

# Steering Committee Members



The Steering Committee is made up of scientists, clinicians, RCC leadership and persons with lived experience from multiple organizations and institutions from across the US.

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# Nationwide Survey of RCCs

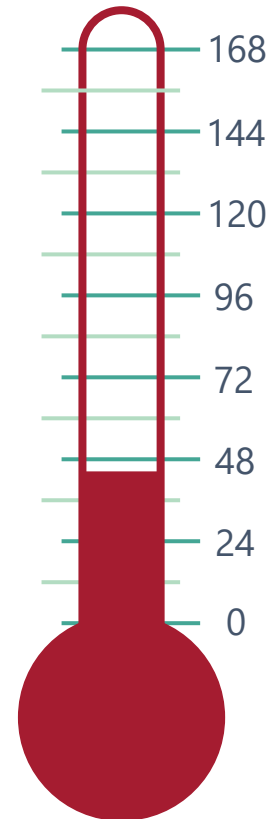


## Goals of this study:

- To gain insight into the types of recovery community centers (RCCs) that exist, and the communities which they serve
- To gain feedback from RCC leadership about potential outcome measures that could be used to capture the positive impact RCCs make on the individuals and communities they serve

*If your RCC has not received a link to this survey, please email us at [recoveryseminars@mgh.harvard.edu](mailto:recoveryseminars@mgh.harvard.edu) or call us at (617) 724-7932 and we will send you a link.*

**Goal: 180 RCCs**

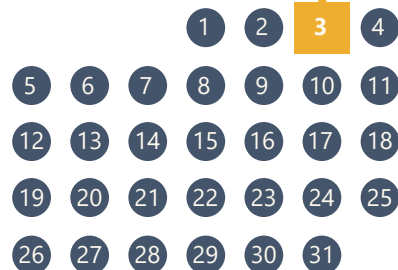




# Upcoming Seminars

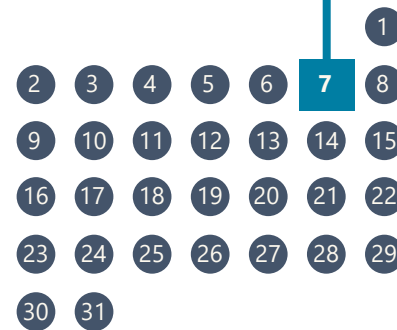
R24 RCC Pilot Studies

December



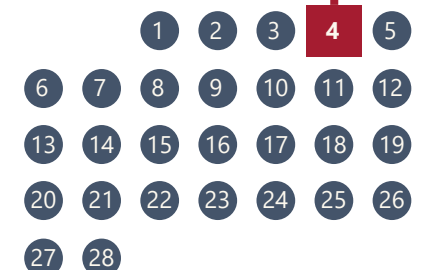
Rural RCCs

January



Tele-recovery

February



# RCC Live Feature



We are featuring a different RCC at the start of each of our seminars in order to allow all participants to learn first-hand about RCCs

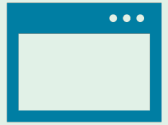
Louray Barton and  
Katlin Johnson

STEPRox





# Polling Questions



A pop-up Zoom window will appear with the poll questions



You must complete all questions before clicking to submit

→ Remember to scroll down to see all the questions!



We will share the poll results after a few minutes



Your responses will remain anonymous



# Presenters



**Roger Weiss**  
Professor of Psychiatry at  
Harvard Medical School



**Lauren Hoffman**  
Post-Doctoral Research  
Fellow at the Recovery  
Research Institute



**Wendy Jones**  
Executive Director of  
Minnesota Recovery  
Connection



**Jan Brown**  
Founder and Executive  
Director of SpiritWorks  
Foundation

**Our seminars in January and February will focus on rural RCCs and tele-recovery. If you are an RCC director and would like to be a speaker at either of those seminars, please contact us!**

# **Medications for the Treatment of Opioid Use Disorder**

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**Roger D. Weiss, MD**

**Chief, Division of Alcohol, Drugs, and Addiction  
McLean Hospital, Belmont, MA**

**Professor of Psychiatry, Harvard Medical School  
[rweiss@mclean.harvard.edu](mailto:rweiss@mclean.harvard.edu)**

# Medications for OUD

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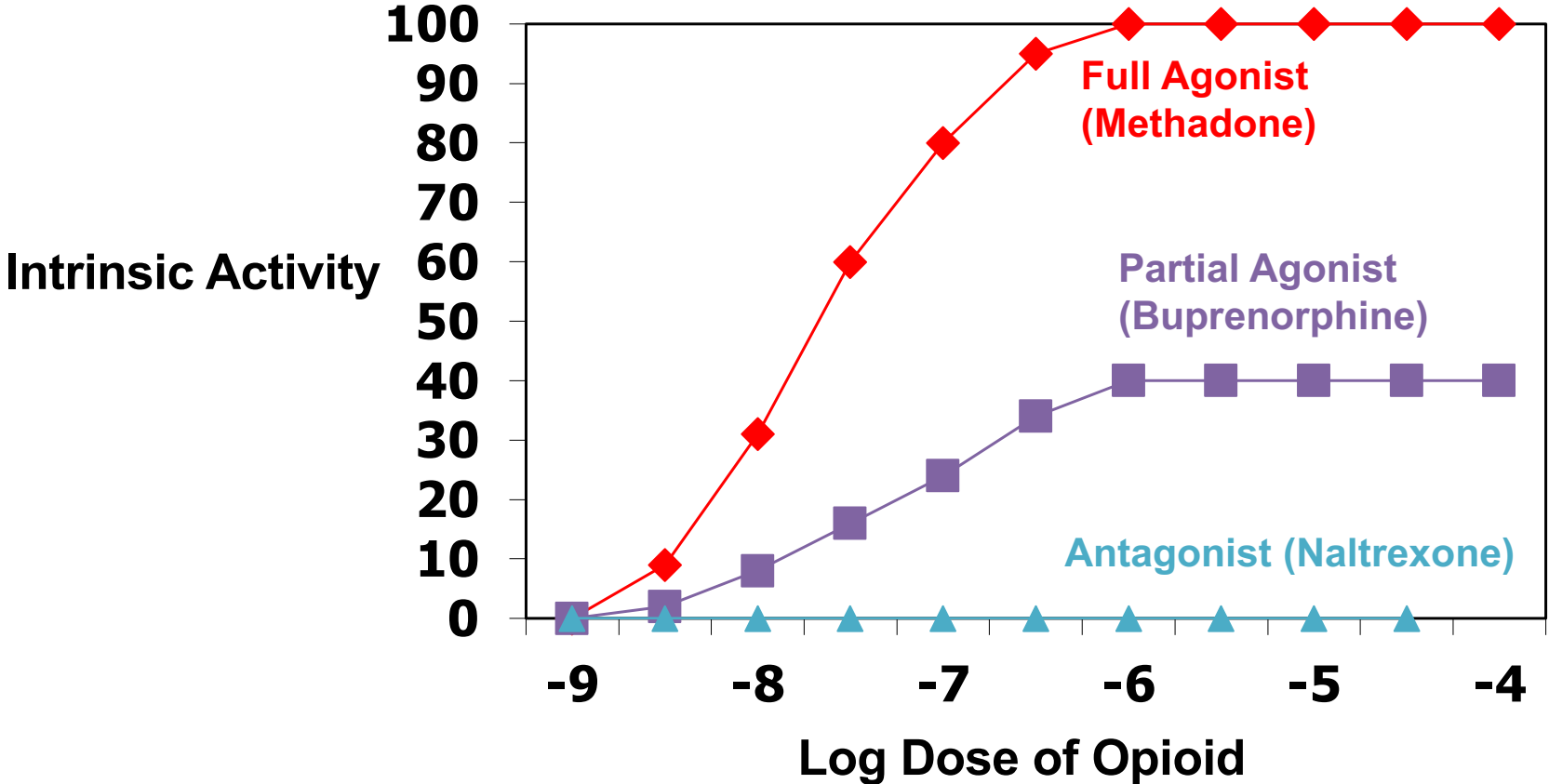
- Methadone: full agonist, available only through opioid treatment programs
- Buprenorphine: partial agonist
  - Sublingual tablets or films, typically with naloxone to discourage injection
  - Injectable subcutaneous long-acting (monthly; weekly formulation to come)
  - Implant (6 months)
- Can be prescribed in office practice (with specialized training for >30 patients)

# Medications for OUD (cont.)

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- Naltrexone: antagonist, with no opioid properties
- Can be given orally or via ~monthly IM gluteal injection
- Patient needs to be detoxified and opioid-free for ~7-14 days prior to initiation
- Can be given in office practice, no special training/waiver needed

# Intrinsic Activity: Full Agonist (Methadone), Partial Agonist (Buprenorphine), Antagonist/Blocker (Naltrexone)

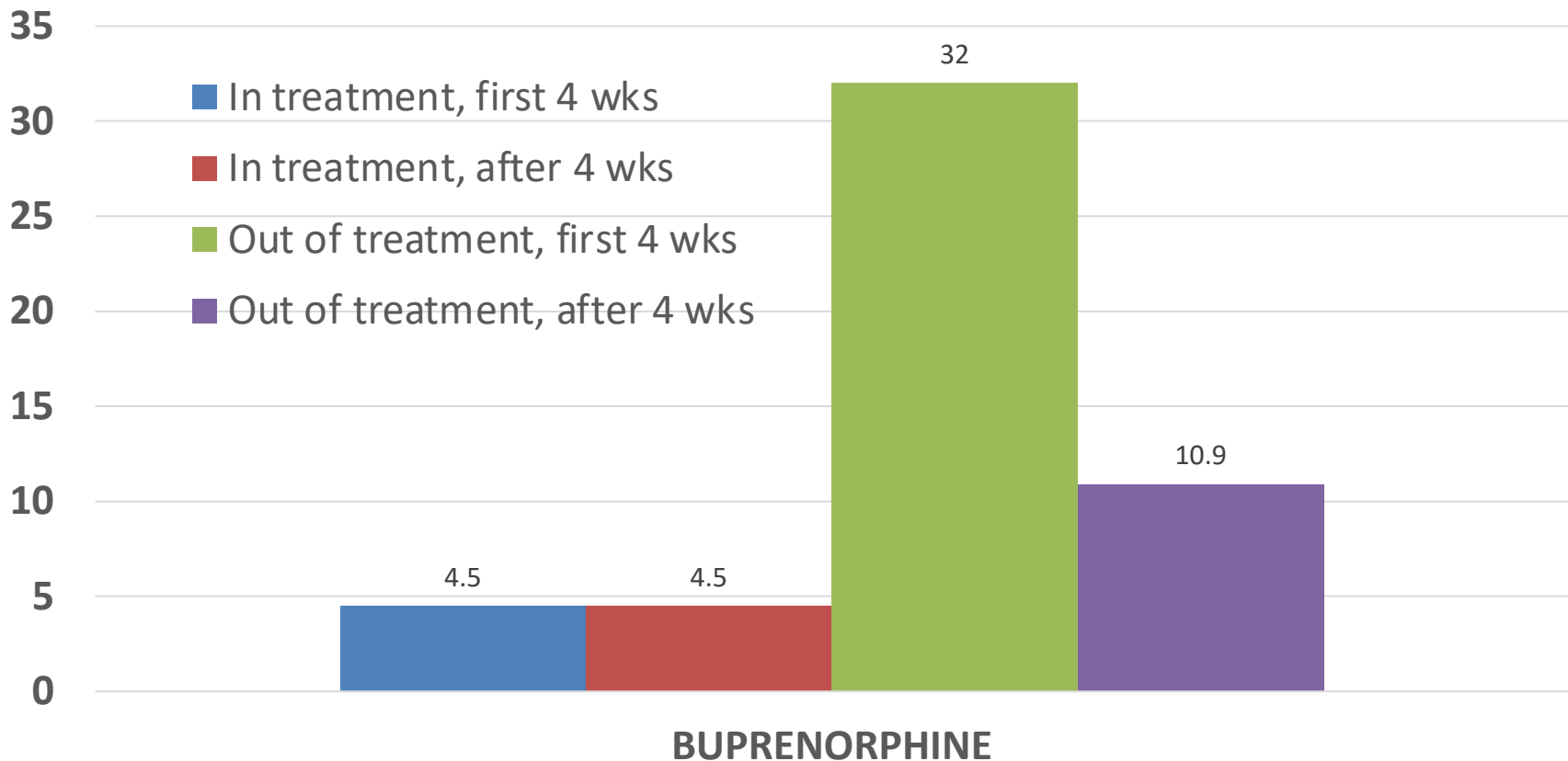


**How effective are  
medications for  
OUD?**



# Medication saves lives: people can die when medication stops

All cause mortality rate per 1000 person years, in and out of treatment



# Prescription Opioid Addiction Treatment Study (POATS)

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- Largest study of treatment of prescription opioid dependence (N=653 at 10 U.S. sites)
- Studied different lengths of buprenorphine-naloxone (bup-nx) + different intensities of counseling
- ‘Success’: abstinence or near-abstinence from opioids
  - 7% success with 4-week taper
  - 49% success while stable on bup-nx x 12 wks
  - 9% success after 2nd taper after 12-wk bup-nx
- Adding counseling to bup-nx and weekly medical management did **not** improve outcome

# Sustained-Release Injectable Buprenorphine for Opioid Use Disorder: Outcomes

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- Multi-site study, N=504
- Injectable buprenorphine vs. placebo × 6 months
  - 6 monthly injectable buprenorphine 6 monthly injections of placebo
  - All received individual drug counseling
  - “Successful outcome” defined as  $\geq 80\%$  opioid-free weeks (weeks 5-24)
- Success rate: 28% (buprenorphine) vs. 2% (placebo)

**How do OUD  
medications compare  
with each other?**

# Sublingual Buprenorphine vs Methadone

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- Both medications are highly effective, though buprenorphine has greater safety profile
- Reduced opioid use, reduced mortality for both
- In general, better retention with methadone
- Results regarding opioid use are mixed; some studies favor buprenorphine, some favor methadone
- Context/setting of treatment is quite different in the United States – opioid treatment program vs. office-based practice

# Sublingual Buprenorphine-Naloxone vs Extended-Release Naltrexone: Summary

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- Both medications are equally effective **once people start them**
- Starting extended-release naltrexone is challenging because it requires detoxification and opioid abstinence first; 30% of pts in multi-site U.S. trial **never received a dose**
- A major challenge: Find optimal ways to get patients from opioid use to naltrexone (the “induction hurdle”)

# Choosing a Medication for Opioid Use Disorder

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- Buprenorphine: Easy on, difficult off
- Naltrexone: Difficult on, easy off
- Both easy-off and difficult-off are mixed blessings
- A challenge: Getting off opioids and onto naltrexone
- Methadone: Built-in structure of the program, for better and for worse
- Agonist vs. antagonist
  - What does the patient/family want?
  - Must be a collaborative process



# **Buprenorphine and behavioral interventions**

# Behavioral Tx in the context of buprenorphine treatment

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- 4 major studies have shown that adding counseling to buprenorphine + medical management (MM) is not superior to buprenorphine + MM alone
- Many patients do well with bupe + MM
- Those with co-occurring psychiatric illness and those with greater severity generally do better with additional behavioral treatment
- However, it's hard to predict and many pts don't want extra treatment
- Mutual-help groups helpful in long-term OUD studies
- Little is known about behavioral tx + naltrexone

**How long should people  
stay on medication for  
OUD?**

# How Long Should Patients Stay on MOUD?

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- National Quality Forum
  - Expert consensus, not empirical trial
  - Based on commercial claims data from RAND Corporation study (want to know a fun fact?)
  - Recommended **at least 6 months** continuous pharmacotherapy for MOUD as a quality measure

# How Long Should Patients Stay on MOUD?

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- Eastwood et al. (2017)
  - Examined data from 54,000 patients receiving publicly funded OUD treatment in UK
  - 22% were able to successfully D/C bupe and not seek treatment again within 6 months
  - Those in treatment > 2 years did better
  - Older, employed, non-crack users did better

# How Long Should Patients Stay on MOUD?

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- No prospective studies have been done
- The idea of stopping MOUD should come from the **patient**, not the treater
- Shared decision-making, with clear discussion of risks, including OD, should occur
- Current study: Retention Duration Discontinuation study (RDD) – first prospective study of discontinuation of MOUD in stable patients

**Thank you!**



# Opioid Use Disorder: Medication Attitudes

Lauren A. Hoffman, PhD

Research Fellow

Recovery Research Institute, Center for Addiction Medicine

Massachusetts General Hospital, Harvard Medical School



MASSACHUSETTS  
GENERAL HOSPITAL

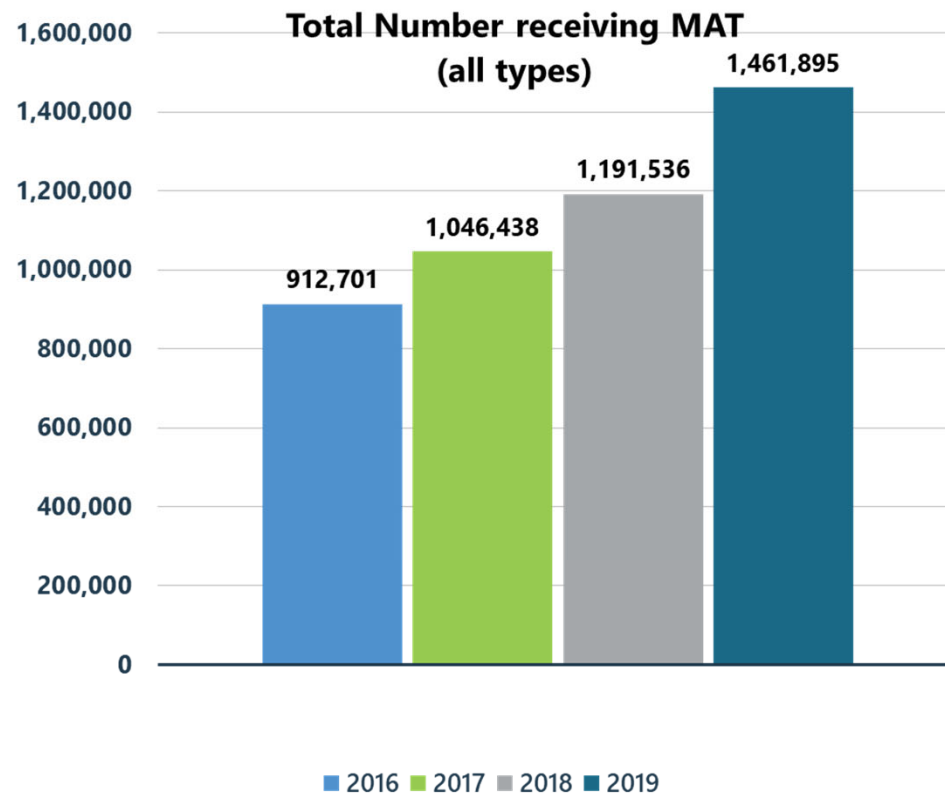
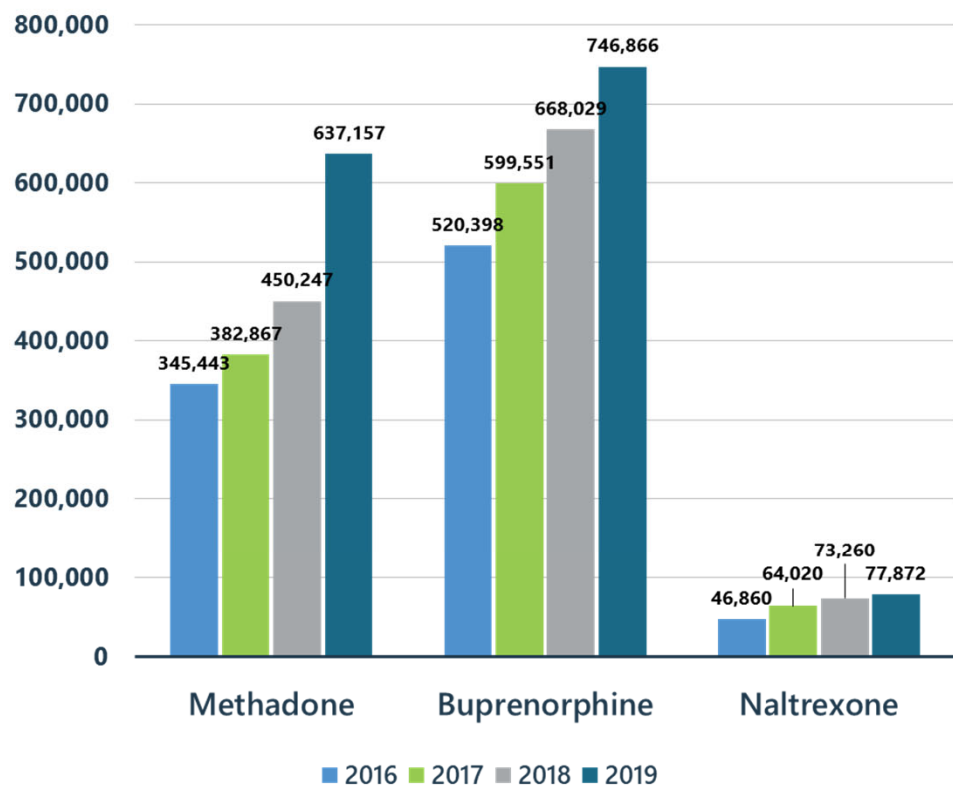


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# Treatment Gains: Number of Individuals Receiving Pharmacotherapy for Opioid Use Disorder (NSDUH; 2019)



# MOUD Treatment

- Unmet need for MOUD Tx:
  - Only ~20% with OUD receiving specialty addiction treatment
- WHY?
  - Barriers to MOUD receipt
    - Institutional, provider, policy, financial
    - Individual-level
      - Acknowledged but lacking scientific evidence
      - Important to gain insight from those with lived experience
  - Likely to impact provision & use of MOUD
    - Negative attitudes impact patient selection of Tx type (Marcus et al., 2018)
    - Positive attitudes associated with greater MOUD Tx retention (Kayman et al., 2006)





# MOUD Attitudes Among Recovering Individuals

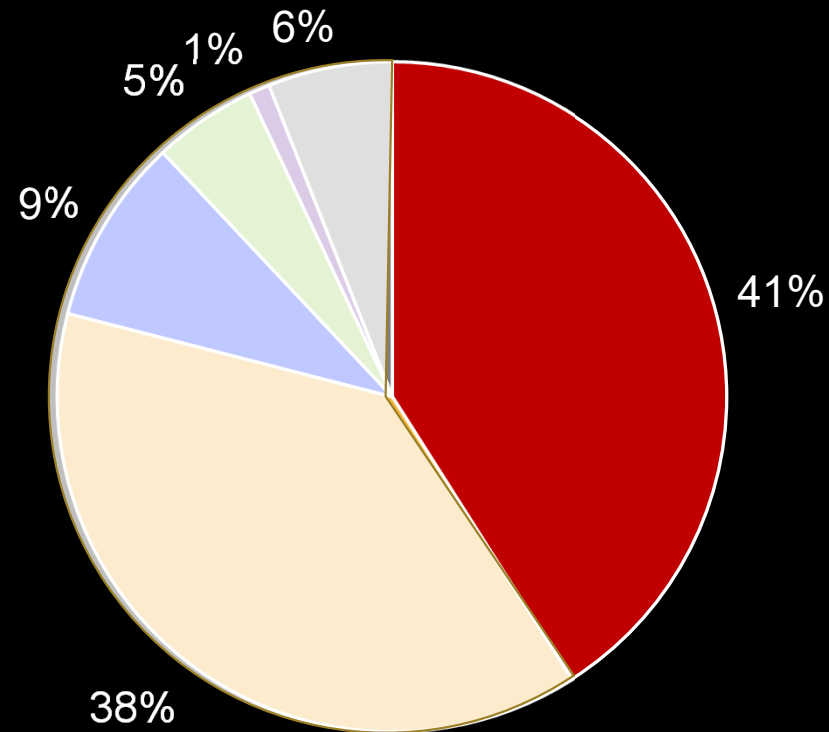
- Clinical commentaries, qualitative studies, anecdotal
  - Touch on predominantly negative attitudes, especially for agonists
  - Scientific research lacking, especially among those with lived experience
    - Positive Attitudes:
      - ~20% individuals in recovery from AOD problems (Bergman et al., 2020)
      - ~31% out-of-treatment individuals w/ past year OUD (Schwartz et al., 2008)
      - ~32-51% Oxford House residents not receiving MOUD Tx (Majer et al., 2008)
      - ~30-40% Black & Latino/a individuals w/ IV drug use (Zaller et al., 2009)

# MOUD ATTITUDES & RCCs



- RCCs May offer a promising venue for fostering MOUD support
  - Especially inclusive
    - Do not follow any particular recovery model (e.g., 12- step)
    - Operate under maxim: “many pathways [to recovery], all should be celebrated”
    - Frequented most often by those with OUD

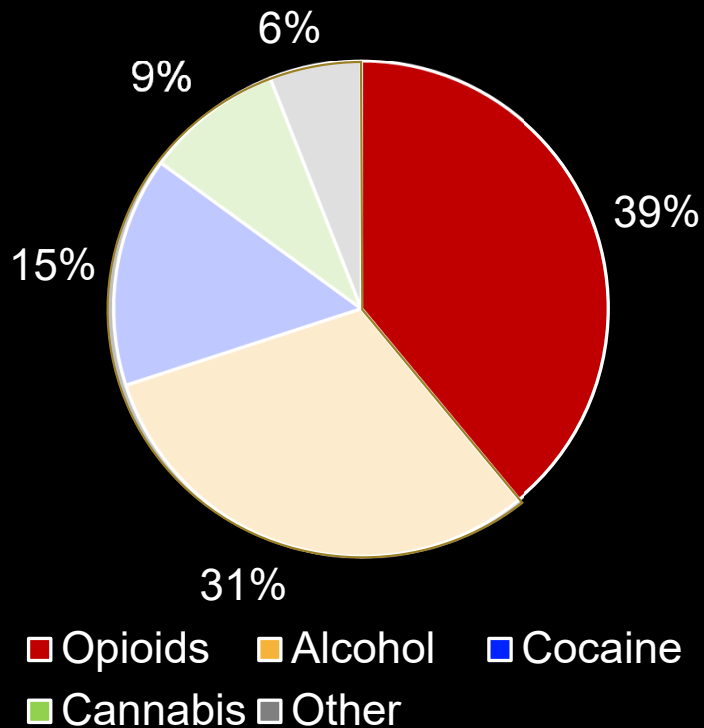
## Primary Substance among RCC Attendees



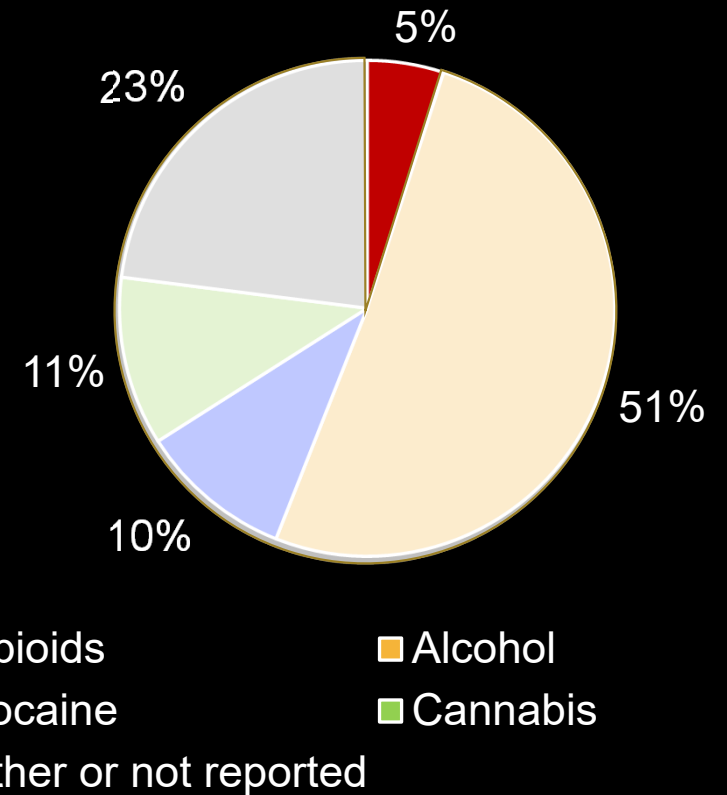
■ Opioids ■ Alcohol ■ Cocaine ■ Cannabis ■ Amphetamines/Meth ■ Other or none

## Primary Substance

### Primary Substance RCCs



### Primary Substance NRS





Do RCCs offer an environment that is supportive and accepting of individuals using medications for OUD Tx?



# Medication Treatment for Opioid Use Disorder: Medication Attitudes at RCCs



Contents lists available at [ScienceDirect](#)

Journal of Substance Abuse Treatment

journal homepage: [www.elsevier.com/locate/jsat](http://www.elsevier.com/locate/jsat)

Check for updates

## Attitudes toward opioid use disorder pharmacotherapy among recovery community center attendees

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**ARTICLE INFO**

**Keywords:**  
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Opioid use disorder  
Buprenorphine  
Methadone  
Naltrexone  
Addiction recovery

**ABSTRACT**

**Background:** Despite their proven efficacy, medications for opioid use disorder (MOUD) are underutilized. Negative beliefs and attitudes toward MOUD are quite common, yet rapidly expanding recovery community centers (RCCs) may offer a promising venue for fostering MOUD support as they operate under the maxim, “many pathways [to recovery], all should be celebrated” and are utilized mainly by those with opioid use disorder. The current study provides a first look at MOUD attitudes and their correlates in RCC attendees.

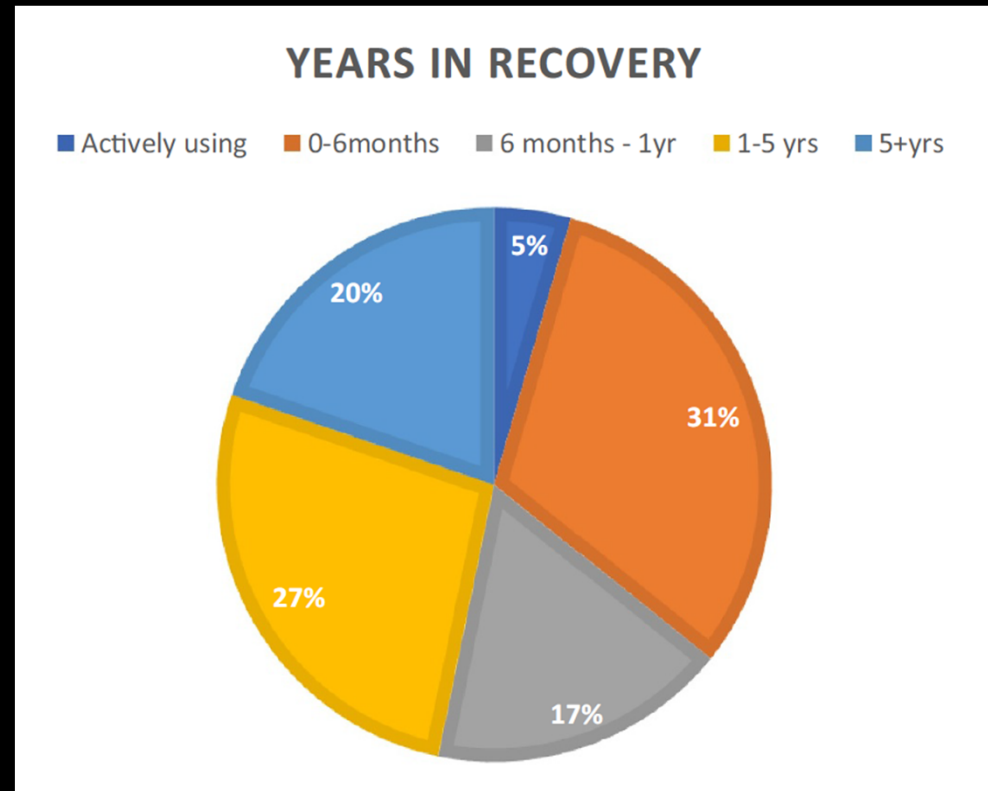
**Methods:** The study conducted a cross-sectional survey ( $N = 320$ ) of recovering adults attending 31 RCCs across New England, assessing demographic, treatment, and recovery-relevant factors, as well attitudes (positive vs. negative) toward the use of agonist and antagonist MOUD. The study used frequencies and confidence intervals to obtain prevalence estimates for positive and negative attitudes toward agonist and antagonist MOUD, and to examine differences between them. Spearman correlations identified correlates of MOUD attitudes (at  $p < 0.10$ ), and significant correlates were assessed for unique contributions via multivariable logistic regression.

**Results:** Positive attitudes were common and more prevalent than negative attitudes for both agonist (positive: 71.4 [66.1, 76.3]%; negative: 28.6 [23.7, 33.9]%) and antagonist (positive: 76.5 [71.4, 81.1]%; negative: 23.5 [18.9, 28.6]%) MOUD, which did not differ. The study identified several correlates of MOUD attitudes at the  $p < 0.10$  level, but only four variables emerged as unique predictors controlling for other correlates. Lifetime history of agonist MOUD treatment was uniquely associated with positive agonist attitudes ( $p = 0.008$ ), whereas greater social support for recovery was associated with positive antagonist attitudes ( $p = 0.007$ ). Lower educational attainment was uniquely associated with negative antagonist attitudes ( $p = 0.005$ ), and a greater degree of spirituality was related to negative attitudes toward both agonists ( $p = 0.005$ ) and antagonists ( $p = 0.01$ ).

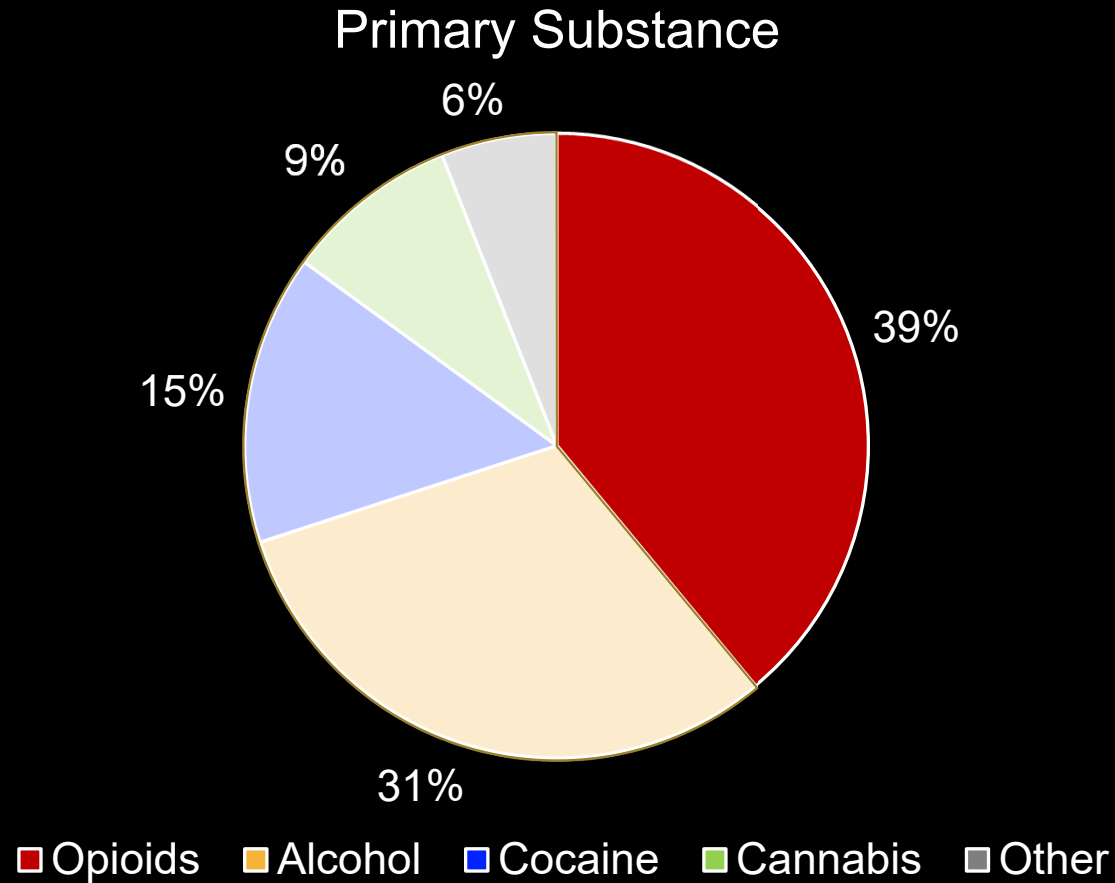
**Conclusions:** Findings reveal very high rates of positive MOUD attitudes among RCC participants, highlighting the potential for this growing tier of recovery support to foster acceptance and peer support for medication-facilitated recovery pathways. Correlates of attitudes further reveal opportunities for facilitating MOUD acceptance within and beyond the RCC network.

# Methods

- Cross-sectional survey
  - Data collection: 2016-2017
- Participants: 336 recovering, adult RCC attendees
- RCCs: 31 across New England region



## RCC Attendees: Primary Substance (N=320)



Primary Substance	% of RCC Attendees
Opioids	39%
Alcohol	31%
Cocaine	15%
Cannabis	9%
Other	6%

# Methods

## Agonist MOUD

“It is a good idea for someone with an OPIOID problem to take a substitute opioid medication like **Suboxone** or **methadone** to help them stop using”

## Antagonist MOUD

“It is a good idea for someone with an OPIOID problem to take an opioid blocking medication like **naltrexone/Vivitrol** to help them stop using”

## AUD

“It is a good idea for someone with an ALCOHOL problem to take a medication to help them stop drinking”

## Mood Disorders

“It is a good idea for someone with an EMOTIONAL problem to take a medication to help”

# Methods

- Likert scale (1 – 6)



Negative Attitude

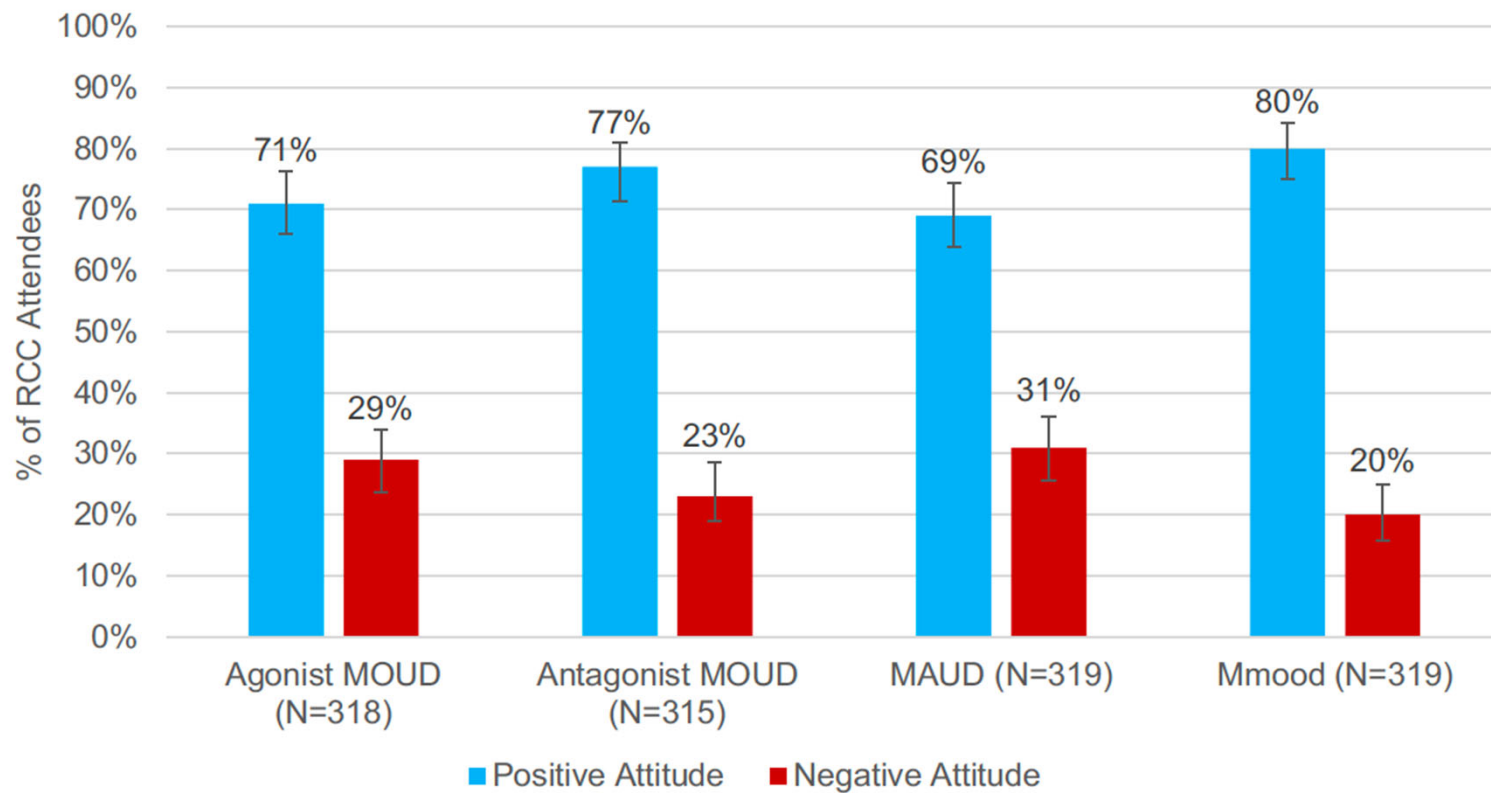


Positive Attitude

# RCC Attendees: MOUD Attitudes



Hoffman, L. A., Vilsaint, C. L., & Kelly, J. F. (2021). Attitudes toward opioid use disorder pharmacotherapy among recovery community center attendees. *Journal of Substance Abuse Treatment*, 131, 108464.





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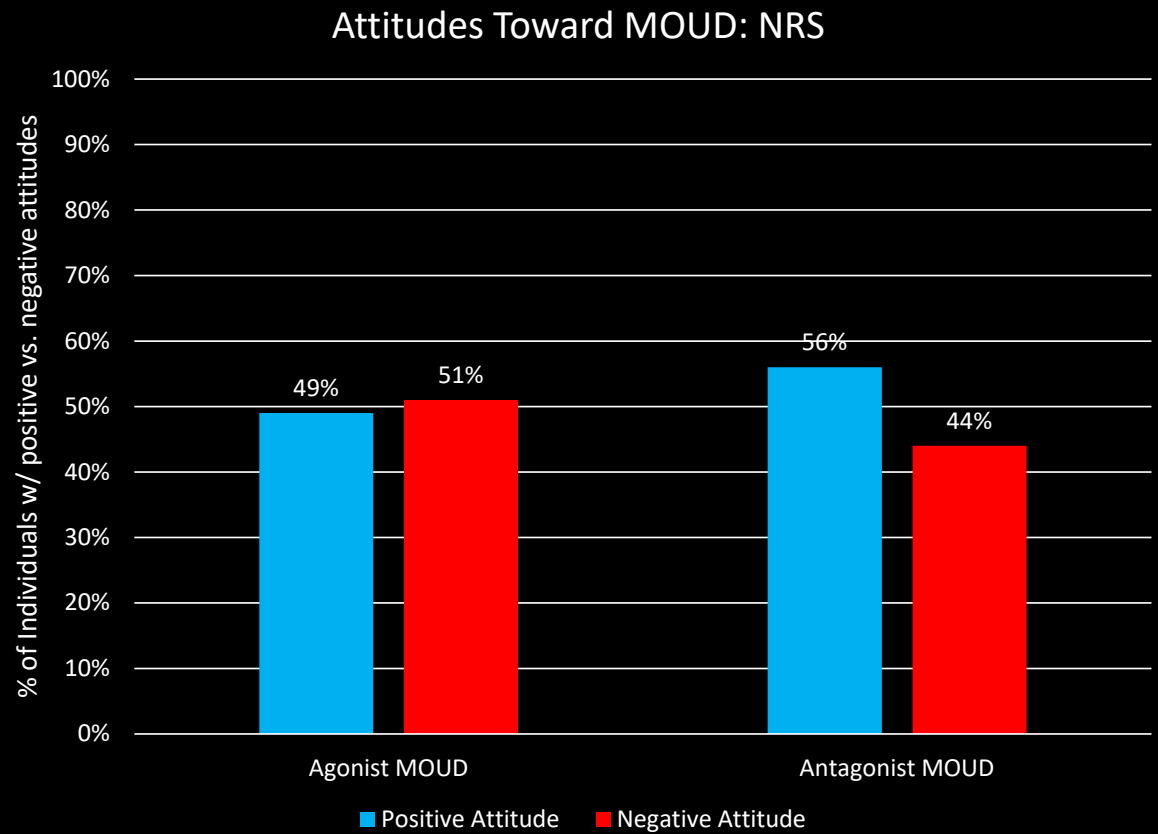
# National Recovery Study (NRS)

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Designed to:

- Estimate national “recovery” prevalence using nationally-representative, probability-based, sample of individuals who self identified as having resolved a significant AOD problem...
- N=2002
- data collected in 2016
- Weighted to accurately reflect US population

# MOUD Attitudes: *Unpublished Data*

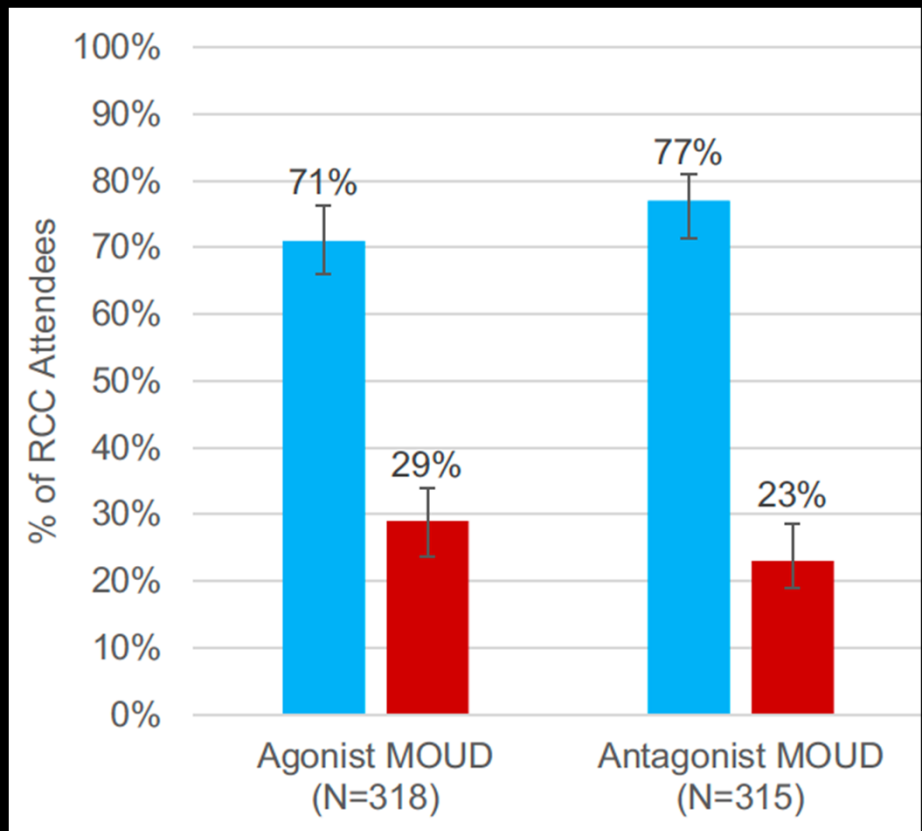


# MOUD Attitudes: Direct Comparison

## Attitudes Toward MOUD: NRS



## Attitudes Toward MOUD: RCCs



# Summary



MOUD AGO attitudes more pos. than presumed: Loud minority vs. Silent majority?

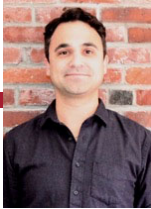


RCCs may be a particularly accepting environment for MOUD patients

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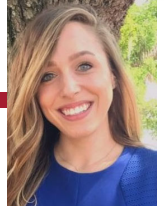
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# ACKNOWLEDGEMENTS



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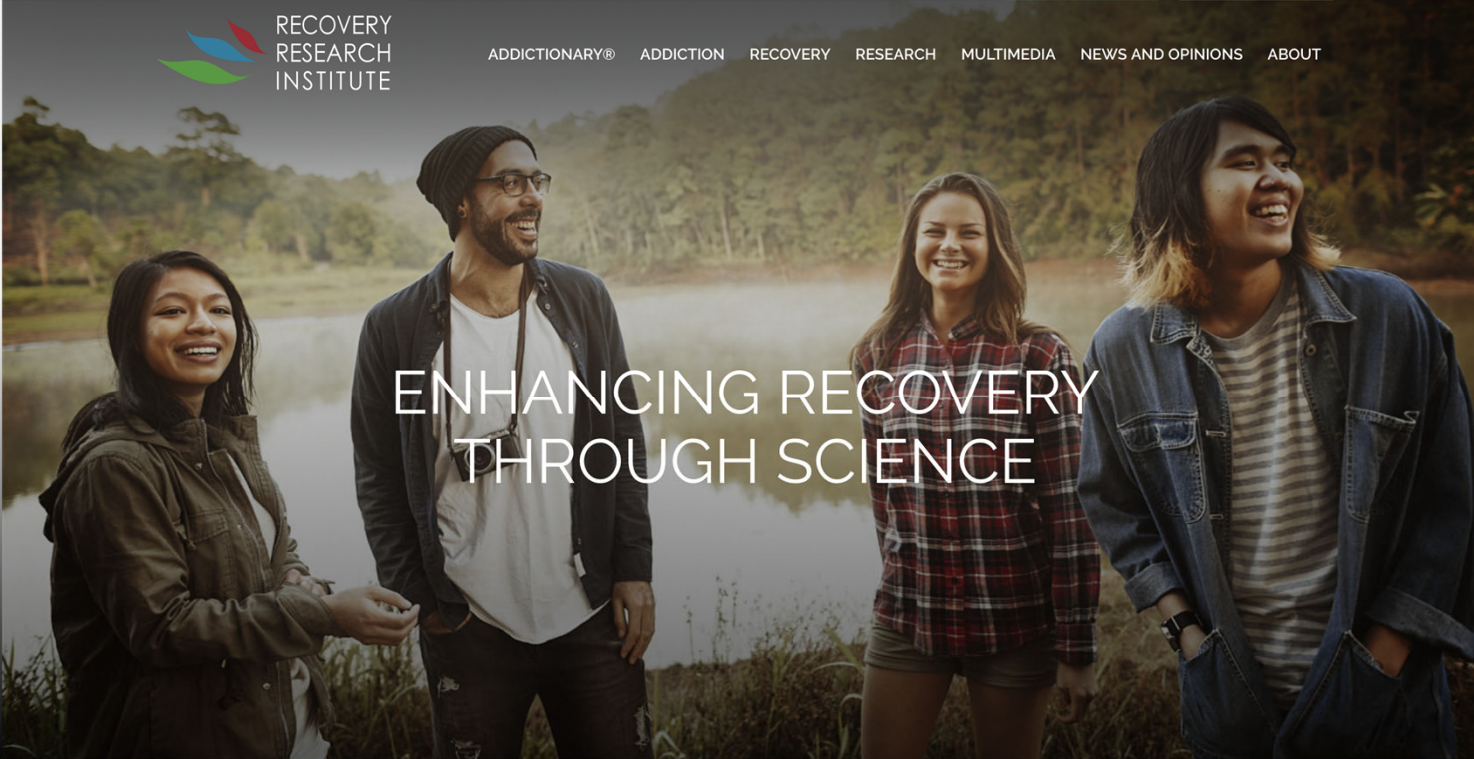


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# *Minnesota Recovery Connection* is a Recovery Community Organization (RCO)

- 501c3 Nonprofit
- Led and governed by members of the recovery community
- Nonclinical
- Inclusive - honor all pathways
- Free services, low threshold access
- Assertive linkages to systems of support

***One-Stop Shop for Recovery***



- Minnesota's first Recovery Community Organization (RCO), established in 2010
- Headquartered in Saint Paul
- Direct peer-to-peer recovery support services in the Twin Cities' metro area
- Statewide education and advocacy services
- Staff: 7 FTEs and 15 PTEs
  - 30 - 40% have lived experience using medications for OUD
- 346 active volunteers
  - Unknown how many have lived experience with MOUD



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<https://minnesotarecovery.org/>



# Direct Support

People



Programs

## Hiring (staff and volunteers):

- All pathways, including harm reduction, emphasized in hiring process.
- Onboarding for all staff includes 46-hour Recovery Coach Academy
- Volunteer onboarding includes all pathways training.

## Culture

- Open discussions at meetings and sharing of stories
- Frequent guest speakers and promotion of resources
- Hold each other accountable for recovery-friendly language that honors all pathways (e.g. avoid “sober” or “clean” and use “in recovery”)

## Environment

- MOUD provider brochures and resources onsite and on website
- Naloxone distribution site
- Posters and positive messaging onsite

## Activities

- 1:1 coaching and resource navigation for people using MOUD
- All recovery meetings - focus on recovery capital, not a particular pathway
- Partnerships with Aliveness Project, Steve Rummeler Hope Network, etc.
- Outreach to MOUD providers

# Public Education

## Recovery Coach Academy:

- 46 hour Peer Recovery Specialist training
- 4 hours dedicated to MOUD and harm reduction
- State's leading trainer of Peer Recovery Specialists

## CEUs for Peer Recovery Specialists:

- Harm Reduction: A Recovery Coaching Pathway
- Peer Support Alliance monthly CEUs - regularly feature MOUD providers, topics

## All Pathways Social/Awareness Events:

- Walk for Recovery
- Rally (Caps) for Recovery



# Advocacy

- Annual Recovery Advocacy Seminar
- Recovery Day on the Hill
- Legislative relations



What do we hear?

What do community members not like?

Any negative reactions?

### **Stigma**

- Participants on MOUD report exclusion from NA, AA, and many traditional mutual aid groups
- Fear of sharing
- Many recovery residences will not accept people on MOUD
- Difficult (and humiliating) to obtain and sustain prescriptions
  - Punitive policies
  - Environments not recovery friendly

### **Ignorance**

- Most Peer Recovery Specialist trainees have little knowledge of MOUD or harm reduction
- Attitudes can be a barrier to learning

### **Challenges**

- Working with people using Methadone
  - Can present as “fuzzy” or “high”
- Lack of accessible and easy to understand information
- Illness, loss of work time if withdrawing from MOUD





## How can you help?

Make every action and decision start from the fact that this is a **HEALTH CONDITION**, not a moral failing.

Require everyone at all levels in your field to complete ongoing **SUD and RECOVERY EDUCATION** and have it taught by or with community members

Integrate SUD health into **MAINSTREAM PRIMARY CARE**. Isolation and separation of SUD care and MOUD reinforces stigma and promotes poor quality services.

**MAKE MOUD AFFORDABLE.** Cost is a significant barrier.



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# The mission of SpiritWorks Foundation is...



Together we are working to break the intergenerational cycle of addiction in families by educating, equipping, empowering and celebrating individuals, families, faith leaders and communities on their journey from addiction to recovery.





# How do we handle MOUD?

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- We believe that there are many pathways to/of recovery, including medication
- We talk about it as a health issue -- people take medications to treat other illnesses
- We have conversations about why we get so upset about people taking MOUD:
  - Internalized stigma
  - Ignorance
  - Discrimination
  - Prejudice



# What services/resources have we implemented to support MOUD?

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Training to educate our members (partners) on:

- Multiple pathways
- Recovery 101
- Recovery ally training
- Stigma



We have many educational materials on our website ([provisionsforthejourney.org](https://provisionsforthejourney.org)) that describe the efficacy of taking medication.



# What do we hear RCC members telling each other about MOUD?



You aren't really clean if you are taking medication.

People are abusing their suboxone and getting high off of it.

They are "using" suboxone or methadone.



"People who are on suboxone are "nodding off" in meetings."



# What do we hear RCC members telling each other about MOUD?

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## However...

Other members are saying that some people need to take medicine to manage their illness, to get well, and to stay well.

Family members whose loved ones have died say that they would gladly give their children MOUD if it would bring them back or give them a few more years with their loved one.



# What do our RCC members like or dislike about MOUD?



- Some people say they don't like taking medications at all
  - We engage them in conversations about this
  - They don't usually have reasons beyond just not wanting to take medications
- Personal experience with taking naltrexone for 9 years
  - I remained abstinent from opioids and alcohol during that time
  - I tell people that I don't think it is anyone's business whether they take medications, unless they want to share it with people





# Change the Name

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National government agencies with words like "abuse" must undergo a **name change**. The term "abuse" increases stigma. The words that we use matter.

- National Institute on Drug **Abuse** (NIDA)
- National Institute on Alcohol **Abuse** and Alcoholism (NIAAA)
- Substance **Abuse** and Mental Health Services Administration (SAMHSA)

<https://actionnetwork.org/petitions/change-the-name-end-the-stigma>



# Change the Name



National government agencies with words like "abuse" must undergo a **name change**. The term "abuse" increases stigma. The words that we use matter.

- National Institute on Drug **Addiction** (NIDA)
- National Institute on Alcohol **Addiction** and Alcoholism (NIAAA)
- Substance **Addiction** and Mental Health Services Administration (SAMHSA)

<https://actionnetwork.org/petitions/change-the-name-end-the-stigma>





# Related Action Items



- **Change the name:** [actionnetwork.org/petitions/change-the-name-end-the-stigma](https://actionnetwork.org/petitions/change-the-name-end-the-stigma)
- **Nationwide Survey** – please participate!
- Opportunities and challenges exist re: MOUDs and RCCs
  - **Conference travel awards** to present your insights
  - **Pilot study funding** to shed more light
  - Tell us what's needed to advocate for improvements

... and now, time for Q&A and Discussion 😊

