



Full length article

Implants and depot injections for treating opioid dependence: Qualitative study of people who use or have used heroin

Joanne Neale^{a,b,*}, Charlotte N.E. Tompkins^a, Rebecca McDonald^a, John Strang^{a,b}

^a King's College London, National Addiction Centre, Institute of Psychiatry, Psychology & Neuroscience, 4 Windsor Walk, London, SE5 8BB, United Kingdom

^b South London and Maudsley NHS Foundation Trust, Bethlem Royal Hospital, Monks Orchard Road, Beckenham, Kent, BR3 3BX, United Kingdom

ARTICLE INFO

Keywords:

Qualitative study
Opioid pharmacotherapy
Opioid dependence
Implants
Depot injections
New materialism

ABSTRACT

Background: Long-acting opioid pharmacotherapy (OPT) is presumed to offer benefits over more conventional OPT formulations. This paper analyzes the views and experiences of people who use or have used heroin in order to explore two novel systems for delivering long-acting OPT: implants and depot injections. New materialism theorizing is used to interpret and frame the findings.

Methods: Qualitative data were generated via seven focus groups conducted during 2017 in London, UK. Participants (n = 44; 28 men and 16 women; ages 33–66 years) had all received OPT. Focus group discussions covered real and potential OPT delivery systems. All participant data relating to implants and depot injections were coded using MAXQDA software and analysed inductively via Iterative Categorisation.

Findings: Participants discussed implants and depot injections in terms of interacting physical, psychological and social factors: dose stability; OPT administration; stopping treatment; co-presence of an antagonist; breaking rituals and habits; reduced choice and control; feeling normal; information needs; getting on with everyday life; and social interaction. Participants identified both benefits and concerns, and variable needs and preferences, with respect to each delivery system.

Conclusions: Implants and depot injections are not 'fixed' medications that can be administered to people to achieve pre-determined treatment aims. Rather, they are complex 'assemblages' with uncertain outcomes. Furthermore, they are themselves part of wider interactive 'assemblages'. Drug developers and treatment providers need to understand this complexity in order to target long-acting OPT at people most likely to benefit from it, and to reduce any unintended negative consequences.

1. Introduction

'Opioid pharmacotherapy' (OPT), 'opioid substitution treatment' (OST) and 'opioid agonist treatment' (OAT) are all terms that describe the administration of medications to people dependent on opioids in order to achieve 'defined treatment aims' (WHO/UNODC/UNAIDS, 2004). Pharmacotherapies for opioid dependence include opioid agonists (e.g., methadone), partial agonists (e.g., buprenorphine), opioid antagonists (e.g., naltrexone), and alpha-2-adrenergic agonists (e.g., lofexidine; Stotts et al., 2010). Traditionally, pharmacotherapy has tended to be taken daily, in liquid or tablet form, and under close medical supervision. More recently, long-acting formulations have become available for clinical practice. For example, the United States Food and Drug Administration (FDA) approved the first buprenorphine implant (6-month duration) in May 2016 and a first buprenorphine depot injection (monthly administration) in November 2017 (Sigmon and Bigelow, 2016). Other products, such as naltrexone implants, have

been developed and the market is expanding (Comer et al., 2007; Hegde et al., 2013; Stotts et al., 2010).

Long-acting OPT is presumed to offer benefits over more conventional OPT formulations. By providing sustained medication release, it makes daily dosing unnecessary, reducing the frequency of clinic/pharmacy visits and obviating the need for take-home doses. This is expected to improve patient adherence, reduce the treatment burden (for both patients and clinicians), and remove the risk of illicit diversion (Sigmon et al., 2006; Sigmon and Bigelow, 2016). These claims have not, however, been tested to-date. Typically, studies of new medicinal products are conducted by natural scientists who assume that medicines have inherent physical properties, which cause predictable changes in patients once administered (Bundy and Quintero, 2017; Gomart, 2002). Their research, conducted primarily for drug development and regulatory purposes, focuses on product characterization, safety and efficacy (such as dose, storage requirements, side effects, adverse reactions, pharmacokinetics, and metabolism; DiMasi, 2002; Gad, 2017;

* Corresponding author: King's College London, National Addiction Centre, Institute of Psychiatry, Psychology & Neuroscience, 4 Windsor Walk, London, SE5 8BB, United Kingdom.
E-mail address: joanne.neale@kcl.ac.uk (J. Neale).

Rosenthal et al., 2013).

Social scientists have, meanwhile, argued that medicines and their effects relate to complex social and cultural factors that vary across time and place (Gomart, 2002; Barad, 2007). Working largely within a social constructivist paradigm, social scientists began to study OPT during the 1990s. Their initial research was descriptive and applied, exploring heroin users' views and experiences of methadone, and their reasons and motivations for engaging with methadone treatment (Jones et al., 1994; Koester et al., 1999; Murphy and Irwin, 1992; Neale, 1998, 1999a, 1999b; Sheridan and Barber, 1996). Later, studies became more theoretical, drawing upon sociological and psychological concepts such as identity, stigma, surveillance, and social control (e.g., Harris and Rhodes, 2013; Monaghan and Wincup, 2013; Radcliffe and Parkes, 2013; Strike et al., 2013; Treloar and valentine, 2013).

In recent years, social scientists have also drawn upon the interdisciplinary field of 'new materialism' to understand methadone and methadone treatment (Fraser and valentine, 2008; Gomart, 2002; Keene, 2013; valentine, 2007). New materialism is distinct from biological and constructivist approaches to understanding the world in that the physical/natural and the social/cultural are considered contiguous rather than distinct. The focus of new materialism is on 'matter,' a generic term used to encompass physical and material things, but also human bodies, other animate organisms, and more abstract concepts such as places, spaces, time, and practices (Braidotti, 2013; Fox, 2016; Fox and Alldred, 2018; Haraway, 1991). Proponents of new materialism maintain that all matter – that is, all human and non-human phenomena – is relational and contingent rather than fixed or stable (Barad, 1996; Coole and Frost, 2010; Fox, 2016). Matter affects and is affected by other matter, and all matter is produced in interacting networks (or 'assemblages') of other matter (Deleuze and Guattari, 1988).

Drawing upon new materialism, and particularly actor-network theory (a key strand of new materialism), Gomart (2002), valentine (2007) and Fraser and valentine (2008) have all argued that methadone, being matter, is neither a stable, pre-existing chemical substance nor a social construction. Methadone is simultaneously a physical phenomenon with biochemical properties and a deeply social, cultural and political phenomenon. It is multivalent, linked to other matter, relational and interactive. Methadone varies from one context to another. It acts pharmacologically (producing tangible physiological effects) but only in interaction with other human and non-human 'actants' (Bundy and Quintero, 2017). In short, methadone's qualities are not inherent in its pharmaceutical properties, but are co-produced within complex networks of other matter (Bundy and Quintero, 2017; Latour, 2005; Law, 1999).

In this paper, our focus is neither on methadone nor on any other specific medication. Our aim is rather to explore two novel systems for delivering long-acting OPT (implants and depot injections), and we do this from the perspective of people who use or have used heroin. Our interest follows from the argument that OPT is likely to be more effective if we take patients' views, experiences and motivations into account when making treatment decisions (Neale, 1999a; Neale, 2013). In the Discussion, we return to new materialism to help interpret and frame our findings.

2. Methods

Data were generated as part of a qualitative focus group (FG) study exploring real and imagined OPT delivery systems: liquids, tablets, nasal sprays, implants and depot injections. Qualitative methods are frequently used to investigate the acceptability of emergent health care interventions, including new medicines. This kind of inquiry can be undertaken using interviews or focus groups conducted with people who have not received the intervention under investigation, but who belong to the target patient population or to a closely related population. For example, a number of published studies have explored

women's hypothesized perceptions of permanent and long-acting contraception, including implants and depot injections (Glasier et al., 2008; Harrington et al., 2015; Zimmerman et al., 1990).

In this study, the participants (n = 44) were all current or former heroin users (28 men and 16 women; ages 33–66 years). The groups were conducted in drug and alcohol services, a peer support recovery service, and a homeless hostel in London, UK, during March and April 2017. Ethical approval for the study was granted by the United Kingdom (UK) NHS Research Ethics Service. Recruitment of participants occurred in several ways: posters with the researchers' contact details were displayed in the services; researchers approached potential participants in person at the services; workers encouraged service users to contact the researchers; and participants from the earlier focus groups introduced the study to their peers. Everyone who expressed interest in taking part (n = 76) completed a basic screening questionnaire that covered gender, age, ethnicity, substance use, prescribed medications, and contact details. The researchers then used the screening information to identify and invite people to the groups.

Groups were organized according to participants' current treatment status to minimize the likelihood of anyone comparing their own treatment with other treatments and then becoming dissatisfied. This resulted in seven groups: oral methadone (FGs 1 and 2); buprenorphine tablets (FGs 3 and 4); injectable OPT (FG5); and former OPT (FGs 6 and 7). Participants in FG6 reported no current opioid use at all whereas participants in FG7 were all current users of street opioids. One participant had previously participated in a trial of depot injection buprenorphine and several others knew people who had had naltrexone implants. In addition, one female participant reported that she had had a contraceptive implant. Others were familiar with the concept of receiving contraception or treatment for mental health problems via depot injections (see Table 1 for additional participant details).

Each group was facilitated by two researchers who used a topic guide to structure the discussions. The guide initially focused on participants' personal experiences of OPT before exploring their views of receiving treatment for opioid dependence via different delivery systems. No specific medications were mentioned as the objective was to focus attention on 'how' the treatment was delivered rather than the particular drug. Participants were provided with a brief verbal description of each delivery system and then asked what they thought about it, including what they liked and disliked. The information provided to participants about implants and depot injections is shown in Table 2.

Groups lasted between 41 and 63 min and were audio recorded. All participants received £10 as a gesture of thanks. Audio recordings were transcribed verbatim and then coded using the qualitative software MAXQDA (version 11). The coding frame comprised deductive codes derived from the topic guide and inductive codes emerging from the data. For this paper, all coded data relating to implants and depot injections were exported from MAXQDA into Microsoft Word documents and then analysed inductively through a process of Iterative Categorisation (Neale, 2016).

In the first stage of the analyses, the coded implant and depot injection data were reviewed line by line to describe aspects of each delivery system that participants liked and disliked. Since similar issues were discussed in relation to both systems, and positive comments were often opposites of the negative comments, the analyses were merged and then grouped into more inductive categories. These categories (n = 10) were subsequently organised under three headings: i. physical factors (four categories); ii. psychological factors (four categories); and iii. social factors (two categories). We use these categories to structure the findings below. Differences between participants' views of the implants and depot injections, and any emergent differences between subgroups of people receiving OPT, were considered and documented as part of the analytical process.

Download English Version:

<https://daneshyari.com/en/article/7502744>

Download Persian Version:

<https://daneshyari.com/article/7502744>

[Daneshyari.com](https://daneshyari.com)