Discrimination & the Opioid Crisis

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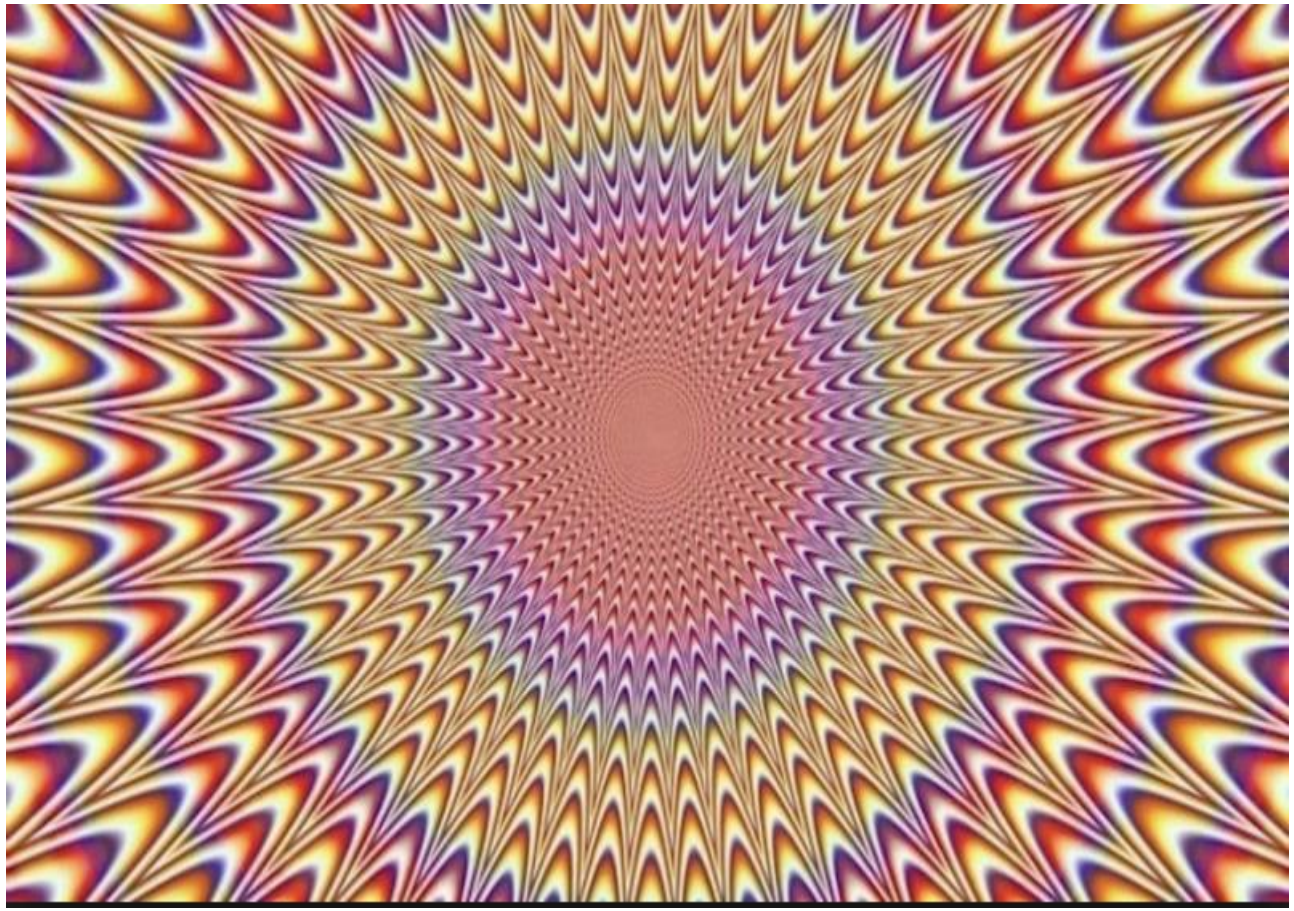
Stigma and Discrimination

- Stigma refers to **negative stereotypes**
- Discrimination is the **behavior that results** from the negative stereotype
- Discrimination in this case means treating someone less favorably than someone else because he or she has a disability
  - Would you treat someone less favorably because they were prescribed insulin for diabetes? What about people with high-cholesterol who are prescribed cholesterol-lowering medication?

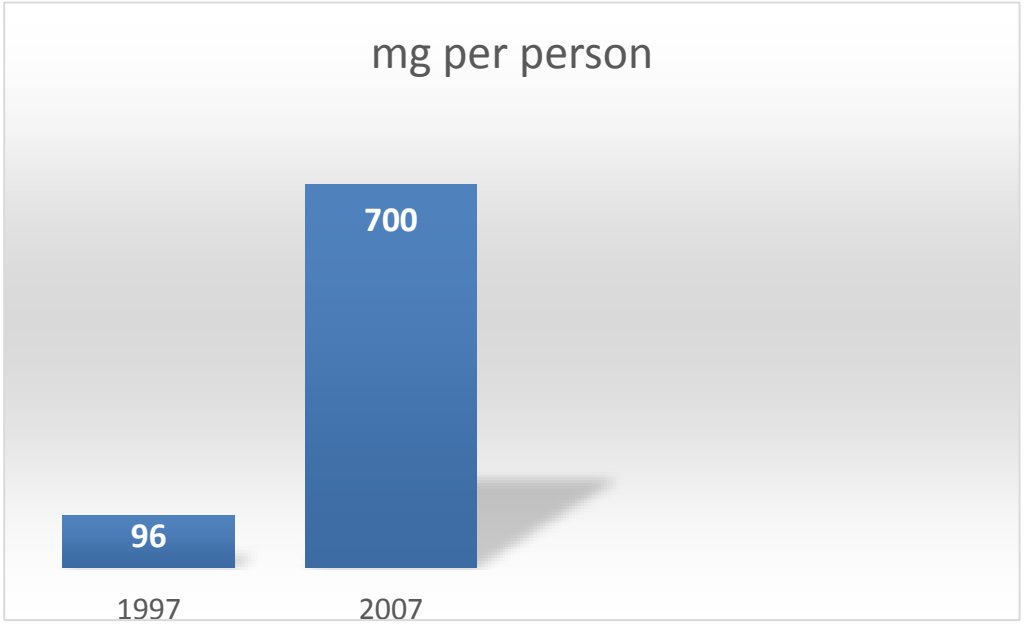
Beliefs

Perceptions



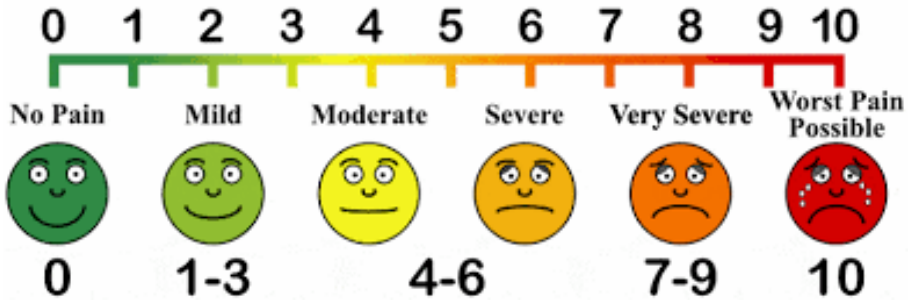
Opioid Use Increase

- Drug distribution through the pharmaceutical supply chain was the equivalent of **96 mg of morphine per person** in 1997
- During 2007, this equivalent was approximately **700 mg per person:** an increase of >600%



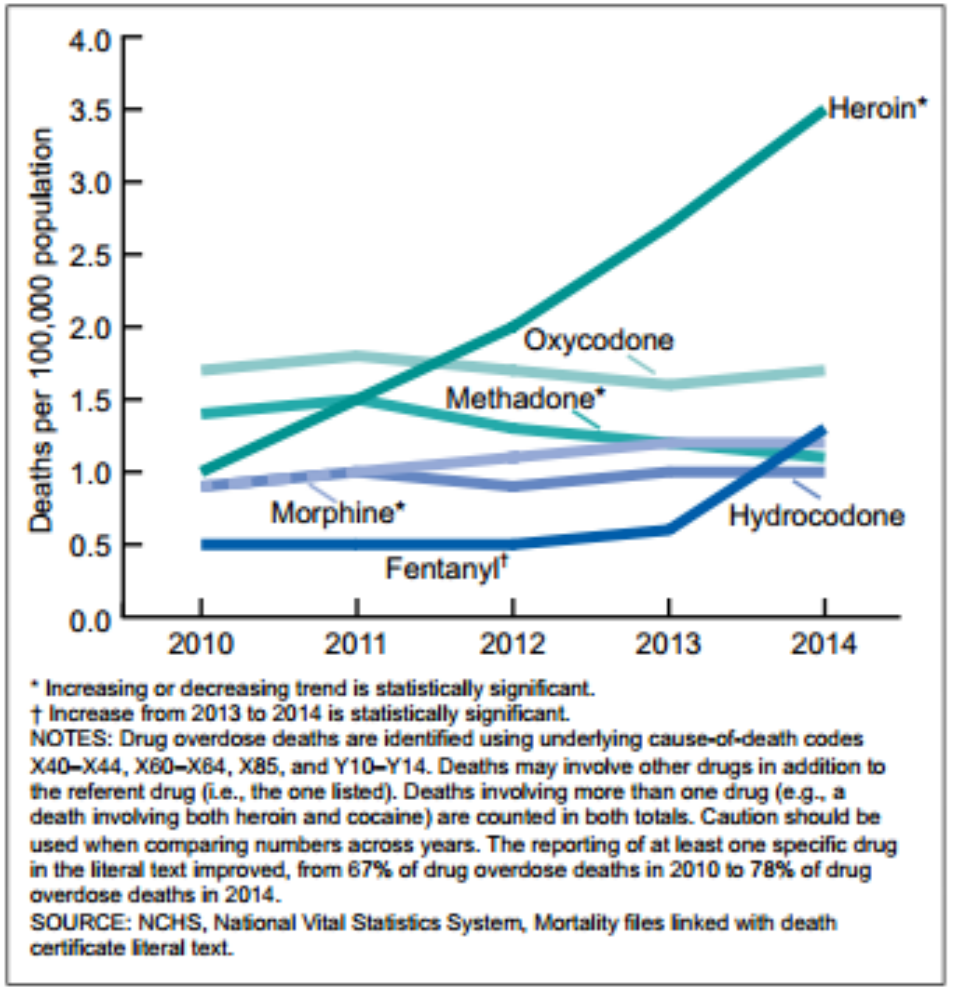
Origins of Opioid Crisis

- **Opioids Myth: Non-Addictive**
  - Porter and Jick letter published in New England Journal of Medicine in 1980; frequently cited in marketing of new synthetic opioids
  - OxyContin brought to market in 1996
- **History of Untreated Pain**
  - Pain was left untreated even for terminally-ill cancer patients
  - Doctors were weary of prescribing opioid medications
- **Pain As 5th vital sign**
  - National initiative rolled out in the late 90s



- **Emergence of Pill Mills**
  - Unrestricted prescribing of pain medications
  - Unlike legitimate pain clinics, pill mills see greater numbers of patients, write more prescription, and do less medical exams. Most are cash-only.
- **Greater availability of heroin**
  - Larger, cheaper supply and more potent than prescription painkillers
- **Leading Cause of Accidental Death**
  - Starting in 2008, drug overdoses became the leading cause of injury death in the United States surpassing car accidents and firearms

Overdose Deaths



* Increasing or decreasing trend is statistically significant.
† Increase from 2013 to 2014 is statistically significant.
NOTES: Drug overdose deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Deaths may involve other drugs in addition to the referent drug (i.e., the one listed). Deaths involving more than one drug (e.g., a death involving both heroin and cocaine) are counted in both totals. Caution should be used when comparing numbers across years. The reporting of at least one specific drug in the literal text improved, from 67% of drug overdose deaths in 2010 to 78% of drug overdose deaths in 2014.
SOURCE: NCHS, National Vital Statistics System, Mortality files linked with death certificate literal text.

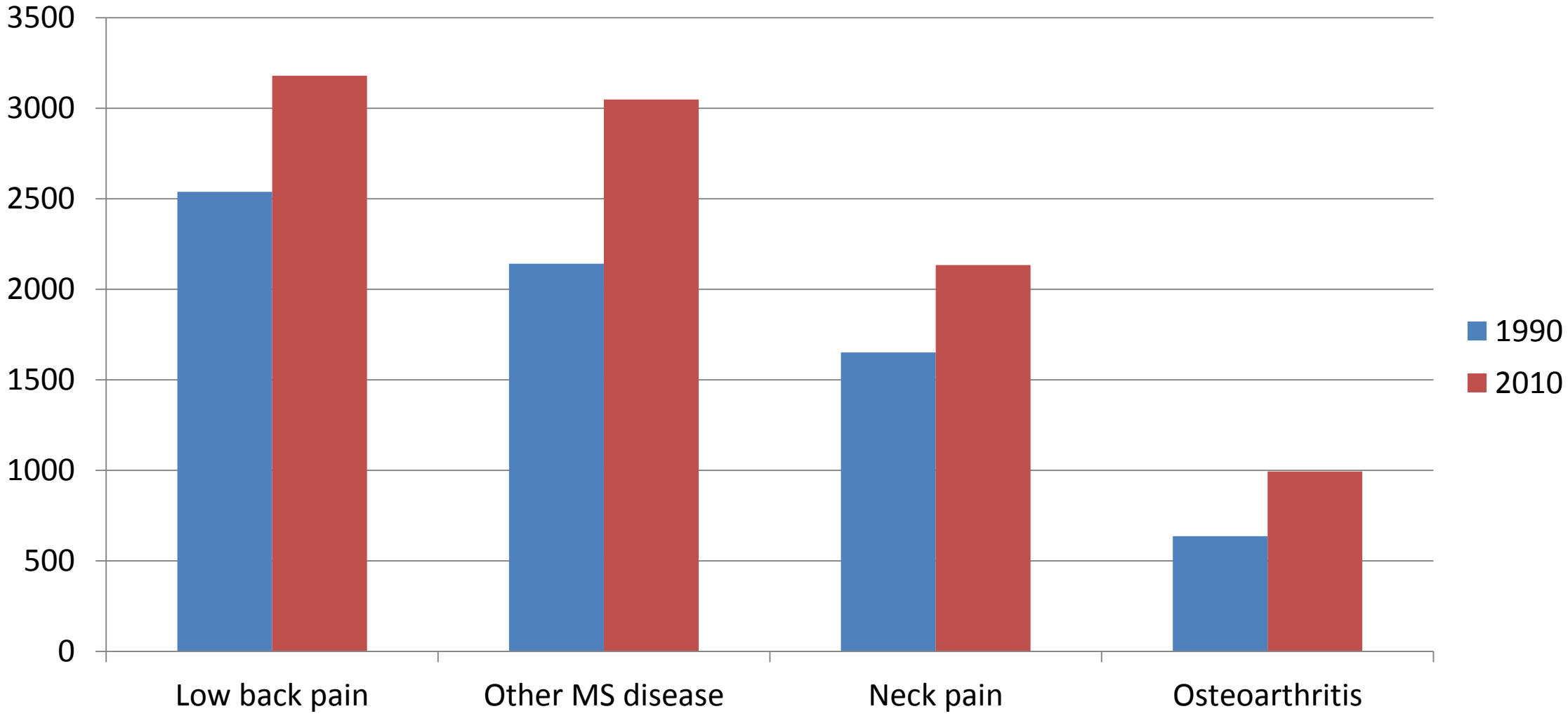
Figure 1. Age-adjusted rates for drug overdose deaths involving selected opioids: United States, 2010–2014

<u>Conclusion:</u> Rising rate of overdose deaths is driven largely by Heroin and Fentanyl

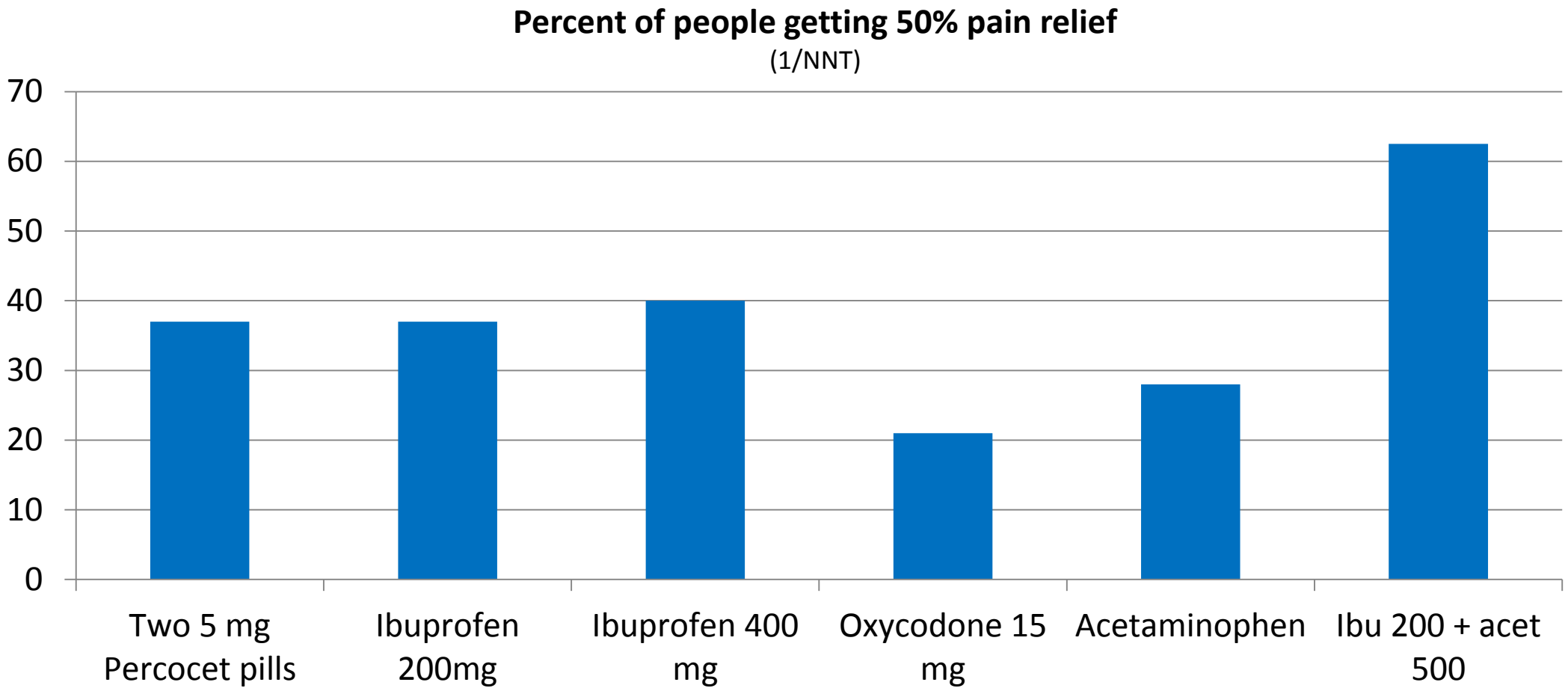
Warner et al. ***National Vital Statistics Report,*** **2016;65(10).**

The State of US Health

Years lived with disability (in thousands)[3]



Effectiveness of pain meds
(from Cochrane reviews)



For every prescription opioid overdose death in 2011, there were…

12 treatment admissions for opioids

25 emergency department visits for opioids

105 people who abused or were dependent on opioids

659 nonmedical opioid users

How has our definition of addiction changed?

- Addiction was thought of as a **moral failing** or **character defect**
- Drug use: criminal issue vs. health issue
- Language matters: move away from *“addicts”*
  - Scientific research has demonstrated that, whether we are aware of it, the use of certain terms implicitly generate biases that can influence the formation and effectiveness of our social and public health policies in addressing them

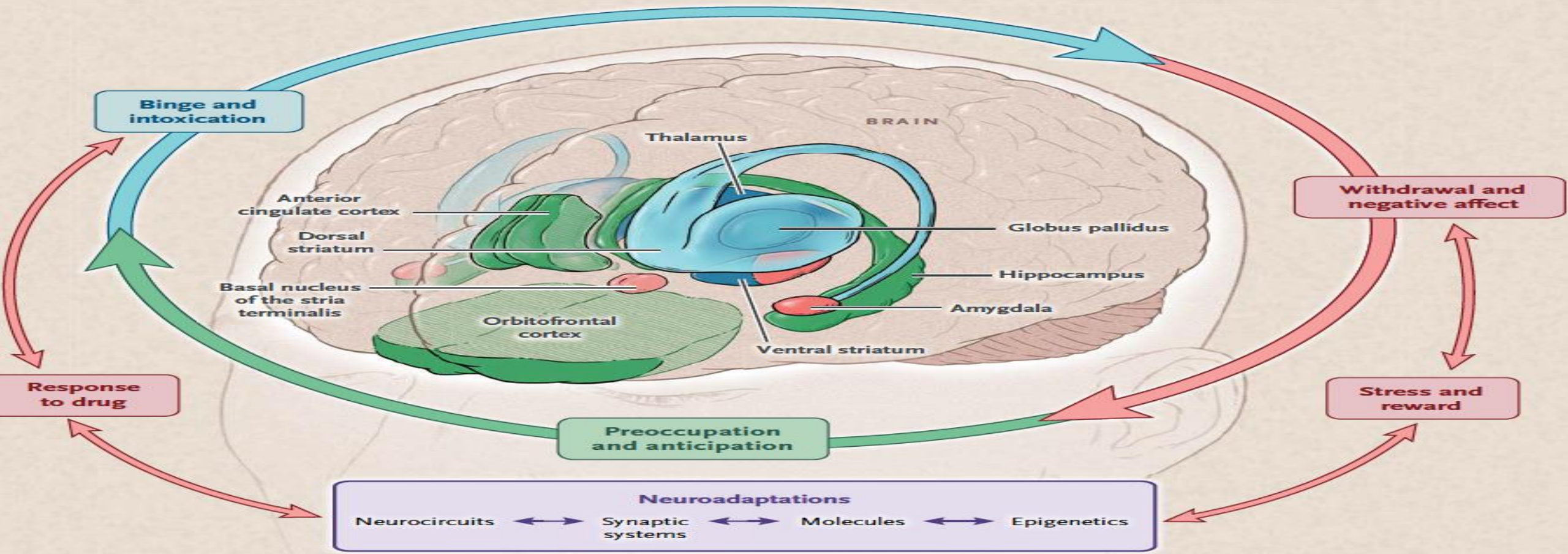
The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

Dan L. Longo, M.D., *Editor*

Neurobiologic Advances from the Brain Disease Model of Addiction

Nora D. Volkow, M.D., George F. Koob, Ph.D., and A. Thomas McLellan, Ph.D.



age of Addiction	Shifting Drivers Resulting from Neuroadaptations		
nge and intoxication	Feeling euphoric	Feeling good	Escaping dysphoria
ithdrawal and negative affect	Feeling reduced energy	Feeling reduced excitement	Feeling depressed, anxious, restless
eoccupation and anticipation	Looking forward	Desiring drug	Obsessing and planning to get drug

Behavioral Changes		
Voluntary action Abstinence Constrained drug taking	Sometimes taking when not intending Sometimes having trouble stopping Sometimes taking more than intended	**Impulsive action** Relapse Compulsive consumption

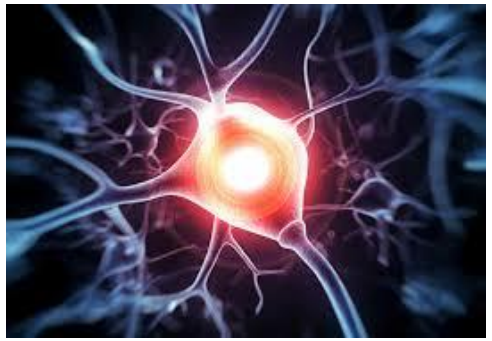
ure 1. **Stages of the Addiction Cycle.**

Defining Addiction

"Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry."

- ASAM

Disease Concept of Addiction



- Although scholarly writings on addiction as a disease date back to the early 1800s, the creation of Alcoholics Anonymous (AA) popularized the disease concept in the mid-20th century

- In 1956, the American Medical Association classified alcoholism as an illness

Defining Addiction

Addiction is a primary, chronic disease

- Biological
- Psychological
- Social

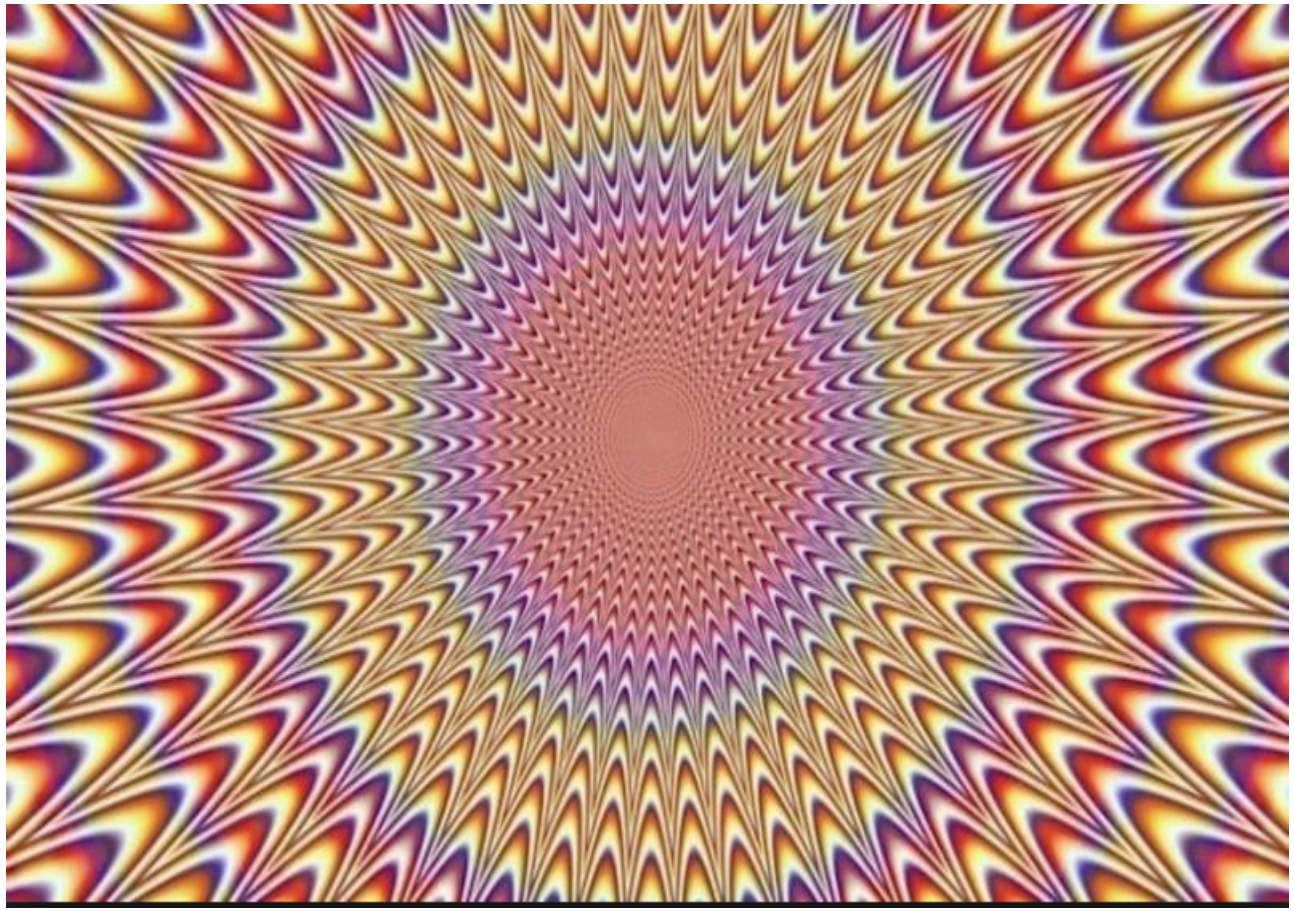
Components

Addiction is a….

chronic health condition

Beliefs

Perceptions



What is recovery?

- Persistent intentional abstinence from intoxication
- Engagement in daily life
- Gaining employment
- Re-establish family and social ties
- Being present in everyday life
- Being able to weather the challenges, daily lows and highs of life without using substances as an external coping skills that has negative side effects and consequences

How has addiction treatment changed?

- Short-term acute interventions vs. chronic disease management model
- Relapse is a part of the disease, **NOT** a failure
  - Similar to other chronic diseases, addiction often involves cycles of relapse and remission
  - Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death

Levels of care and where we treat opioid use

It is estimated that **23% of individuals** who use heroin develop addiction

Welcome MAT

Medications

Recovery Work

Intensive Psycho, Social and Behavioral treatments

The Case for MAT

- MAT is “the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.”--SAMHSA

- Research indicates that methadone and buprenorphine have a strong evidence base supporting their clinical effectiveness. Strong support for Vivitrol.

- MAT is the **gold standard** for opioid use disorder (OUD) treatment:
  - Reduces drug use
  - Reduces risk of overdose
  - Prevents injection behaviors
  - Reduces criminal behavior

MAT Supports Recovery

- persistent intentional abstinence from intoxication
- engagement in daily life
- gaining employment
- reestablish family and social ties
- being present in everyday life
- being able to weather the challenges, daily lows and highs of life without using substances as an external coping skills that has negative side effects and consequences

Unmet Need for OUD

- More than **two-thirds** of U.S. clinics and treatment centers still do not offer MAT medications (Stateline, 2016)
- 10% to 40% of individuals with addictions receive treatment
- Only a fraction of those that get treatment get MAT
  - 300,000-400,000 people on methadone in a given year
  - 40,000 on buprenorphine
  - 5-10,000 on Naltrexone
- Only **10%** of the people who need to be on MAT for opioid use disorder (OUC) are receiving it

Evidenced Based☺- Utilization☹

Literature Review of MAT Effectiveness

1. Bentzley BS, Barth KS, Back SE, Book SW (2015). Discontinuation of buprenorphine maintenance therapy: Perspectives and outcomes. *J Sub Abuse Treat*,52:48-57.
2. Fiellin DA, Schottenfeld RS, Cutter CJ, et al (2014). Primary Care–Based Bup Taper vs Maintenance Therapy for Prescription Opioid Dependence: A Randomized Clinical Trial. *JAMA Intern Med;*174(12):1947-1954.
3. Hser Y, Evans E, Huang D, et al (2015). Long-term outcomes after randomization to buprenorphine/naloxone versus methadone in a multi-site trial. *Addiction;*111:695-705.
4. Ling W, Hillhouse M, Domier C, et al. Buprenorphine tapering schedule and illicit opioid use. *Addiction.* 2009;104(2):256-265.
5. Nosyk B, Anglin D, Brissette S, et al (2013). A call for evidence-based medical treatment of opioid dependence in the United States and Canada. *Health Affairs*; 32(8)1462-1469.
6. Sees KL, Delucchi KL, Masson C, et a (2000)l. Methadone maintenance v 180 day psychosocially enriched detoxification for treatment of opioid dependence. *JAMA* 283(10):1303-1310
7. Sigmon, S. C., Dunn, K. E., Saulsgiver, K, et al. (2013). A randomized, double-blind evaluation of buprenorphine taper duration in primary prescription opioid abusers. *JAMA Psychiatry*.
8. Warden D, Subramaniam GA, Carmody T, et al (2012). Predictors of attrition with buprenorphine/naloxone treatment in opioid dependent youth. *Addictive Behaviors* 37:1046–1053.
9. Weiss RD, Potter JS, Fiellin D, et al. A Two-Phase Randomized Controlled Trial of Adjunctive Counseling during Brief and Extended Buprenorphine-Naloxone Treatment for Prescription Opioid Dependence. *Arch Gen Psychiatry*. 2011;68(12):1238–46.
10. Woody GE, Poole SA, Subramaniam G, et al. Extended vs short-term buprenorphine-naloxone for treatment of opioid-addicted youth: a randomized trial. *JAMA*. 2008;300(17):2003-2011.

The Bias Against MAT

Belief that use of medication conflicts with abstinence-based treatment programs like 12-step programs*

The Bias Against MAT

Belief that abstinence is more effective than MAT

- Many people, including individuals who have worked in the treatment field, have recovered from addiction without the use of medications

The Bias Against MAT

Perception that MAT is not treating the underlying causes of addiction.

The Bias Against MAT

Negative **perceptions** around methadone clinics; patients may try to limit their time there

The Bias Against MAT

Belief that people on MAT are not in recovery; not “clean”

The Bias Against MAT

Belief that MAT is a substitution of one drug for the other; fighting fire with fire

The Bias Against MAT

Belief that opioid use is not in my scope an should be treated by specialty addiction providers

Stopping/Tapering MAT

- **There is no evidence to support stopping MAT**
  - *95% of methadone patients do not achieve abstinence when attempting to taper off (Nosyk, et al. 2013)*
  - *Over 90% of buprenorphine patients relapse within 8 weeks of taper completion (Weiss, et al. 2011)*
- **Successful patients are commonly maintained on**
  - *Methadone for 24+ months, Buprenorphine for 18+ months*
- **Typically patients with continuous sobriety for 1-2+ years have the best outcomes**
  - *Treatment <6 months has worse outcomes*

VERDICT

Bias against MAT is deadly

Leading Cause of Accidental Death

Starting in 2008, drug overdoses became the leading cause of injury death in the United States surpassing car accidents and firearms

Sound Familiar?

- Similar to the 1990s with patients who had suicidal depression and were being judged for taking Prozac

Patient Impact

- Neglected a full range of treatment options
- Pressure from child welfare, jail, prison, and parole/probation systems to stop MAT
- **Restricted access** to recovery support services
  - For example, many recovery houses do not allow residents to be on MAT
- The previous two points can lead patients stop MAT before it is clinically appropriate

Biases within MAT

- Methadone and buprenorphine are narcotics
  - Bias towards using Vivitrol because it is “safer”

- Diversion of methadone and buprenorphine
  - Used to get “high” and street value

- “Addiction doctors agree that all three medications should be available to patients, because one may be more effective than another, depending in part on the person’s age, length of time as an addict ☹, home and work environment and underlying mental health issues. The American Medical Association, the American Academy of Addiction Psychiatry and the American Society of Addiction Medicine unequivocally support their use.” (Stateline, 2016)

MAT Methadone Bias

- Treating and opioid with an opioid? Fire with Fire?
- Overdose trends in the US: Long acting or extended release
- Methadone is long acting – stays in your system 24-36 hours but the pain control or analgesia only lasts 6-8 hours

Pain management vs OUD treatment

- Talking about pill form vs liquid form
- Observed in clinic vs pills taken in the community (diversion)

3 P's: Providers, Perceptions, Payment

- **Perceptions: The perceptions of MAT and its value among patients, practitioners, and institutions**
  - Some practitioners do not believe that MAT is more effective than abstinence-based treatment—when patients are treated without medication—despite science-based evidence
- **Providers: The availability of qualified practitioners and their capacity to meet patient demand for MAT**
  - Hiring physicians can be expensive for clinics, especially small centers Physicians receive little education in addiction care & are reluctant to extend their practice to patients with addictions
- **Payment: The availability and limits of insurance coverage for MAT**
  - Few private insurers and state Medicaid programs cover all of the MAT medications approved by the Food and Drug Administration. Other face hurdles such as prior authorization requirements or "fail first" policies.

How do we impact discrimination?

Share the evidence!

Recognize MAT for what it is:
The gold standard of OUD treatment

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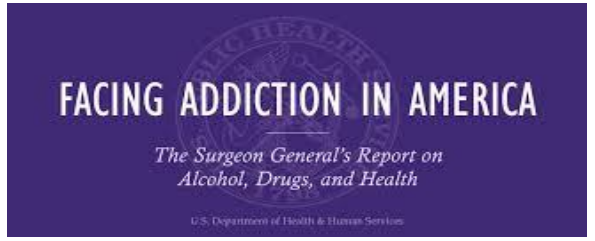
Embracing Many Pathways to Recovery

- All patients are offered MAT: Methadone, Buprenorphine, Naltrexone
- Patient Centered Care: All patients have an option of any of the three medications to treat SUD. There are pros and cons to each. There should be consideration of where they are in life, phase of treatment, and what the patient needs
- Treatment works better with patient buy-in

Other Important Interventions

- Screening for substance use in the primary care setting
  - Front door to the health care system
- SBIRT
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an **evidence-based practice** used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs
  - The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.

Policy Interventions



- **Affordable Care Act/Medicaid expansion**
  - Individuals with mental health and substance use disorders were the single largest beneficiaries of Medicaid expansion with **nearly one-third of new Medicaid enrollees having a either a mental health and/or Substance Use Disorder**

- **Physician Buprenorphine Prescribing Limit Raised to 275 Patients**
  - June 2016 SAMHSA raised doctor prescribing limit from 100 to 275 patients
- **Comprehensive Addiction & Recovery Act (CARA)**
  - Allows Nurse Practitioners and Physician Assistants to prescribe buprenorphine for up to 30 patients
  - First addiction bill passed through Congress in 40 years
- **21st Century Cures Act**
  - Allocated $1 billion in State Targeted Response grants to curb opioid abuse and increase treatment capacity
- **Surgeon General Report**
  - First Surgeon General report on addiction

Resources on Opioid Use

- **Centers for Disease Control and Prevention**
  - Overdose Data
  - Guidelines for Prescribing Opioids for Chronic Pain
- **Substance Abuse and Mental Health Services Agency**
  - Data on Prescription Opioid and Heroin Use from the annual National Survey on Drug Use and Health
  - Medication-Assisted Treatment
    - Information on certification, oversight, DATA-2000 waivers, legislation, regulation, and more
- **Office on National Drug Control Policy** (*archived website*)
  - National Drug Control Strategy
  - Data on Methadone, Buprenorphine treatment and drug poisoning deaths
- **National Institutes on Drug Abuse**
  - Opioid Epidemic Strategies & Resources

https://www.thenationalcouncil.org/mat/

EVIDENCE BASE FOR MAT

Want the evidence base for MAT? Check out this interactive presentation by Arthur Robin Williams, M.D.

RESOURCES FROM THE SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS

WEBINARS

ADDITIONAL RESOURCES

PCSS MAT TRAINING

PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

PCSS-MAT is a collaborative effort led by **American Academy of Addiction Psychiatry** in partnership with: **American Osteopathic Academy of Addiction Medicine**, **American Psychiatric Association**, **American Society of Addiction Medicine** and **Association for Medical Education and Research in Substance Abuse**.

For more information visit: www.pcssmat.org
For questions email: pcssmat@aaap.org

Twitter: @PCSSProjects

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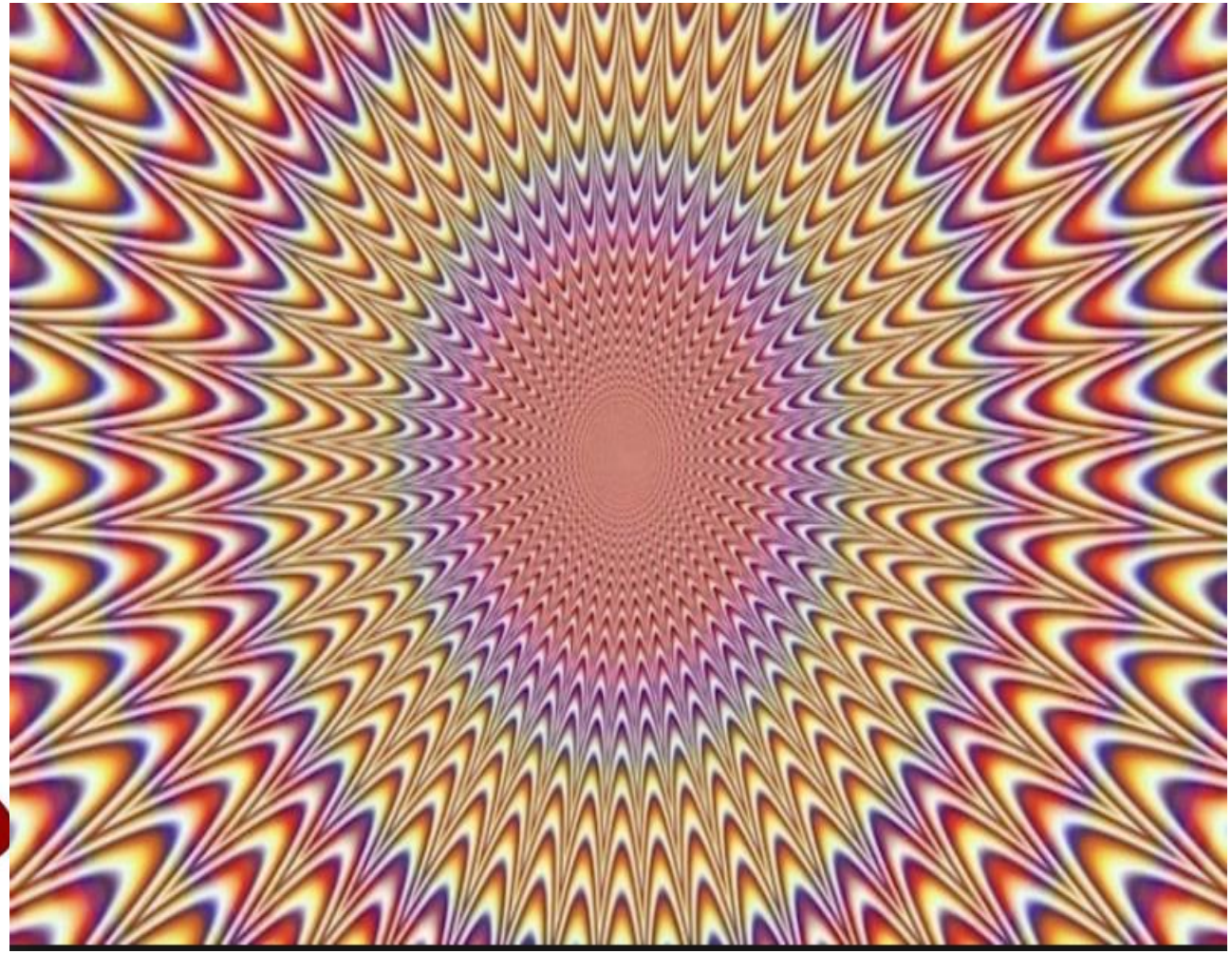
8 Times + 8 Different Ways = Changes in Beliefs and Perceptions



Treatment Works, People Recover

- Research shows that the earlier drug use begins, the more likely it will progress to addiction | Teen alcohol and drug use is declining
- More and more individuals are engaged in MAT
- Over 23 million Americans are in recovery from addiction to alcohol and other drugs

Thank You!

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