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MACS Webinar

"Confronting stigma in addiction care"

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No disclosures

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Maryland Addiction Consultation Service (MACS)

Provides support to prescribers and their practices in addressing the needs of their patients with substance use disorders and chronic pain management.

All Services are FREE

- Phone consultation for clinical questions
- Education and training opportunities related to substance use disorders and chronic pain management
- Assistance with addiction and behavioral health resources and referrals
- Technical assistance to practices implementing or expanding office-based addiction treatment services
- MACS TeleECHO Clinics: collaborative medical education through didactic presentations and case-based learning

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Objectives

- **To increase knowledge of biases related to addiction and how words matter**
- **To learn what to do when general stigma arises**
- **To learn what to do when stigma related to medications for substance use disorders arises**

Stigma

- **“a mark of disgrace associated with a particular circumstance, quality, or person”**
- **“a set of negative and often unfair beliefs that a society or group of people have about something”**
- **“a strong feeling of disapproval that most people in a society have about something, especially when this is unfair”**
- **“a strong lack of respect for a person or a group of people or a bad opinion of them because they have done something society does not approve”**

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Words

- **Bias- an inclination to favor or oppose a person, group, idea, or thing in an unfair, inaccurate, or prejudicial way. Biases can be conscious or unconscious, and can be held by individuals, groups, or institutions. Explicit bias and stigma greatly overlap.**

- **Prejudice- an unfavorable or negative attitude towards a person or group that's formed without good reason or prior experience**

- **Empathy- the ability to understand and share the feelings of another person, to see things from their perspective rather than your own. Imagining what someone else might be thinking or feeling may lead to compassionate actions**

- **Compassion- the feeling of sympathy and sorrow for another person's suffering, combined with a strong desire to help relieve it**

How ethical principles interact with stigma

- **Autonomy**
- **Justice**
- **Justice**
- **Fidelity**
- **Futility**

Autonomy

- **Patients have personal liberty and can choose their own actions**
- **Patients can make "poor" choices. Limits?**
- **Some judgment by clinician whether a drug is impacting decision-making**

Beneficence

- **Obligation of health care providers to deliver care to the full benefit of patients (without stigma)**
- **Use of shared decision making**

Justice

- **Requires absence of stigma**
- **Mandates that patients with substance use disorder are treated as any other patient would be treated (Americans with Disabilities Act)**
- **Cannot discriminate against a complication based on its cause**
- **Obligation that providers advocate for their patients with substance use disorder- helping them avoid discrimination and assisting them in accessing services/treatment they need**

Futility

- **Medical treatment must be evidence based and not based on personal experience (devoid of stigma)**
- **Often must weight autonomy, beneficence and justice against futility**
- **Futility often best assessed using multi-disciplinary team approach (an ethics committee) with medical (physicians, nurses, social workers), legal, lay and religious representation**

Stigma and addiction

- **75% of primary care physicians would not want a person with opioid use disorder (OUD) to marry into their family and two thirds viewed people with opioid use disorder as dangerous**
- **54% of ED providers prefer not to work with patients with substance use who have pain – a far greater number than other medical conditions with a behavioral component**
- **Communities leery of treatment programs**
- **Lawmakers pass bills limiting treatment**
- **Many housing and recovery programs do not allow individuals to be on medication for OUD**
- **NA meetings do not allow someone on MOUD to speak or chair**
- **Legalistic/moral view of addiction- for "bad" people, incarceration is the answer**

Answers to stigma

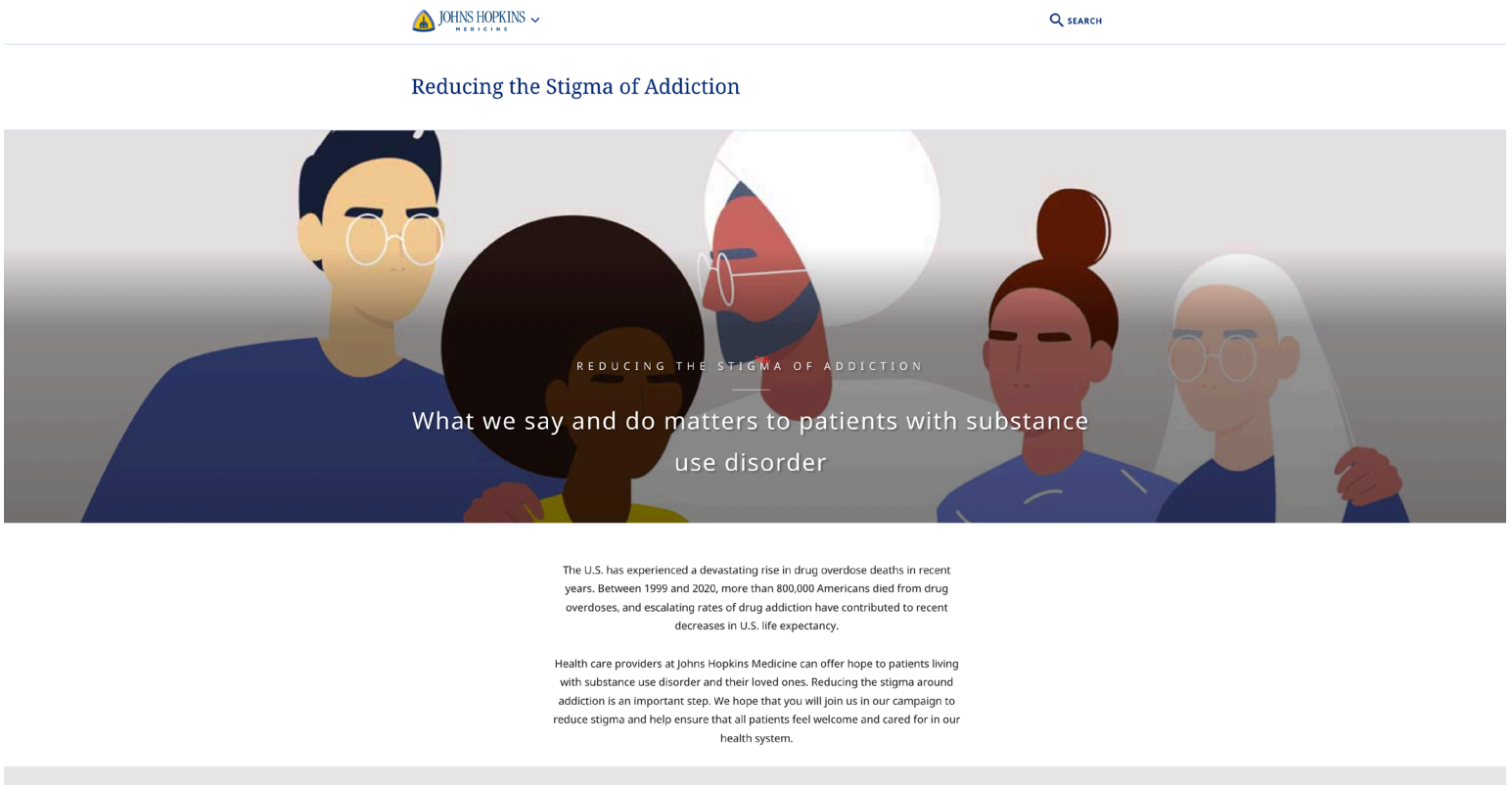
- **Use of “person-first” language**
- **Education about addiction**
- **Public education that (medication) treatment works**
- **Education that MOUD is not substituting one drug for another**
- **Humanizing people with addiction**
- **Peer recovery coaches in medical (and non-medical) settings**

Can we impact stigma related to addiction?

- Aim of study was to evaluate the effect of OUD-related messages delivered by different messengers on stigma and attitudes toward people with OUD among health care professionals.
- Eight groups were exposed to 1 of 2 message frames. One frame (Words Matter) emphasized the harm of stigmatizing language, and the other (Medication Treatment Works) focused on the effectiveness of medications approved by the US Food and Drug Administration for the treatment of OUD. Message frames were communicated through either a visual campaign alone or a visual campaign in combination with a written narrative vignette from the perspective of a simulated patient with OUD, a clinician, or a health care system administrator.
- Messages about non-stigmatizing language and effective medication for OUD reduced stigma among health care professionals. Stigma-reduction efforts targeting health care professionals may improve health care system capacity to serve people with OUD.

Kennedy-Hendricks A, McGinty EE, Summers A, Krenn S, Fingerhood MI, Barry CL. Effect of Exposure to Visual Campaigns and Narrative Vignettes on Addiction Stigma Among Health Care Professionals: A Randomized Clinical Trial. JAMA Netw Open. 2022 Feb 1;5(2):e2146971. doi: 10.1001/jamanetworkopen.2021.46971. PMID: 35119460; PMCID: PMC8817201.

Anti-stigma Campaign at Johns Hopkins



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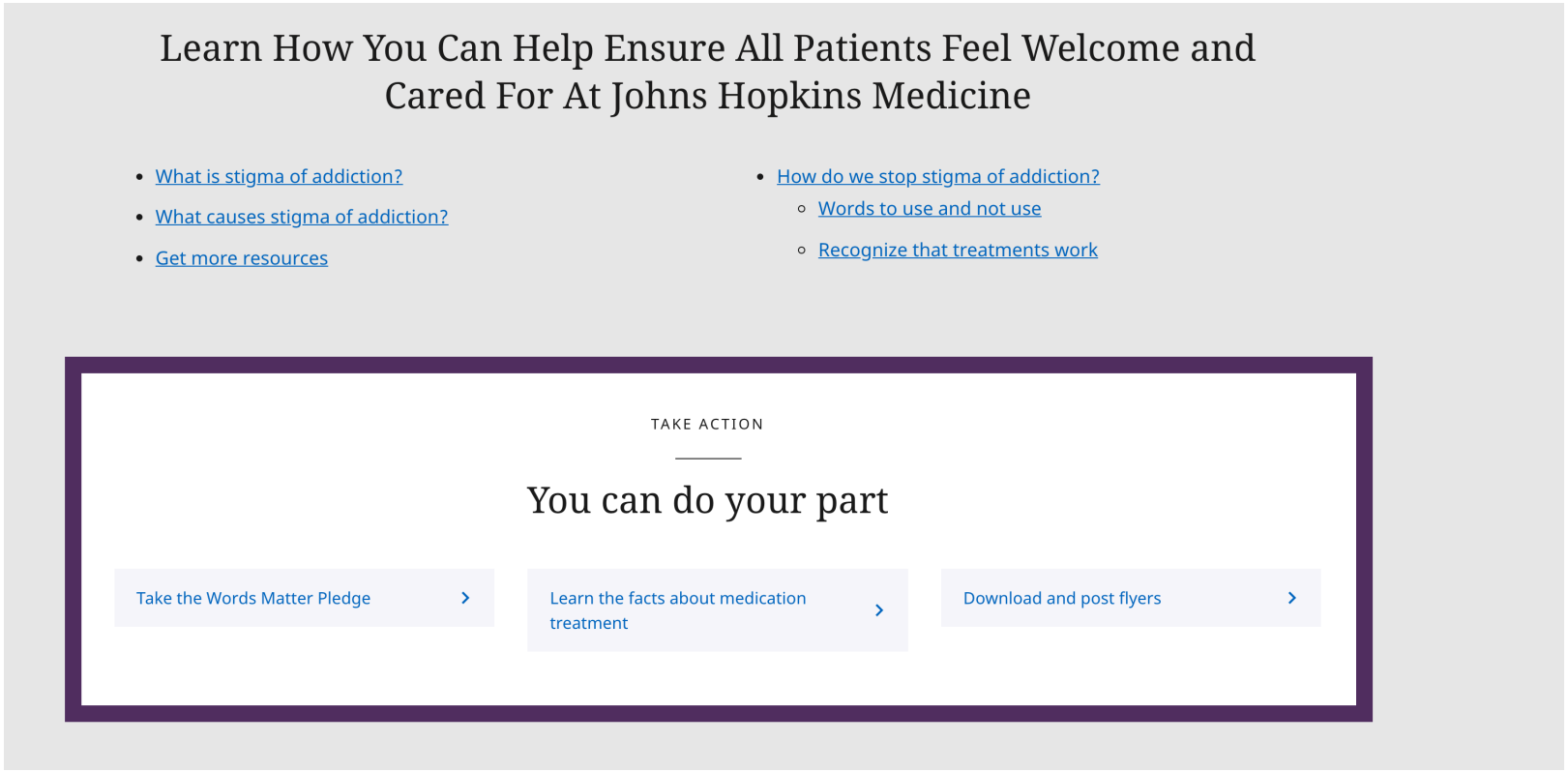
Anti-stigma Campaign at Johns Hopkins



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Words to use and not use

Instead of these stigmatizing words and phrases…	Try these preferred alternatives
•Substance abuse/drug abuse	•Substance use disorder
•Drug habit	•Addiction
•Abuser •Substance abuser •Drug abuser •Addict •Alcoholic •Drunk •Junkie •User	•Person with a substance use disorder
•Addicted baby	•Babies exposed to opioids
•Problem	•Risky, unhealthy or heavy use
•Clean (person)	•In recovery
•Clean (or dirty) toxicology results	•Negative (or positive) toxicology results
•Substitution therapy •Replacement therapy •Medication-assisted treatment	•Medication for opioid or alcohol use disorder

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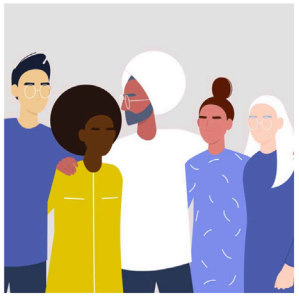
Anti-stigma Campaign: Take the Pledge

Reducing the Stigma of Addiction

Stigma of Addiction

The Words Matter Pledge

I understand that the language I use relating to addiction is important. I believe that words matter and that using the right language helps decrease stigma. I will choose language that leads to more effective treatment and compassionate support in families and communities for those with substance use disorders.



I pledge to:

- Treat all people with a substance use disorder with dignity and respect.
- Talk about substance use disorder as a chronic illness, not a moral failing.
- Be a leader in reducing stigma and promoting recovery from this disease.

Full Name:

Organization:

Personal or Professional Role:

Date

Sign the Pledge

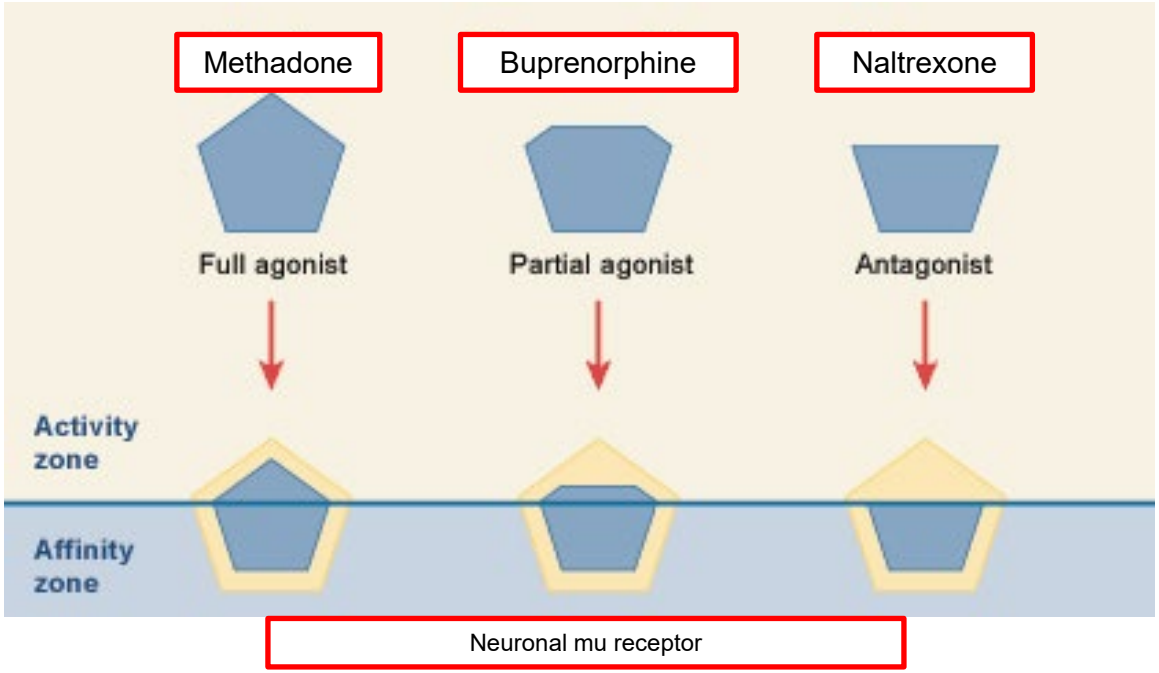
Options for OUD Treatment

- **Medication for opioid use disorder (MOUD)- methadone, buprenorphine or naltrexone**
- **Simple detoxification and no other treatment**
- **Counseling and/or peer support without MOUD**
- **Referral to short or long term residential treatment**

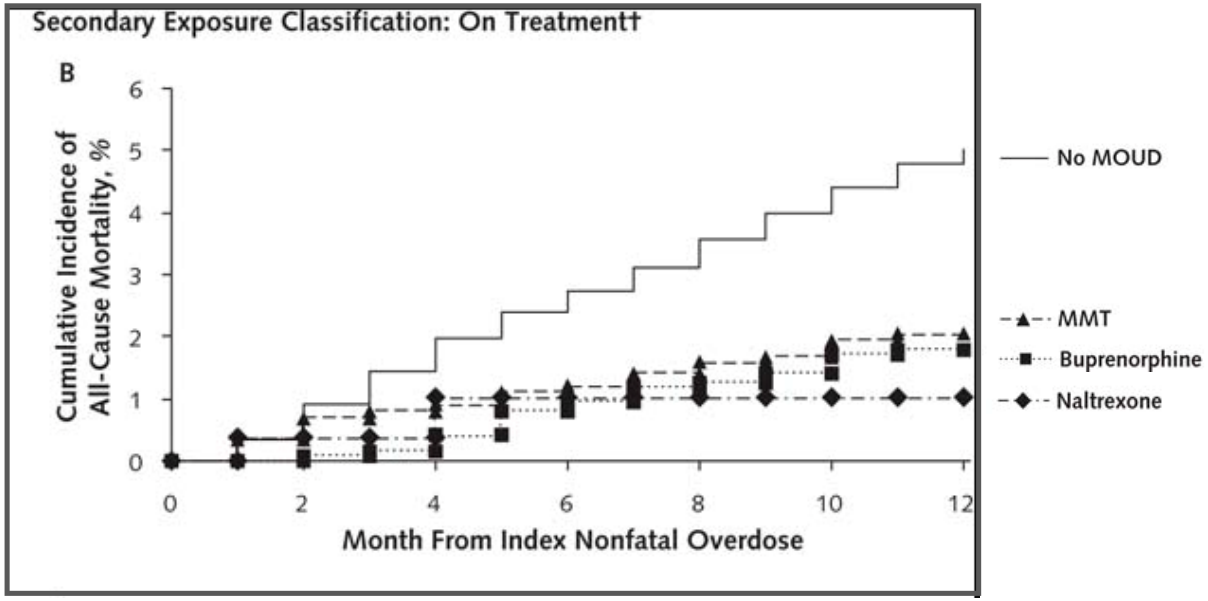
Goals of Pharmacotherapy

Mitigate withdrawal	Prevent or manage withdrawal symptoms
Reduce drug use	Reduce drug use and sustain reduction or abstinence
Improve morbidity and mortality	Prevent, reduce and/or manage the physical and social complications of continued opioid use

Medications for Opioid Use Disorder



MOUD Decreases Mortality



Larochelle, Annals of Internal Medicine 2018

Major Features of Buprenorphine

Partial agonist at mu receptor

- Comparatively minimal respiratory suppression and no respiratory arrest when used as prescribed

Long acting

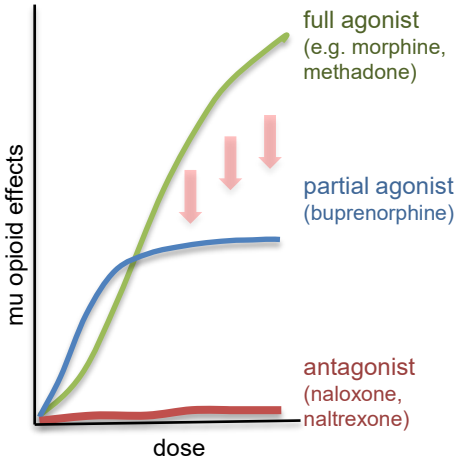
- Half-life ~ 24-36 Hours

High affinity for mu receptor

- *Blocks* other opioids
- *Displaces* other opioids
  - Can precipitate withdrawal

Slow dissociation from mu receptor

- *Stays on receptor for a long time*



SAMHSA, 2018
Orman & Keating, 2009

Major Features of Methadone

***Full Agonist* at mu receptor**

Long acting

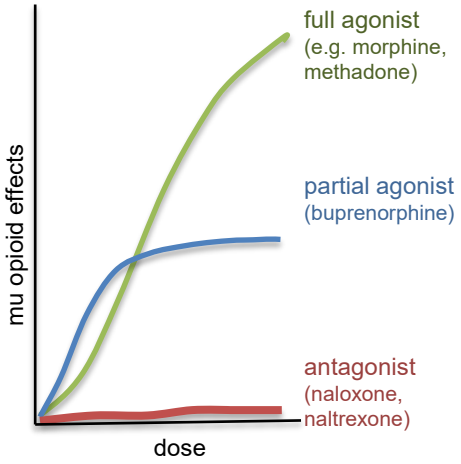
- Half-life ~ 15-60 Hours

Weak affinity for mu receptor

- *Can be displaced by partial agonists (e,g. burprenorphine) and antagonists (e.g.naloxone, naltrexone),* which can both precipitate withdrawal

Monitoring

- Significant respiratory suppression and potential respiratory arrest in overdose
- QT prolongation



Major Features of Naltrexone

Full Antagonist at mu receptor

- Competitive binding at mu receptor

Long acting

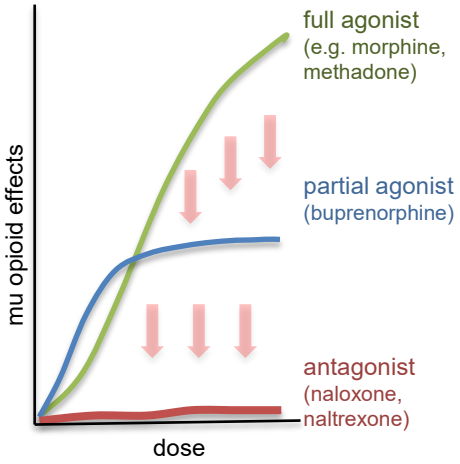
- Half-life:
  - Oral ~ 4 Hours
  - IM ~ 5-10 days

High affinity for mu receptor

- *Blocks* other opioids
- *Displaces* other opioids
  - Can precipitate withdrawal

Formulations

- *Tablets: Revia®: FDA approved in 1984*
- *Extended-Release intramuscular injection: Vivitrol®: FDA approved in 2010*



SAMHSA, 2018

Medication stigma in peer recovery

- Individuals using medications face stigma in peer support settings, which can be contradictory and counterproductive to their recovery.
- Qualitative interviews with staff, peers, and clients of a community-based buprenorphine treatment program were used to establish the core components of the curriculum to support client needs.
- Staff, peers, and clients indicated a need and desire to establish a peer recovery group that recognizes persons on medication as being in recovery and destigmatizes use of medication to treat opioid addiction. A respectful environment, holistic perspective on health, spirituality, sharing, and celebration were all established as necessary pillars of the AIM (Ability, Inspiration and Motivation) group curriculum.

Krawczyk N, Negron T, Nieto M, Agus D, Fingerhood MI. Overcoming medication stigma in peer recovery: A new paradigm. Subst Abus. 2018;39(4):404-409. doi: 10.1080/08897077.2018.1439798. Epub 2018 Apr 4. PMID: 29432086; PMCID: PMC6087684.

Scenario 1

- **KL is a 34F, former pre-school teacher, admitted with a fever to 104 and a large painful leg abscess that was drained in the emergency room. She is being treated with intravenous antibiotics, but on the second day of treatment announces she wishes to leave.**

- **Should she be able to leave?**
- **Do patients have the right to make a "bad" decision?**
- **Can patients make a decision that leads to harm?**
- **What might facilitate her staying?**

Scenario 1 continued

- **KL states she is in pain and wants to leave in order to use. Her care team has not prescribed opioids for pain because "she is already addicted to them"**

- **What should you say to the the team?**
- **Should she receive opioids for pain?**
- **Should medication for OUD be prescribed? Which one?**

Scenario 1 continued

- **She is started on hydromorphone PRN for pain and methadone for OUD, but the next day when you return, she tells you that she decided she does not want to be on methadone as her mother told her she "needs to be in treatment, but not on that stuff the makes you a zombie". You also learn that she is not receiving any hydromorphone despite reporting significant pain**

- ***Why is she not receiving pain medication?***
- ***How do you respond to her new reluctance to be on methadone?***

Scenario 2

- **JK is a 28 F, mother of 2 girls, 3 and 5, with a past history of injection drug use in the ED with chest pain. She finished treatment for aortic valve endocarditis 3 months ago and is doing well on methadone for opioid use disorder. Evaluation reveals an ascending aorta dissection originating at the aortic valve. With the emergent need for surgery, cardiology is contacted, but the cardiologist believes that the patient should not be considered for surgery as this would be futile care for a patient with addiction who would not be adherent to anti-coagulation medication after surgery**

- ***Stigma?***
- ***Is this "futile" care? Who decides? Bias?***
- ***What should be done in caring for the patient?***

Scenario 3

- **JB is a 24F artist started on buprenorphine 4 months ago, who is doing well. This is her first time on MOUD. She started using opioid pills as a teen and this is the longest she has ever gone not using "street" opioids. However, at her current visit, she asks to be tapered off buprenorphine. She relates going to a NA meeting where she was told she wasn't "clean".**

- ***How do you respond?***

Scenario 4

- **Your experiences in providing care…**

Summary

- **Please recognize your biases related to addiction and realize words matter**
- **Use appropriate words/terms when providing clinical care**
- **Speak up when stigma arises**
- **Advocate for life-saving MOUD**
- **Continue to work to create hope for our patients with addiction**

QUESTIONS?

TYPE QUESTIONS INTO THE CHAT OR RAISE HAND

Additional questions:

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