MEDICATION ASSISTED RECOVERY

EMERGING TRENDS IN THE TREATMENT OF SUBSTANCE USE DISORDERS

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Editor's Note: This article introduces what will be a continuing series of columns in Counselor *on medication-assisted treatment.*

Despite all the scientific evidence attesting to the safety and efficacy of treatment medications, medication-assisted treatment (MAT) continues to be one of the most effective yet misunderstood interventions in the addiction treatment field[i]. The mere mention of addiction medications can elicit such strong negative reactions from people in recovery and addiction professionals alike that these attitudes have been described as an "anti-medication bias" (White & Coon, 2003).

The apparent incompatibility between the scientific literature suggesting the benefits of MAT versus the widespread resistance against pharmacological interventions in addiction treatment have caused a significant challenge within behavioral healthcare, and a deep confusion in people seeking treatment. This article will offer a brief overview of MAT and will explore the controversy and seeming incongruence between what the science shows and what the attitudes and practices are by many counselors. In addition, medication assisted recovery will be positioned within the context of a comprehensive recovery process.

The negative reactions against MAT, some suggest are not without merit since historically most attempts to treat addictive disorders with medications/substances have led to severe

consequences (i.e., giving morphine to those with heroin dependence or cocaine to alcoholics) and have intensified rather than ameliorated the problems (see White, 1998 for a comprehensive historic overview). Furthermore, many suggest using medications in the treatment of addictive disorders is simply replacing "one drug for another" or produces an artificial/false recovery process viewed as illegitimate when compared to the recovery obtained by those not assisted with medications. Taken as a whole, these views have contributed to a ubiquitous bias against medication-assisted interventions leading to the tendency in many to be suspicious of and resistant to the consideration of medications in addiction recovery treatment.

Notwithstanding the intensity of arguments and opinions in opposition to MAT, consensus now exists and extensive scientific evidence clearly demonstrates the short and long-term efficacy of medications used in the treatment of addiction. The World Health Organization/ United Nations Office of Drugs and Crime (WHO/UNODC, 2004), the National Institute of Health (NIH, 1997), the National Institute on Drug Abuse (NIDA, 1999, 2007), the Office of National Drug Control Policy (ONDCP, 2000), the Centers for Disease Control (CDC, 2002), the Substance Abuse and Mental Health Service Administration/ Center for Substance Abuse Treatment (SAMHSA/CSAT, see TIP 40–2004, TIP 43–2005, TIP 45–2006 and TIP 49–2009) and several other national/international organizations all agree that medications such as methadone, buprenorphine and naltrexone are safe and effective treatment options when taken as prescribed and as part of a comprehensive recovery plan. Extensive research has found that MAT not only produces exceptionally favorable direct outcomes (abstinence, treatment compliance, retention, decreased medical and physical complications), but also numerous indirect benefits (employment, reduced criminal behavior and legal involvement, family reunification, physical health and overall quality of life) for people served.

The science to service gap

It can be difficult to reconcile the massive body of scientific research and global consensus on the efficacy of MAT with the widespread negative attitudes towards treatment medications held by so many. Interestingly, this divide is not unique to addiction counseling and is actually confirmation of a phenomenon now being referred to as the Science to Service gap. This gap is troubling because although significant progress has been made over the last several years around our understanding of the causes, consequences and effective treatments of addiction, many counselors do not effectively practice and in some instances are not aware of most scientific findings and evidence-based interventions recommended in the treatment of addiction (see Miller & Carroll, 2006 and Emmelkamp & Vedel, 2006).

To make matters worse, numerous counselors often dismiss MAT therapeutic options due to their own "ingrained ideologies" or because of their own experiences and biases (Leshner, 1997). Surprisingly, even some counselors working within MAT settings view medications negatively. Many of the arguments against MAT are typically not informed by the extensive data that consistently demonstrates the efficacy of these medications. In fact, most of the challenges found in MAT settings are not due to the medications themselves. Rather, they are caused more so by misguided public policy (criminalize rather than treat addictive disorders); a lack of recovery support services (housing, employment, transportation, medical services); insufficient funding (despite the fact that MAT is one of the least expensive and most effective interventions); and the persistent stigma that continues to exist around addiction treatment and recovery (White & Coon, 2003).

Mutual support groups & 12 Step fellowships and MAT

MAT is an area of robust controversy within the recovery community and mutual support/12 Step fellowships as well. This debate tends to focus on two main issues: whether medication-assisted treatment should prevent or disqualify a person from 12 Step fellowship involvement; and whether recovery obtained with medication-assistance is "legitimate" since many believe all should have the goal of being medication and drug-free (NIH, 1997). Many argue that addiction medications violate the very foundation of the 12 Step fellowships and those who get medication-assistance for their recovery should not be allowed to participate and attend. Another position is the view that the only requirement for membership is a desire to stop using alcohol/substances, and nothing in the 12 Step literature of Alcoholic Anonymous (AA) suggests the use of medications disqualifies a person from participation in the fellowship.

The AA publication *The AA member—Medications and other drugs* (1984)[ii] suggests that taking the position that no one within the fellowship should take medications "has meant disaster" for some members. Although clearly cautioning against the tendency to misuse medication, the publication recommends that while it may reduce the risk of relapse to avoid medication, it's "wrong to deprive any alcoholic of medication that can alleviate or control other disabling physical and/or emotional problems."[iii] People are encouraged to seek non-medication supported alternatives where ever possible, and if medications are necessary, to report any problems around medication management issues or relapse to their medical provider. The fact that many members of 12 Step fellowships are opposed to MAT is not so much a representation of any official position of 12 Step philosophy or tradition, as much as it is an example of "personalities before principles."

On a positive note, opposition within the recovery community is not as profound toward medications for some medical/psychiatric disorders and recently, some have noted progress around this issues (White, 2007, 2009) in that many within the recovery community have moved closer to embracing (or at least tolerating) those that use medications as part of their recovery journey. However, numerous stories continue to prevail around the negative experiences people in recovery endure after disclosing they have used medication in their recovery process. This is an enormous challenge that not only prevents many from seeking and maintaining MAT services, but also from actively participating in these 12 Step groups which have been found by millions to be an essential cornerstone of many recovery programs. In response to this challenge, Methadone Anonymous[iv] and other mutual support groups supportive of MAT have started to develop around the nation.

Evolving notions of addiction and recovery

An emerging recovery paradigm has been gaining momentum on numerous levels (the recovery community, counselors, treatment providers, state/federal systems of care) which has been reshaping clinical and treatment practices. This movement has been drawing attention toward an emerging recovery orientation and away from the traditional acute care/disorder/diagnosis driven system. The acute care model of addiction is being challenged since many are now arguing that this model has led us to assume that addiction can be treated with brief and isolated episodes of care when the research is showing that most people will require multiple treatment episodes over many years to improve their outcomes and achieve sustained recovery (Dennis & Scott, 2007). Several important and substantive changes are emerging in the field, such as recovery-oriented standards or care; individualized and person-centered care; recovery supports; and increased acceptance of and expanding treatment medication options. Optimistically, there also appears to be a movement towards evolving models of addiction recovery that embrace more of a motivational enhancement, holistic and individualized recovery process and an abandonment of the more disease focused, label-driven, confrontational and 'cookie cutter' approaches to addiction recovery (CSAT, 1999).

There is growing diversity in how addiction and recovery are being defined and ongoing evolution of causal models of addiction. Despite its ubiquity, there are disparate views[v] toward and little consensus on the definition of addiction. The term *addiction* has been criticized by many including Erickson (2007) as being too broadly applied, vague, stigmatizing and unscientific which is likely why as he suggests it does not even appear in the standard diagnostic text of mental disorders. Leshner (2001) stated that "the entire concept of addiction has suffered greatly from imprecision and misconception."

Several recent efforts have focused specifically on the expansion and clarification of the term recovery and how this concept is used and defined by treatment professionals, researchers and people in recovery. The Betty Ford Institute Consensus Panel (2007) recently released a comprehensive definition of

recovery that includes several elements such as sobriety, time frame and method. Fortunately, the Consensus Panel definitively answered the question from their perspective about medication-assisted recovery meeting the criteria for sobriety if the person is abstinent from all non-prescribed medications and alcohol. SAMHSA convened a panel of stakeholders and experts to develop a working definition of recovery because it was identified that no working definition existed to guide federal policy, research or other efforts around recovery. The National Summit on Recovery Conference Report (2005) identified several criteria[vi] of recovery including: multiple pathways, self-directed, holistic, hopeful, positive social identity and peer supported. These definitions represent a huge shift from traditional definitions which typically focused almost exclusively on abstinence/sobriety from drugs and alcohol.

Historically, the principal causal model of addiction[vii] has been a *moral model* which posits that people choose to use substance because they lack moral character and if they are sufficiently motivated to discontinue their substance use (and reduce the negative impacts of their behavior on themselves and others) they can do so by simply exerting will power and making a decision to change (CSAT, 1999). Significant progress has been made around expanding the causal models of addiction to include greater understanding of and emphasis upon psychological, biological and spiritual factors. This important shift has translated to important changes around clinical practice as well as recovery advocacy, but much more progress is needed around challenging various models of addiction.

The science of addiction and recovery

Scientific advances and consensus documents from the leading researchers and institutes on addiction have resulted in a shift toward scientific thinking and an enormous body of research has emerged around the nature of addiction recovery. This trend has not only significantly increased our understanding around the nature and treatment of addiction, but more importantly has facilitated the transformation of many ideas, theories and practices within the field.

By using brain imaging techniques to explore the impact of substance use on the brain, NIDA researchers have made enormous scientific progress toward our understanding of how the brain is impacted and actually changed over time by prolonged exposure to substances. These changes—which not only impact

the way the brain responds to the substances, but change the function, structure and chemistry of the brain—remain long after abstinence is achieved, and can significantly impair how the brain processes and stores information, which in turn, negatively impacts important functions such as decision making, judgment, learning and memory (Volkow & Li, 2009: Fowler, et al, 2007; Kosten & George, 2002; Volkow, et al. 2003; NIDA, 2007). New scientific findings on brain plasticity are further challenging the previously held rigid view that once brain damage occurs it is irreversible (Volkow & Li, 2009).

Challenging the conventional wisdom around addiction even further, Thomas McLellan and his colleagues (McLellan et al., 2000) proposed that drug dependence is remarkably similar to other chronic medical disorders such as hypertension, diabetes (type 2) and asthma, in terms of genetic heritability, predictable course, environmental factors as well as relapse rates. These findings have profound implications for how we treat addiction in that they challenge the historical view that addiction is different from other medical disorders, and argue that it is a chronic relapsing disorder.

The science of addiction is playing a central role in guiding the development of treatment interventions. Research findings are informing effective treatment practice and medications are now being viewed as effective components of treatment for addiction, when used "in conjunction with a program addressing the psychosocial needs of the patient" (McCance-Katz & Kosten, 2005).

NIDA has identified components of comprehensive treatment which include behavioral therapy and counseling, recovery supports and medications all as essential elements of effective addiction treatment (see Figure 1).

Medication Assisted Recovery

SAMHSA defines MAT as "the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders." The primary goal of the MAT is to promote recovery from addiction by reducing the need (withdrawal) or incentives (block euphoric effects) for using substances. Medications used to treat addiction typically assist the person to stabilize by reducing withdrawal symptoms and drug cravings. While all addiction medications have different pharmacological properties, benefits and side effects, determining which medication is best for each person is ideally based upon their recovery and treatment history, preferences, co-occurring psychiatric and medical disorders and other factors, such as recovery goals, family involvement, employment, insurance coverage and access to services.

There are two primary MAT options: medical detoxification and medication maintenance. Although detoxification is an important treatment option for people with substance dependence (particularly those with opioid and alcohol dependence), detoxification is designed to treat the most severe and acute physiological withdrawal symptoms and is not intended as a standalone treatment choice. Ideally, detoxification is used as an initial and "first stage of addiction treatment" (NIDA, 1999). For a thorough discussion of detoxification treatment options including the medications used to manage various medical detoxification protocols, review: TIP 45—Detoxification and Substance Abuse Treatment (CSAT, 2006)[viii].

Medication maintenance, by far the most common MAT protocol, is typically a daily regimen designed to address both acute and chronic aspects of the addictive disorder and to assist the person to stabilize by reducing the negative side effects (sleeplessness, nausea, constipation, difficulty concentrating, and in some cases withdrawal) associated with discontinued substance use. Most maintenance medications (methadone, buprenorphine, disulfiram) require the

Figure 1

The following is a partial list of the primary MAT options currently being utilized in the United States for alcohol, opioid and nicotine use disorders:

Alcohol Use Disorders:	Disulfiram (Antabuse©)
	Acamprosate (Campral©)
	Naltrexone (ReVia©, Vivitrol©)
Opioid Use Disorders:	Methadone
	Naltrexone/Naloxone
	Buprenorphine (Subutex©)
	Buprenorphine & Naloxone (Suboxone©)
Nicotine Use Disorders:	Bupropion (Wellbutrin©)
	Varenicline (Chantix©)
	Nicotine replacement (Nicoderm©)

person to regularly take the medication in order to receive the benefits. In other words, the medications offer a corrective benefit (a person continues to receive the benefits offered by the medication as long as he continues to take the medication) rather than a curative one. Recommended length of treatment and dosage levels have both been areas of controversy, especially with methadone maintenance. However, as researchers continue to work to determine how these medications assist with the recovery process, it is expected that further clarity will be possible in the near future. For more information on MAT and various maintenance treatment options, review: TIP 40—Clinical guidelines for the use of buprenorphine in the treatment of opioid addiction (CSAT, 2004); TIP 43—Medication-assisted treatment for opioid addiction in opioid treatment programs (CSAT, 2005); and TIP 49—Incorporating alcohol pharma- cotherapies into medical practice (CSAT, 2009). [ix]

Several medications are currently being evaluated for their efficacy in the treatment of various substance use disorders (Volkow & Li, 2009), each with their own unique pharmacological profile and specific biological target within the brain. Since scientific development in this area is rapidly increasing, we may soon have a multitude of MAT options to choose from, including prophylactic vaccines that may one day provide preventative and protective benefits to the individual far before a person consumes their first drink or drug.

Although MAT includes one or more medications by definition, Medication assisted recovery (MAR) is "a process of recovery that emphasizes individual supports and includes pharmacotherapy as part of a holistic approach specific to one's condition, strengths and goals" (Rosier, 2008). The idea that recovery is a process that is essential to the formulation and definition of MAR since medication, while providing some important benefits, does little to fundamentally change the behaviors, cognitions and attitudes surrounding substance use. Ultimately, a person taking medication(s) will obtain little or no sustainable benefits, other than those earned through the hard and persistent work of his or her recovery process. In nearly every instance, medications simply assist the person to reduce the enduring negative effects (withdrawal) of discontinued substance use experienced in early recovery. Medication assisted recovery is comparable to recovery obtained without medication assistance in nearly every manner and requires the same level of dedication, hard work and recovery supports to ensure recovery success. The challenges of developing a new positive social identity in recovery; making changes to relationships, coping strategies and behaviors; avoid unsafe and illegal activities; developing new strategies to manage triggers and cues to prevent relapse; and restoring one's spirit and spiritual connection still await most in their recovery journey regardless of whether an individual utilizes a MAT option or alternative strategy.

One of the many barriers to promoting MAR is the lack of public awareness that MAT is a safe, effective and beneficial treatment option. Until recently, little information has been available publicly and written for general audiences and people seeking MAT services. There is a tremendous need for increased understanding, training and education on MAT for addiction counselors, medical professionals, health care professionals and those involved in public policy. Addiction professionals and counselors have a unique obligation to increase their knowledge of this rapidly evolving area of our profession and even more importantly to confirm their own attitudes and practices towards MAT are research and science-based and not entirely personally driven or motivated regardless of whether they are positive or negative.

Many challenges still confront our profession: major funding challenges at the federal and state levels; ensuring that federal parity legislation is implemented to guarantee all Americans fair and equal

access to needed insurance coverage for substance use and mental disorders; a workforce development crisis which includes limited number of qualified and trained professionals; and persistent stigma towards mental illness, addiction and people in recovery everywhere. Although major strides have been made, our work is far from complete. White (2009) suggests that "it is time to end the iconic image of medication-assisted recovery from a shadowed face sipping methadone. It is time that image became one of the faces and voices of real people expressing the role medication-assisted treatment played, or continues to play, in their recovery from addiction." As we continue to enhance the MAT options available, increase professional competency around and public awareness of medication assisted recovery, everyone will benefit.

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Footnotes

i The term addiction will be used interchangeably with substance use disorders throughout this article.

ii To download a copy of this publication, visit http://www.aa.org/pdf/products/p-11_aamembersMedDrug.pdf

iii (The AA member—Medications and other drugs, 1984, page 13)

iv For more information, visit www.methadoneanonymous.org and www.methadonesupport.org

v Some hold the term addiction in high regard asking where the field would be without it whereas others argue with contempt that addiction has been so broadly applied and corrupted by society that it no longer holds any scientific value and should be abandoned.

vi Available at http://pfr.samhsa.gov/docs/ROSCs_principles_elements_handout.pdf

vii It can be argued that the moral model is still the predominant model of addiction since the primary response to addiction continues to be incarceration rather than treatment for people with addictive disorders.

viii This document is free of change and available in hardcopy or pdf download at http://ncadi.samhsa.gov/

ix These documents are free of change and available in hardcopy or pdf download at http://ncadi.samhsa.gov/