Dawn Farm's Position on Buprenorphine Maintenance

History

Dawn Farm has had a longstanding commitment to helping opiate addicts, especially IV heroin addicts. But withdrawal from opiates produces symptoms that clearly make it more difficult for opiate addicts to join the recovering community. So even though our treatment approach had a history of proven success, we were excited about the FDA approval of buprenorphine (Suboxone, Subutex) in 2002. Any drug that reduced the suffering associated with opiate withdrawal without significant mood altering effects was cause for celebration.

Today, Dawn Farm still believes that buprenorphine can be a very helpful detoxification tool. But over the last several years we've watched long-term buprenorphine maintenance become a treatment norm around us, apparently following a tradition that began with methadone maintenance. We are profoundly troubled by this trend.

Dawn Farm has been especially concerned as we've observed three disturbing developments:

1. Young (18-22 year old) first-time treatment seekers with early stage addictions are being placed on buprenorphine and maintained on it indefinitely. This is routinely done without any meaningful discussion of treatment options.
2. Growing numbers of our incoming clients routinely misused buprenorphine, including Suboxone, the preparation that is promoted as having no misuse value.
3. Growing numbers of clients contact us seeking help to detoxify ***from*** (not with) buprenorphine.

Dawn Farm has always opposed most forms of drug maintenance treatment. We believe they reflect a view that opiate addicts can't achieve lasting, drug-free recovery. We are concerned that the changes we've seen in how buprenorphine is prescribed are based upon that view.

We know better. For decades, we have seen IV opiate addicts achieve lasting, abstinent recovery. The recovering community in our area includes hundreds of successful, drug-free opiate addicts—many of them in their early 20s. Our experience indicates that drug-free recovery is possible for *any addict*—when provided with high quality treatment of adequate intensity and duration.

All of Dawn Farm's sites display a quote on the wall by the esteemed addiction physician George Vaillant:

"If you want to treat an illness that has no easy cure,
first of all, treat them with hope."

We believe that hope consists in an expectation of recovery—an expectation borne out by our experience.

So as we consider the subject of buprenorphine maintenance, we ask four basic questions:

Is it **necessary** for achieving stable recovery?

Is it **helpful** to achieving stable recovery?

Is it **harmful** to the goal of achieving stable recovery?

Is it **compatible** with other proven treatments and paths to recovery?

1. Is it <u>necessary</u>?

We frequently hear the argument that buprenorphine maintenance is *necessary* for a variety of reasons. Let's address a few of them.

"Other treatments for opiate addiction often fail."

Other treatments do frequently fail. Addiction is a chronic illness and, like other chronic illnesses, there is no cure. We can, however, minimize relapses my providing treatment of adequate intensity and duration. Recovery for opiate addicts is an achievable goal.

It is worth noting that there is one specific group of opiate addicts that is consistently offered care of

appropriate intensity and duration—with the expectation that they *can* actually achieve full drug-free recovery. This group's outcomes are consistently stellar, with 5 year relapse rates below 25%. This group is *health professionals*.[1] Doctors and nurses are *not* treated with drug maintenance.[2]

"Addicts don't want drug-free recovery."

Our experience tells us that this is a myth—and a reflection of helpers' low expectations. Dawn Farm believes that active addicts hate their lives—and that most will migrate toward drug-free recovery contingent on two important conditions: access to quality recovery support and treatment services, and helpers who consistently communicate *hope* for full recovery.

"Opiate replacement is needed for overdose prevention."

This is a frequently cited argument for buprenorphine maintenance. It's compelling if you believe that stable recovery is unlikely—a premise we know to be untrue. Treatment decisions for health professionals are not based on an expectation of relapse and overdose—and their outcomes are measurably better. The disparity in outcomes between addicted doctors and "street addicts" comes perilously close to raising potent questions about class prejudice in the treatment field.

2. Is it <u>helpful</u> to achieving stable recovery?

We have a number of clients who take medications. For individuals suffering from co-occurring clinical depression or other disorders, medications can greatly assist our clients as they navigate early recovery. While we are conservative about psychotropic medications, we clearly see their benefit in individual cases (see our position paper on Mood Disorders).

However, we simply are not seeing buprenorphine maintenance patients achieving stable recovery. We have a number of outpatient clients who come to us on opiate replacement therapy—we are not seeing clinical success among them.

3. Is it <u>harmful</u> to achieving stable recovery?

Buprenorphine works to quell withdrawal and craving for the same reason as methadone because it is recognized by opioid receptors in the brain as a potent narcotic. It is not difficult to transfer an addict's dependency from one object to another, especially to another drug and especially when the addict is on the cusp of abstinence and extremely vulnerable.

Like methadone, buprenorphine produces a picture of stability with no withdrawal and little or no craving/pre-occupation, but it does so because it produces an "upload" effect. In fact, the person on maintenance is only as stable as the assurance of his next dose. The situation is analogous to long term methadone patients who are decreasingly capable of (or interested in) getting off the drug the longer that are on it. The longer patients are maintained on methadone, the less likely they will ever become drug free.[3] Not surprisingly, a similar pattern is becoming apparent with buprenorphine patients on "stable" maintenance.[4]

Nationally, practitioners have begun expressing concern that buprenorphine maintenance actually *interferes* with achieving stable recovery.

These concerns include:

- There are early indicators that buprenorphine maintenance does not allow for neurobiological healing, i.e.

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[1] DuPont RL, McLellan AT, Carr G., (2009). How are addicted physicians treated? A national survey of Physician Health Programs. *Journal of Substance Abuse Treatment*, 1-7.

[2] Berge KH, Seppala M, Schipper A. (2009). Chemical dependency and the physician. *Mayo Clin Proc*, 625-631.

[3] Calsyn DA, Malcy JA, Saxon AJ. (2006). Slow tapering from methadone maintenance in a program encouraging indefinite maintenance. *Journal of Substance Abuse Treatment*, 159-163.; Magura, S. & Rosenblum, A. (2001). Leaving methadone treatment: Lessons learned, lessons forgotten, and lessons ignored. *Mount Sinai Journal of Medicine*, 68(1), 62–74.

[4] Helwick C (2010, May 24) For Prescription Opioid Dependence, Relapses Associated With Shorter Treatment Course. Retrieved October 25, 2011 from, http://www.medscape.com/viewarticle/722342. Helwick reported findings from a presentation by Roger Weiss, MD on the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study. Researchers found that tapering with buprenorphine during a 9-month period, whether initially or after a period of substantial improvement, led to nearly universal relapse.

increasing production of the body's own opioids and replenishing opioid receptors.[5]

- Cognitive impairment has been found in methadone and buprenorphine maintenance patients when compared to abstinent recovering opiate addicts.[6]
- Buprenorphine blunts the emotional experiences of the user, interfering with key emotional aspects of recovery, including the development of new coping skills.[7]
- Buprenorphine maintenance patients may be less motivated to engage in activities of self-care we generally associate with stable, full recovery. These include 12 step attendance *and* involvement, breaking ties with aspects of the addictive lifestyle, building relationships with recovering people, etc.[8]

We find these concerns credible, though we don't believe we know enough yet about the neurobiology of recovery[9] to speak definitively on the matter.

4. Is it <u>compatible</u> with proven treatments and paths to recovery?

An obvious question is, "Why not buprenorphine AND traditional treatment and recovery supports?"

One big barrier is the ambivalence 12 step groups have toward opioid replacement treatment.[10] Officially, opioid replacement patients are welcome in these fellowships but are not considered to be in recovery. This leaves the opioid replacement patient in the position of hiding their use of medication if they wish to be embraced by these fellowships—a very precarious position for an aspiring member of a fellowship that advocates rigorous honesty.

We're sadly persuaded that the driving force behind buprenorphine maintenance has little to do with any conviction that it constitutes an ideal approach. It appears, rather, to be driven by a resignation to suboptimal resources—practitioners can't offer enough monitoring, they can't offer more than short-term residential or inpatient treatment, they can't offer community-based recovery support services, they can't offer outpatient treatment of sufficient duration

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[5] Gold MS, Pottash ALC, Extein I. (1981). Evidence for an endorphin dysfunction in methadone addicts: Lack of ACTH response to naloxone. *Drug and Alcohol Dependence*, 8 (3), pp. 257-262. Blum K, Chen TJ, Bailey J, Bowirrat A, Femino J, Chen AL, Simpatico T, Morse S, Giordano J, Damle U, Kerner M, Braverman ER, Fornari F, Downs BW, Rector C, Barh D, Oscar-Berman M. (2011). Can the Chronic Administration of the Combination of Buprenorphine and Naloxone Block Dopaminergic Activity Causing Anti-reward and Relapse Potential? *Molecular Neurobiology*. Online First. There is very little research on this topic, and the research that does exist focuses on methadone. However, maintenance patients often report loss of interest in sex and exercise; two activities that the body's own opioid system play important roles in. This loss of interest suggests that this endogenous opioid system does not return to normal functioning while on maintenance treatments.

[6] Martin M, Hurley RA, Taber KH. (2007) Is opiate addiction associated with longstanding neurobiological changes. *J. Neuropsychiatry Clin. Neurosci*. 19: 242–248.; Mintzer MZ, Stitzer ML. (2002). Cognitive impairment in methadone maintenance patients. *Drug Alcohol Depend.* 67(1):41–51.; Darke S, Sims J, McDonald S, Wickes W. (2000). Cognitive impairment among methadone maintenance patients. *Addiction.* 95(5):687–695.; Davis, P., Liddiard, H. and McMillan, T. M. (2002) Neuropsychological deficits and opiate abuse, *Drug and Alcohol Dependence*, 67, 1, 105-108.; Rapeli P, Fabritius C, Alho H, Salaspuro M, Wahlbeck K, Kalska H. (2007). Methadone vs. buprenorphine/naloxone during early opioid substitution treatment: a naturalistic comparison of cognitive performance relative to healthy controls. *BMC Clin Pharmacol*. 7:5

[7] Savvas SM, Somogyi AA, White JM. (2011). The effect of methadone on emotional reactivity. *Addiction*, in press. This article speaks to the blunting of emotional reactivity in methadone patients. There has not yet been similar research on buprenorphine patients.

[8] Amato L, M. S. (2011). Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence. *Cochrane Database of Systematic Reviews*.; Schwartz RP, Kelly SM, O'Grady KE, Gandhi D, Jaffe JH. (2011). Interim methadone treatment compared to standard methadone treatment: 4-month findings. *J Subst Abuse Treat.* 41(1):21-9.; Helwick C (2010, May 24) For Prescription Opioid Dependence, Relapses Associated With Shorter Treatment Course. Retrieved October 25, 2011 from, http://www.medscape.com/viewarticle/722342; Fiellin DA, Pantalon MV, Chawarski MC, Moore BA, Sullivan LE, O'Connor PG, Schottenfeld RS. (2006). Counseling plus buprenorphine-naloxone maintenance therapy for opioid dependence. *N Engl J Med.* 355:365-374
Amato et al.'s meta-analysis of methadone maintenance treatment (MMT) found no benefit from added psychosocial support. Schwartz et al. compared interim methadone (IM) patients receiving no counseling with standard methadone (SM) patients receiving counseling. IM patients tested positive for illicit drugs at the same rate but engaged in less criminal activity and spent less money on drugs. These findings suggest that MMT patients are not "available" to benefit from these interventions which are the mainstay of abstinence based recovery. Helwick reported similar findings from a presentation by Roger Weiss, MD on the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study. Patients receiving buprenorphine and counseling fared no better than patients without the counseling. Fiellin, et al. reported similar findings. Again, suggesting that ORT patients are not "available" to benefit from these interventions which are the mainstay of abstinence based recovery.

[9] See White, W. (2007). *In search of the neurobiology of addiction recovery: A brief commentary on science and stigma*. Retrieved from www.williamwhitepapers.com

[10] White, W. (2011). Narcotics Anonymous and the pharmacotherapeutic treatment of opioid addiction. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Intellectual disability Services.

and intensity, they can't address all of the client's other problems that can interfere with recovery, etc.

We understand that practical constraints challenge most practitioners, and we can respect the necessity of choosing a second best option when the best is not available. However, in such situations we expect informed consent:

> "The best treatment plan for you would include long term treatment, long term community-based recovery support and recovery monitoring for 5 years with rapid re-intervention in the event of a problem. However, this isn't an option for you. So . . ."

The patients and families we encounter have had no such conversation.

The recovery process (i.e. treatment, mutual aid groups, community) is, at its core, a structure to support individuals long enough to go through the anxiety and distress of transferring their dependency from a drug to non-destructive, non-shaming sources of supply (human and spiritual relationships). The essential elements of this process are a very high level of structure and social support over a sustained period of time along with a sufficiently strong personal need to take the risk of going through a day without drugs.

Buprenorphine, like methadone, quells the need for a substitute. You can make participation in therapy or 12 step meetings a condition for continued access to the drugs but the motivation to participate is *pursuit of the drug*, not a sense of having found a sufficient substitute. The individual's progress is dependent upon the next dose rather than on trusting, functional relationships with human beings.

Mutual aid groups, rather than treatment, actually deserve the credit for creating long-term support for the behavior and lifestyle changes necessary to maintain recovery. Considered in this context, what practitioner working with cardiac, obesity or Type II diabetes patients wouldn't envy a no-cost, vibrant community of support to help initiate and maintain behavior and lifestyle changes over decades? In this respect, the addiction treatment field has a long head start over practitioners treating other chronic conditions and has enjoyed considerable success for decades. Consequently, we believe that the move toward buprenorphine maintenance has not added an effective tool to the historical strength of the recovering community—rather it has wandered away from it.

Further, many treatment providers have historically failed to effectively promote the concept of addiction as a chronic illness. Instead they have sold treatment under an acute care model, with time-limited doses of treatment, all the while paradoxically promoting an image of permanent, full recovery unsupported by their outcomes.

We believe that the most stable adjustment to recovery comes with access to a source of supplies that is limitless, non-confining and available everywhere. In this respect, the limitations of opiate replacement therapy are obvious.

Clearly, buprenorphine doesn't have to be an either/or decision, but practitioners are telling us that buprenorphine clients don't want the rest of the "recovery lifestyle." Why is that? Is there something about the drug that reduces motivation? Does it interfere with experiencing the benefits of sobriety? We routinely see men and women who begin the process of recovery as hopeless addicts, only to find that they have the ability to function *without a drug.* They can become free in the truest sense of the word—limited only by their own hopes, dreams and willingness to continue to grow.

In summary, we are not persuaded that opiate replacement therapy is either necessary or fundamentally helpful for opiate addicts seeking recovery. We see clear examples of real harm to stable recovery caused by buprenorphine. And we continue to encounter ways in which this maintenance approach is incompatible with interventions that produce meaningful long-term abstinence. We are especially troubled by the fact that buprenorphine is routinely offered to IV heroin addicts but not to impaired physicians.

Why would we move toward buprenorphine maintenance—when we have a model[11] that works?

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[11] DuPont, R. L., McLellan, A. T., Carr, G., G (2009). How are addicted physicians treated? A national survey of Physician Health Programs. *Journal of Substance Abuse Treatment*, 1-7.