PCSS MAT TRAINING
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For Medication Assisted Treatment

Stigma in Methadone and Buprenorphine Maintenance Treatment

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	Commercial Interest	What was received?	For what role?
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Educational Objectives

- At the conclusion of this activity participants should be able to:
  - Describe the History of Methadone Maintenance
  - Describe the Effectiveness of Opioid Agonist Treatment
  - Understand the Key Myths of Opioid Agonist Therapy
  - Empathize with Patients Taking Methadone or Buprenorphine
  - Feel Empowered to Support Patients and Their Significant Others

Target Audience

- The overarching goal of PCSS-MAT is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.

Accreditation Statement

- The American Society of Addiction Medicine (ASAM) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Designation Statement

- The American Society of Addiction Medicine (ASAM) designates this enduring material for a maximum of one (1) *AMA PRA Category 1 Credit*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

- Dawn will fill out both of the below
  - Date of Release: March 27, 2015
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Participation in this CME Activity

- In order to complete this online module you will need Adobe Reader. To install for free click the link below:
  - http://get.adobe.com/reader/

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Methadone Stigma

- "My Wife's Opinion Is That Methadone Maintenance Treatment Is As Close To **Evil** As You Can Get, Without Killing Someone."
- A "successful" patient taking methadone quoting his wife's attitude toward treatment with methadone.
- This is a true story related to me by one of my long term patients taking methadone.
- Why is there such demonization of a proven evidence-based treatment for opioid addiction?

History Of Opioid Agonist Therapy

- In the late 1800's and early 1900's there were many available formulations of morphine and heroin, which was a branded product of the Bayer Pharmaceutical Company.
- Some people misused these products and became addicted.
- In 1914 the federal Harrison Act made it illegal for physicians to prescribe opiates to opiate addicted patients.
- In the early 1920's "morphine clinics" were established to treat opiate addicted patients. These clinics were supposed to "cure" the addiction, not maintain patients on morphine.

History Of Opioid Agonist Therapy-2

- The morphine clinics in NYC, New Orleans, Shreveport, and ~ 40 others, were ordered closed in 1923—because they "maintained," and did not "cure" the addiction.
- Heroin and morphine addiction continued, and the demographics changed from middle class patients to the urban underground. Jazz musicians were disproportionately affected.
- Two large "Narcotic Farms," in Lexington, KY, and Fort Worth Texas opened in 1935. In today's terminology they would be considered therapeutic communities. Heroin addiction was considered a criminal problem.
- Heroin addicted patients were sent to these "farms," were given a brief "detoxification treatment," initially with morphine, and starting in the late 1940s with methadone, and then put to work on the farm, in the kitchens, in the musical bands, etc.
- Unfortunately, most patients relapsed upon returning to their home cities. The farms closed in 1975.

History Of Opioid Agonist Therapy-3

- In the late 1950's, there was a heroin epidemic in New York City
- Dr. Marie Nyswander, a psychiatrist, became interested in treating these patients.
- The problem was nearly 100% relapse rates with abstinence based treatment—the only modality available.
- Dr. Vincent Dole, a research internist with interest in metabolism, working at Rockefeller University, became interested in Dr. Nyswander's work.

History Of Opioid Agonist Therapy-4

- His hypothesis concerning the high relapse rates: The opiate addicted brain lacks something, which heroin is providing. It would be at least 10 more years until the endogenous opioid system was to be discovered.
- Dr. Dole suggested treatment with methadone, a long acting synthetic opioid, and so began methadone maintenance in the mid 1960's.
- Dr. Dole envisioned heroin addiction as a "metabolic" disorder, which could be treated with methadone to stabilize and normalize the brain.
- Then rehabilitation could be pursued.

A Medical Treatment for Diacetylmorphine (Heroin) Addiction

A Clinical Trial With Methadone Hydrochloride

Vincent P. Dole, MD, and Marie Nyswander, MD

A group of 22 patients, previously addicted to diacetylmorphine (heroin), have been stabilized with oral methadone hydrochloride. This medication appears to have two useful effects: (1) relief of narcotic hunger, and (2) induction of sufficient tolerance to block the euphoric effect of an average illegal dose of diacetylmorphine. With this medication, and a comprehensive program of rehabilitation, patients have shown marked improvement; they have returned to school, obtained jobs, and have become reconciled with their families. Medical and psychometric tests have disclosed no signs of toxicity, apart from constipation. This treatment requires careful medical supervision and many social services. In our opinion, both the medication and the supporting program are essential.

ough review of evidence available in 1957,[1] concluded that "The advisability of establishing clinics or some equivalent system to dispense opiates to addicts cannot be settled on the basis of objective facts. Any position taken is necessarily based in part on opinion, and on this question opinions are divided." With respect to previous trials of maintenance treatment, the Council found that "Assessment of the operations of the narcotic dispensaries between 1919 and 1923 is difficult because of the paucity of published material. Much of the small amount of data that is available is not sufficiently objective to be of great value in formulating any clear-cut opinion of the purpose of the clinics, the way in which they operated, or the results attained." No new studies bearing on the question

JAMA Classics: Celebrating 125 Years
Methadone Maintenance 4 Decades Later
Thousands of Lives Saved But Still Controversial
Commentary by Herbert D. Kleber, MD
JAMA. 2008;300(19):2303-2305

From the Rockefeller Institute, and Manhattan General Division of Beth Israel Hospital, New York.
Reprint requests to Rockefeller Institute, New York 10021 (Dr. Dole).

JAMA. 1965;193(8):646-650

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Effectiveness of Methadone Maintenance Treatment

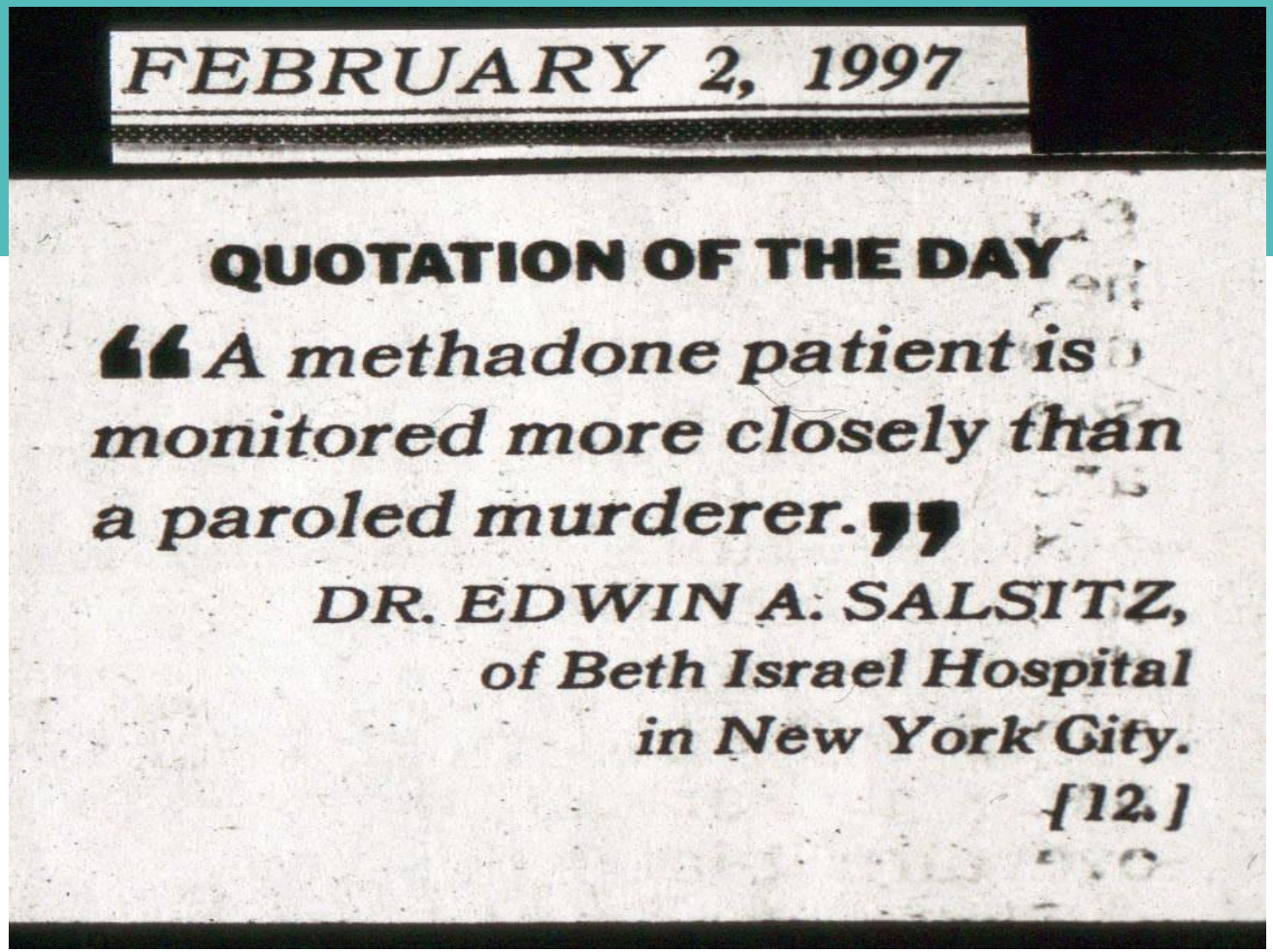
- The original 1965 publication describes the results for 22 heroin addicted patients treated with methadone, including relief of “narcotic hunger” (craving), and “opioid blockade” (cross tolerance).
- Each patient was helped with Rehabilitation: Obtaining a GED, coached on employment interviews, helped with family reconciliation, etc.
- Drs. Dole and Nyswander, and also Dr. Mary Jeanne Kreek, published widely, and their original papers remain valid today.

Methadone Maintenance

- In 1972, regulations were enacted which established the federally regulated methadone clinic system. Methadone for the treatment of opioid addiction could only be accessed through these specialized clinics. Other regulations dealing with counseling, take home privileges, urine drug testing, dosing, etc. were included in these regulations.
- Although methadone was shown to be effective, these unique regulations, requiring daily attendance at the clinics, observed dosing, and other burdensome requirements, set the stage for the development of stigma. No other medical treatment was, and still is, so restricted.

Methadone Maintenance

- In some cases patients have to travel long distances to the clinics, patients are concerned that they will be seen entering or leaving the clinic, significant others do not understand the need for the medication, vacation requests will be refused, and many physicians and other health care providers, now separated from the “clinic system,” do not understand the rationale or science of treatment with methadone. All these factors create a sense of shame, embarrassment, and failure among the patients. Due to the stigma, they rarely disclose they are taking methadone.



FEBRUARY 2, 1997

QUOTATION OF THE DAY

"A methadone patient is monitored more closely than a paroled murderer."

DR. EDWIN A. SALSITZ, of Beth Israel Hospital in New York City.

[12.]

- This Quote Reflects How Many Patients in Methadone Maintenance Feel About the Regulations.
- The regulations have changed and improved significantly since 1997, but remain a unique feature in medical treatment in the USA.

Methadone--Effectiveness

- Conclusion of a 1997 NIH Consensus Conference on the Effective Treatment of Opioid Addiction:
  - Opiate dependence is a brain-related medical disorder that can be effectively treated with significant benefits for the patient and society, and society must make a commitment to offer effective treatment for opiate dependence to all who need it. All opiate-dependent persons under legal supervision should have access to methadone maintenance therapy, and the U.S. Office of National Drug Control Policy and the U.S. Department of Justice should take the necessary steps to implement this recommendation. There is a need for improved training for physicians and other health care professionals and in medical schools in the diagnosis and treatment of opiate dependence. The unnecessary regulations of methadone maintenance therapy and other long-acting opiate agonist treatment programs should be reduced, and coverage for these programs should be a required benefit in public and private insurance programs

*N.B. Predates buprenorphine availability and references “opiate dependence” from earlier DSM versions rather than the revised “opioid use disorder” in DSM-5.

Methadone and Buprenorphine – Effectiveness

- In a comprehensive review of methadone effectiveness, published in *Psychiatric Services* in 2013*, the authors conclude:*
- "Overall, there is a high level of evidence for the effectiveness of MMT in improving treatment retention and decreasing illicit opioid use."
- In a comprehensive review of buprenorphine effectiveness published in *Psychiatric Services* in 2014 the authors conclude:
- "Overall, a high level of evidence was found for the effectiveness of BMT in improving treatment retention and decreasing illicit opioid use."

Methadone (and Buprenorphine) Stigma Case 1a

- Mr. Smith is a 58 year old male, who has been on methadone maintenance for a total of 42 years. He was in a MMTP(OTP) for 26 years, then transferred to an investigational “Medical Maintenance” office based opioid treatment program. His medication is dispensed not prescribed. His current dose is 80mg. He is self employed in a successful business, has a wife and 14 year old daughter.
- Mr. Smith told his spouse he had tapered off methadone many years ago. She knows about his past history of heroin addiction, but believes he is not taking methadone at this time.

Methadone (and Buprenorphine) Stigma—Case 1b

- Mr. Smith has chronic Hepatitis C infection. He failed previous Hep C treatment, and currently has a suspicious nodule in his liver. He has never told any of his treating physicians that he is taking methadone.
- His reasons for not telling his spouse:
- *She would think its Substituting One Drug or One Addiction for another. She would be disappointed in me.*
- His reasons for not telling his physicians:
- *They look at you differently. They treat you like an "Addict."*

Methadone (and Buprenorphine) Stigma Case 1c

- Mr. Smith has decided that he will finally tell his spouse about the methadone. He asks if she can come in during the next visit, and we can all discuss together.
- As is usually the case, the spouse was gracious, and told Mr. Smith that there never was a need for the secrecy. We did an addiction 101, and a methadone 101.
- She knew him when he was actively addicted, and was grateful for the many years of stability.
- Mr. Smith is not yet ready to disclose to his other physicians. I have offered to speak to the physicians and explain the treatment with methadone.

Methadone (and Buprenorphine) Stigma

- Unfortunately, Mr. Smith's sense of stigmatization is common among opioid agonist treatment patients, and based on previous negative reactions to disclosure. Among the most common Myths:
  - Why Not Taper Off?
  - Substituting One Drug/Addiction for Another
  - Methadone (and now Buprenorphine) is Harmful
  - You are not in Recovery
  - You should not get pregnant
  - You are on methadone; no need for post-op pain meds

Methadone (and Buprenorphine) Stigma

- Myth: Why Not Taper Off?
  - Numerous studies over the last 50 years, comparing methadone maintenance to tapering, have consistently demonstrated that relapse is the rule. Relapse rates reported are generally in the 80—100% range over time. Similar rates of relapse are now reported comparing buprenorphine maintenance to tapering.
  - Of particular note was the decrease in HIV seropositivity in patients on methadone maintenance versus patients who had discontinued maintenance and relapsed to IVDU in the early 1980's.

Methadone (and Buprenorphine) Stigma

- Myth: Substituting One Drug/Addiction For Another
  - The term opioid substitution treatment (OST) is widely used in Europe, Australia, and elsewhere. Terminology is important, and this term is misleading to many patients, and particularly significant others. Methadone and Buprenorphine Maintenance are treatments for opioid use disorder. A clear distinction should be made between physical dependence and addiction. Methadone and buprenorphine maintained patients, with negative UDT's, and no other criteria for opioid use disorder, are physically dependent, but not addicted to the medication.

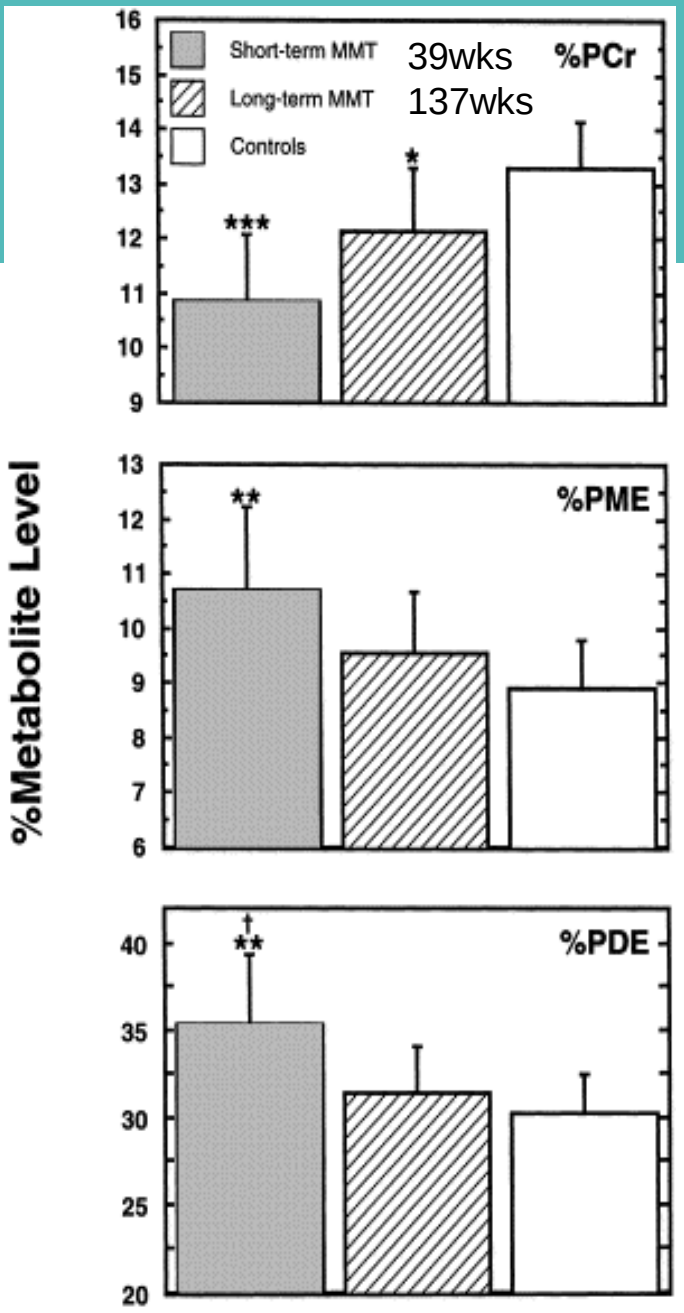
Methadone Stigma

- The next 2 slides demonstrate the effects of methadone maintenance on 2 small groups of methadone maintained patients: one group on methadone for 39 weeks, the other on methadone for 137 weeks. Both groups are compared to controls. Two markers of brain neurochemistry are measured: PCr(Phosphocreatine), a marker of brain bioenergetic status, and PME(Phosphomonoester) and PDE(Phosphodiester), markers for brain cell membrane integrity.
- Please review the next slide with the data, and the following slide with the conclusion.

Methadone (and Buprenorphine) Stigma

- The next 2 slides demonstrate the effects of methadone maintenance on 2 small groups of methadone maintained patients: one group on methadone for 39 weeks, the other on methadone for 137 weeks. Both groups are compared to controls. Two categories of brain neurochemistry markers are measured:
  - PCr, a marker of brain bioenergetic status (higher levels indicate higher metabolic rate which is coupled with better cerebral perfusion)
  - PME and PDE, markers for brain cell membrane integrity (higher levels indicate higher membrane turnover and less stability)
- Please review the next slide with the data, and the following slide with the conclusion.

Cerebral phosphorus metabolite abnormalities in opiate-dependent polydrug abusers in **methadone maintenance**



Phosphorous MR Spectroscopy

Fig. 3. Metabolite levels in control subjects (n=16) and in short- (n=7) and long-term (n=8) methadone maintenance treatment (MMT) subgroups. Shown are means±S.D. of percent metabolite measures. Post hoc Scheffé test results: *P<0.05 vs. control subjects; **P<0.01 vs. control subjects; ***P<0.0001 vs. control subjects ;†P<0.05 vs. long-term MMT group

Psychiatry Research: Neuroimaging
Volume 90, Issue 3 , 30 June 1999, Pages 143-152
Kaufman,M

Methadone Stigma

- From these data, we conclude that polydrug abusers in MMT have 31P-MRS results consistent with abnormal brain metabolism and phospholipid balance. The nearly normal metabolite profile in long-term MMT subjects suggests that prolonged MMT may be associated with improved neurochemistry.

- The improved PCr, PDE, and PME may reflect improved cerebral blood flow and metabolism.

- So, treatment, rather than substitution is the more accurate term.

Methadone (and Buprenorphine) Stigma

- Myth: Methadone and Buprenorphine Have Harmful Adverse Effects
  - All opioids share common adverse or side effects: most common are constipation, increased sweating, and pruritus. All opioids may decrease testosterone levels. Opioids, however, do not result in organ damage, as compared to alcohol, tobacco, and cocaine. The common side effects should be monitored and appropriately treated.
  - Methadone does prolong the QTc interval at clinically relevant doses. EKG's will detect this problem
  - Opioids do decrease salivary flow and may have some effect on osteoclast/osteoblast function, but the myth that methadone "rots teeth and bones," although very prevalent, is a myth.

Methadone (and Buprenorphine) Stigma

- Myth: You Should Not Get Pregnant
  - Methadone Maintenance Treatment has been the evidenced-based treatment gold standard for pregnant opioid addicted women for over 40 years. Buprenorphine maintenance is now recognized as an alternative medication for some pregnant women. All outcomes, both for the mother and neonate are improved, as compared to ongoing active opioid addiction.
  - Breast feeding, if the mother is HIV-, is safe and encouraged.
  - The Neonatal Abstinence Syndrome, is treatable using established guidelines, and should not be used to further stigmatize the mother and the neonate.

Methadone (and Buprenorphine) Stigma

- Myth: No Need for Post-Op Pain Meds
  - A common patient complaint is the fear of inadequate pain management post-operatively, and in other scenarios. Many patients will not disclose their maintenance, having had negative experiences. ”You are on methadone, and don’t need pain meds.” Or, “you are drug seeking.”
  - It is recognized that the maintenance medications will not treat new acute pain.
  - There are ongoing efforts to educate health care providers on the treatment of pain in opioid agonist maintained patients.

Methadone (and Buprenorphine) Stigma

- Myth: You Are Not in Recovery
  - Many addiction treatment providers insist on total abstinence, including properly prescribed medications, as a criterion for "recovery." This issue often becomes one of ideology rather than science. A methadone or buprenorphine maintained patient, with no use of illicit or non-prescribed drugs, negative UDT's, attending to personal, family, work, and community responsibilities, should be considered to be in "recovery" or remission.*
  - There are patient groups, such as the National Alliance of Methadone Advocates, who advocate and educate on Medication Assisted Recovery.
  - Recovery is a personal term, best left to each patient to define for themselves.

* The DSM 5 criteria for opioid use disorder excludes tolerance and physical dependence, if the opioid is legally prescribed, as in the case of opioid agonist therapy. These patients are considered to be in full remission.

Methadone (and Buprenorphine) Stigma Case 1c

- Mr. Smith has decided that he will finally tell his spouse about the methadone. He asks if she can come in during the next visit, and we can all discuss together.
- As is usually the case, the spouse was gracious, and told Mr. Smith that there never was a need for the secrecy. We did an addiction 101, and a methadone 101.
- She knew him when he was actively addicted, and was grateful for the many years of stability.
- Mr. Smith is not yet ready to disclose to his other physicians. I have offered to speak to the physicians and explain the treatment with methadone.

Methadone (and Buprenorphine) Stigma Case 1d

- Reluctance to disclose methadone status to healthcare providers is very common among methadone maintained patients.
- The usual first question is: “Why are you still taking the methadone?”
- Patients often detect a marked change in the provider’s attitude, changing from friendly to suspicious to hostile.
- Patients are concerned they won’t get the highest quality care: “He treats me like an addict,” “I could tell she was worried I would steal syringes.”

Methadone (and Buprenorphine) Stigma

- Physicians and other Health Care Providers
  - Most health care providers have had limited education about addiction in general and opioid agonist therapy in particular. Methadone, and opioid treatment programs are often a “black box.” Many of the patients they encounter are using other illicit and non-prescribed drugs. The patients who are doing well, like Mr. Smith are “invisible” to the health care system.
  - On the following slide are listed some of the occupations among my patients in the “Medical Maintenance Program,” an admittedly select group, but more common than most assume.

Occupations of OAT Patients

- Teacher
- Electrician
- Plumber
- Social Worker
- Psychologist
- Chauffer
- Computer/IT
- Drug Counselor
- Accountant
- Retail Manager
- Home Security Systems
- Restauranteur
- Fish Dept. Manager
- Movie Editing
- Student (Ph.D)
- HVAC Tech.
- Stamps
- School Principal
- Artist
- Advertising VP

- Bus Driver—MTA*
- Sanitation Driver*
- Con Ed Utility*
- Subway Signal—MTA*
- Sales
- Secretarial
- Administrator
- Piano Teacher
- Elevator Repair
- Lawyer
- Physician
- Landscape
- Car Salesman/Repair
- Videographer
- Heavy Equipment
- Contractor
- Entrepreneur
- Musician
- Nurse

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*** Safety Sensitive—Employer's OK**

Methadone (and Buprenorphine) Stigma

- Physicians
  - Opioid Addicted physicians are generally under the supervision and care of their state impaired physician boards. While it is true that addicted physicians overall have excellent outcomes with abstinence based treatment no one treatment modality works for everyone.
  - In a recent review very few of the state physician committees allow the use of buprenorphine (none allow methadone) as a treatment for opioid addiction. This is a complex issue, but certainly does not diminish stigma vis a vis opioid agonist therapy.

Ms. Jones Case 2a

- Ms. Jones is a 67 yo female who has been on methadone maintenance for 37 years. Her spouse understands the treatment, but remains resentful that she does not taper. The spouse refuses to come to the office for a discussion.
- Her current dose is 60mg., down from 90mg., with the goal of a transfer to buprenorphine, as she considers moving to Florida.
- On her last visit she relates an unpleasant experience watching Saturday Night Live with her spouse.
- As frequently occurs in the media, methadone becomes synonymous with futile, ridiculous, dangerous, stupid, vile, inappropriate, and worse.
- On the next slide, please see what upset Ms. Jones.

SM: You must be excited to see him when he comes back?

Mrs. Claus: By the time he stumbles in at 6AM, Chris has eaten roughly 2 Billion cookies, so he pukes for a solid day! She continues -

THEN HE SPENDS A WEEK IN A **METHADONE CLINIC** TO COME DOWN FROM THE SUGAR HIGH.

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Aidy Bryant, Seth Meyers. SNL, 12/8/12

Methadone (and Buprenorphine) Stigma Ms Jones 2b

- This gratuitous use of “methadone” is all too common.
- Here is a definition of “methadonian” from the Urban Dictionary, an online “dictionary:”
  - A person who is on methadone maintenance and uses methadone as their drug of choice, is extremely lethargic and can be found in a stupor, zombie like all day long. Can usually be found either standing, leaning or nodding out on a corner not far from the clinic. Methadonian is a term found most commonly in the ghettoes of New York City, where there are more methadone clinics than anywhere else in the World. Just as there are crackheads, dope fiends and speed freaks, there are Methadonians.

Methadone (and Buprenorphine) Stigma

- What Can Heath Care Providers Do?
  - First we need to educate our colleagues about addiction and specifically opioid agonist therapy.
  - We need to advocate for our patients by speaking to their significant others, and other providers, if patients give permission.
  - We need to write letters to newspapers, journals, TV stations, etc., when they convey incorrect or hurtful information about opioid agonist therapy.
  - We need to support patient advocacy groups.

Methadone (and Buprenorphine) Stigma - Final Thoughts

- All Treatments Work for Some Patients, No One Treatment Works for All Patients.
- Treatment decisions should not be ideologically driven.
- Addiction is a chronic disease. For some patients indefinite pharmacologic treatment will provide the best outcome. This is no different from other common chronic disorders such as hypertension.
- Paradoxically, it is precisely the patients who have done well on treatment with methadone, who feel the most stigmatized, and are asked repeatedly: “When and why don’t you “get off” this stuff?”

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PCSS-MAT Mentoring Program

- PCSS-MAT Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.
- PCSS-MAT Mentors comprise a national network of trained providers with expertise in **medication-assisted treatment, addictions** and **clinical education**.
- Our 3-tiered mentoring approach allows every mentor/mentee relationship to be unique and catered to the specific needs of both parties.
- The mentoring program is available, at no cost to providers.

For more information on requesting or becoming a mentor visit:

pcssmat.org/mentoring

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PCSS-MAT Listserv

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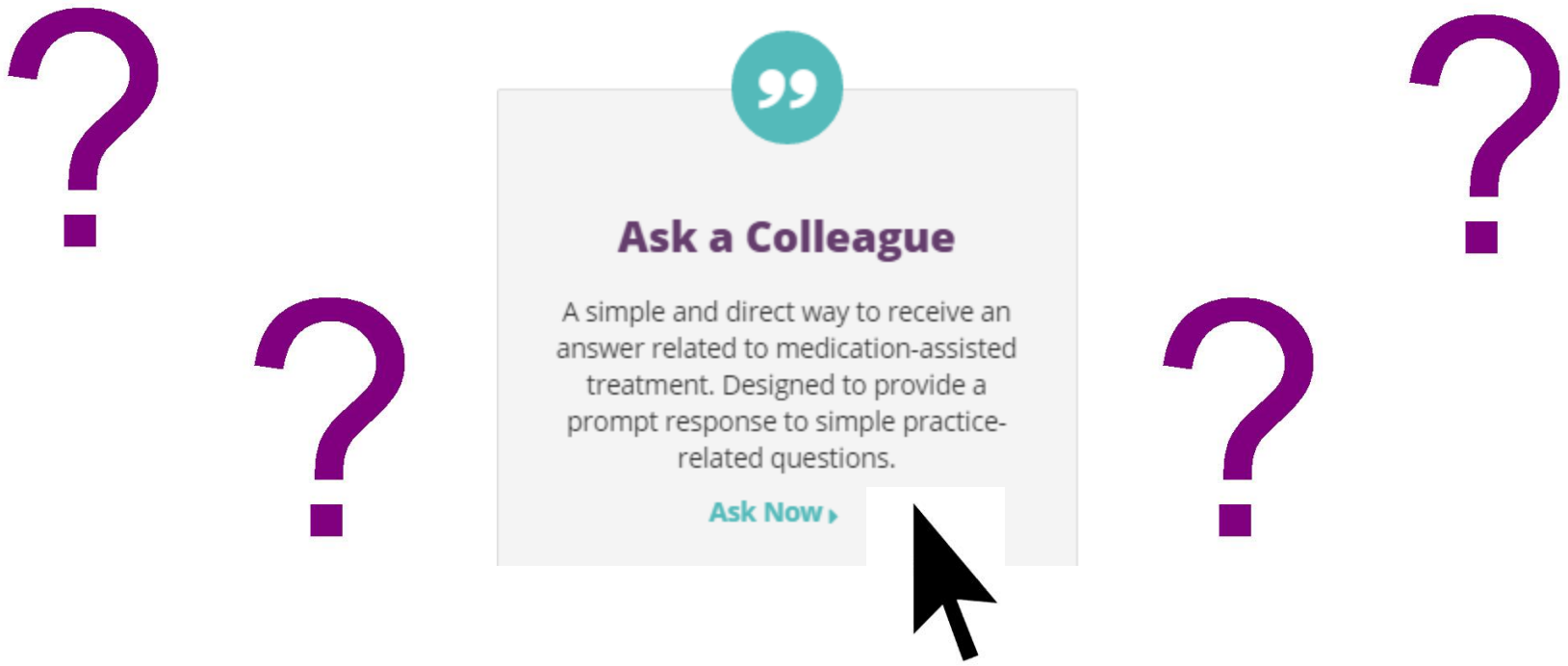

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