatments. "

ONLINE FIRST

Adjunctive Counseling During Brief and Extended Buprenorphine-Naloxone Treatment for Prescription Opioid Dependence

A 2-Phase Randomized Controlled Trial

Roger D. Weiss, MD; Jennifer Sharpe Potter, PhD; David A. Fiellin, MD; Marilyn Byrne, MSW; Hilary S. Connery, MD, PhD; William Dickinson, DO; John Gardin, PhD; Margaret L. Griffin, PhD; Marc N. Gourevitch, MD, MPH; Deborah L. Haller, PhD; Albert L. Hasson, MSW; Zhen Huang, MS; Petra Jacobs, MD; Andrzej S. Kosinski, PhD; Robert Lindblad, MD; Elinore F. McCance-Katz, MD; Scott E. Provost, MSW; Jeffrey Selzer, MD; Eugene C. Somoza, MD, PhD; Susan C. Sonne, PharmD; Walter Ling, MD

Context: No randomized trials have examined treatments for prescription opioid dependence, despite its increasing prevalence.

Objective: To evaluate the efficacy of brief and extended buprenorphine hydrochloride–naloxone hydrochloride treatment, with different counseling intensities, for patients dependent on prescription opioids.

Design: Multisite, randomized clinical trial using a 2-phase adaptive treatment research design. Brief treatment (phase 1) included 2-week buprenorphine-naloxone stabilization, 2-week taper, and 8-week postmedication follow-up. Patients with successful opioid use outcomes exited the study; unsuccessful patients entered phase 2: extended (12-week) buprenorphine-naloxone treatment, 4-week taper, and 8-week postmedication follow-up.

Setting: Ten US sites.

Patients: A total of 653 treatment-seeking outpatients dependent on prescription opioids.

Interventions: In both phases, patients were randomized to standard medical management (SMM) or SMM plus opioid dependence counseling; all received buprenorphine-naloxone.

Main Outcome Measures: Predefined "successful outcome" in each phase: composite measures indicating minimal or no opioid use based on urine test–confirmed self-reports.

Results: During phase 1, only 6.6% (43 of 653) of patients had successful outcomes, with no difference between SMM and SMM plus opioid dependence counseling. In contrast, 49.2% (177 of 360) attained successful outcomes in phase 2 during extended buprenorphine-naloxone treatment (week 12), with no difference between counseling conditions. Success rates 8 weeks after completing the buprenorphine-naloxone taper (phase 2, week 24) dropped to 8.6% (31 of 360), again with no counseling difference. In secondary analyses, successful phase 2 outcomes were more common while taking buprenorphine-naloxone than 8 weeks after taper (49.2% [177 of 360] vs 8.6% [31 of 360], $P < .001$). Chronic pain did not affect opioid use outcomes; a history of ever using heroin was associated with lower phase 2 success rates while taking buprenorphine-naloxone.

Conclusions: Prescription opioid–dependent patients are most likely to reduce opioid use during buprenorphine-naloxone treatment; if tapered off buprenorphine-naloxone, even after 12 weeks of treatment, the likelihood of an unsuccessful outcome is high, even in patients receiving counseling in addition to SMM.

Trial Registration: clinicaltrials.gov Identifier: NCT00316277

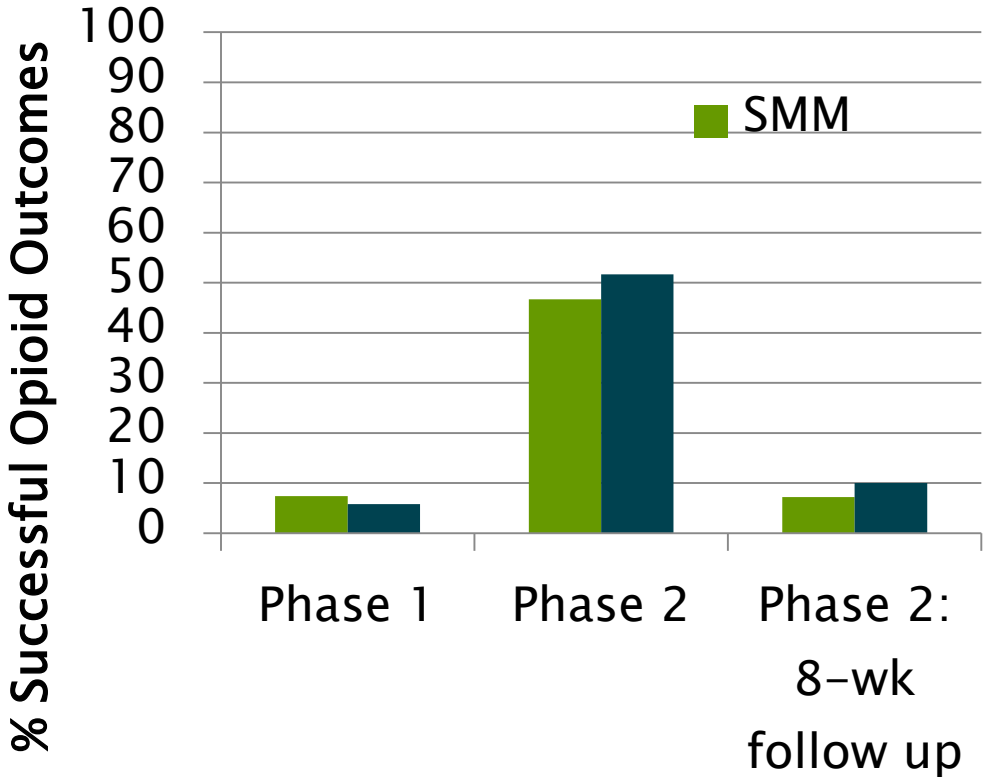
Arch Gen Psychiatry. 2011;68(12):1238-1246.
Published online November 7, 2011.
doi:10.1001/archgenpsychiatry.2011.121

Methods

- Study Design: Multisite, randomized clinical trial
  - 2-phases:
    - **Brief treatment:** 2-week suboxone stabilization, 2-week taper, 8-week follow-up
    - **Extended treatment:** patients with unsuccessful opioid use outcomes received an additional 12-weeks of suboxone, a 4-week taper, + 8-week follow-up
    - **Successful outcome**: minimal or no opioid use (urinalysis, self report)
- Sample: 653 treatment-seeking outpatients dependent on prescription opioids (M age=33 [SD=10]; 40% women; 91% White)
- Intervention: Participants randomized to standard medical management (SMM) or SMM + opioid dependence counseling
  - All received buprenorphine-naloxone

Results: Successful Opioid Outcome

- Phase 1: 7% of patients had successful outcomes
- Phase 2: 49% of patients had successful outcomes
- Secondary Analyses:
  - Successful phase 2 outcomes were more common while taking suboxone than 8 weeks after taper ($p<.001$)
- Weiss et al, (2013) 42 month follow found approx:
  - One third off of suboxone and in remission
  - One third on suboxone and in remission
  - One third doing poorly



Drug and Alcohol Dependence 150 (2015) 112–119

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Dorian R. Dodd[a], Jessica A. Dreifuss[a,b], R. Kathryn

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Keywords:
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Treatment
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Heroin

ABSTRACT

Background: Despite th
not examined long-ter
the Prescription Opioid
Methods: POATS was a
of buprenorphine-nalo
with participants rand
participants (N = 375 o
approximately 18, 30, a
by follow-up participat
Results: At Month 42, m
therapy; 29.4% were re
dependence; 7.5% were
opioids without agonis
more likely to meet DS
p < .05). Engagement in
nence. Eight percent (n
injection heroin use.
Conclusions: Long-term
improvement from bas
and/or injection opioid

At 42 Month follow-up from this multi-site community treatment study of opioid agonist therapy:

- 32% abstinent and no longer on agonist therapy
- 29% on agonist therapy but in OUD remission
- 8% using while on agonist therapy
- 31% using without agonist therapy

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At 42 Month follow-up from this multi-site community treatment study of opioid agonist therapy:

nt and no longer on
apy

nist therapy but in
on

ile on agonist thera

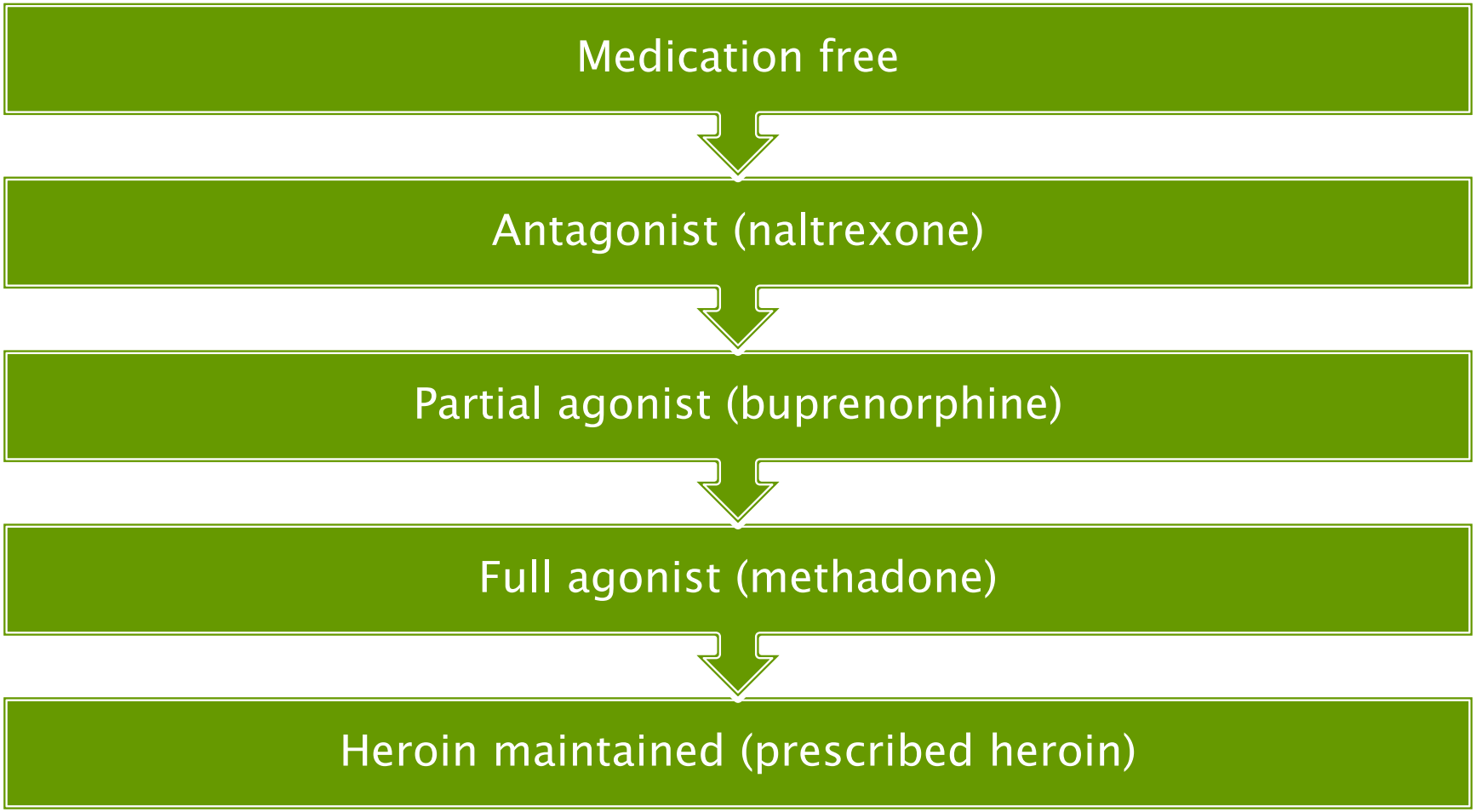
ithout agonist
therapy)

Hazelden Betty Ford (and likely Caron Foundation) now in favor of bup/nlx

Objections to MAT…

- “Still using an opioid”/”not clean”
- “Crutch”
- “They’re still “addicted”/dependent”
- “They’re not in recovery”
- “They’re treading water; not going anywhere/not moving forward”
- “It’s just social control”
- “Liquid handcuffs”

Hierarchy of Stigma in OUD Recovery



Challenges and potential solutions for MAT stigma

MAT stigma challenges	Suggestions to help reduce stigma around MAT
Medications used for w/d without controversy for decades; “well ok, but surely not ‘forever’ “	Inform about acute and post-acute w/d; not every substance use disorder is the same
Contention around continuing on medication – origin? (taking a “drug” to “treat a drug (problem”)?	Methadone/bup-nalx are medicines not “drugs” (Bill W. asked Dole to devise medicines like methadone to treat AUD (Dole, 1991; ACER)
Historical tx philosophy contention between “drug free/abstinence” based approaches and MAT approaches (especially agonist rx)	Evidence strongly indicates MAT are best practices for OUD
Medication iatrogenics (gonna make things worse)	Make distinction between use of a medicine to aid recovery vs. use of a drug that hinders recovery
Suboxone/methadone “addiction”	Make clear the distinction between “dependence” vs “addiction”

What can we do about stigma and discrimination in OUD?

- **Education** about nature of addiction; most people achieve remission but can take time; MAT is the most effective approach to facilitating long-term remission; need to **celebrate every pathway** that save lives and facilitates long-term change, remission, and recovery

- **Personal witness** need more people who are on MAT or have used it to facilitate recovery to speak out, tell their story of recovery and how MAT helped (see http://www.marsproject.org/)

- **Change our language/terminology** to be consistent with the nature of the condition and the policies/procedures we wish to implement to address it; move away from “heroin addicts” to person-first and “opioid use disorder”; need to shift away from “MAT” to “Opioid use disorder treatment”

Thank you for your attention!

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