Using Medication to Support Recovery: Research and Practice Updates
Table of Contents

Glossary of Terms................................................................................................................................. 1
A summary of FDA-approved medications for treating substance use disorders

Medication Supported Recovery – What’s in a Name?................................................................. 1
A call for new terminology from New York State

Vivitrol and Suboxone:
Two New Approaches for Treating Opioid Dependent Patients........................................... 2
Agonist and antagonist medications that are changing the face of opioid treatment

An Interview with Adam Gordon................................................................................................. 4
Details about medication-assisted treatment at the VA

Reflections on Medication-Supported Recovery........................................................................ 6
The new recovery-oriented movement in pharmacotherapy

Resources Links ................................................................................................................................. 8

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Editorial Board
Michael T. Flaherty, PhD
James Aiello, MA, MEd
Jessica Williams
Holly Hagle, PhD

Regional Enterprise Tower
425 Sixth Avenue, Suite 1710
Pittsburgh, PA 15219
Phone: 412-258-8565
Fax: 412-391-2528

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Resource Links: Spring 2011
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Glossary of Terms

Adapted from the NIATx guide, Getting Started with Medication-Assisted Treatment

The FDA has approved several medications that have been proven effective in treating people with alcohol or other substance use disorders. The medications are most effective when they are part of a comprehensive treatment program that includes behavioral counseling or therapy, the patient’s active participation in a support group or 12-step program, and a long-term plan for managing the disorder. Substance use medications (with the exception of disulfiram, or Antabuse®) are classified by how they target the opioid receptor sites in the brain: agonist, partial agonist, or antagonist.

Most opioids that are abused—heroin, morphine, and prescription opiates like OxyContin® and Vicodin®—are agonists. Agonists bind to the opioid receptors in the brain and activate them, producing a feeling of euphoria. Partial agonists also bind to brain receptors, but do not produce the full effect of an agonist. Antagonists bind to receptors but block rather than activate them. They prevent receptors from being activated by an agonist.

For alcohol-use disorders

The first medication approved for alcohol use disorders, disulfiram (Antabuse®), is used in aversive therapy. Drinking alcohol after taking disulfiram causes severe discomfort, ranging from facial flushing to headache and vomiting. Newer medications approved for treating alcohol dependence includeacamprosate calcium (Campral®) and naltrexone (ReVia®, Vivitrol®, Depade®). These medications decrease craving, especially that related to protracted withdrawal.

For opioid dependence

There are two forms of buprenorphine: Subutex® (pure “bup”) and Suboxone®. Suboxone® also contains naloxone, an opiate-blocking agent. Naloxone deters intravenous use of buprenorphine. If Suboxone® is injected, it will result in opioid withdrawal. It is the often the choice for use in outpatient settings.

CONTINUED ON PAGE 3

Medication Supported Recovery What’s in a Name?

Dr. Steven Kipnis, M.D., FACP, FASAM, Medical Director in the Office of Health, Wellness and Medical Direction at the Office of Alcoholism and Substance Abuse Services, New York

HIGHLIGHTS:

- Given that medication-assisted treatment of SUDs has advanced far beyond the days of only disulfiram (Antabuse) and methadone, we need a new term to refer to the range of available pharmacotherapies to treat dependence on various substances.
- Pharmacological treatment requires a stronger alliance between counseling and medical staff; organizational shifts are needed to fully embrace the ability of a medication to support an individual in his or her recovery.
- The term Medication-Supported Recovery (MSR) is proposed to embrace individuals successfully maintained on an addiction medication and free of illicit substance use.

Historically, abstinence-based and drug-free treatment have meant the elimination of use/reliance on medication. Today, many providers still struggle philosophically with the use of medications for substance use disorders (SUDs). Advancements in the study of neuroscience and the development of new addiction medications offer providers an increased ability to address addictive craving and withdrawal. There is clear evidence that addiction medications should be incorporated into mainstream addiction treatment, which has thus far been referred to as Medication Assisted Treatment.

The treatment of SUDs has advanced from the days when disulfiram (Antabuse) was the only medication used to promote long-term recovery in alcohol-dependent clients and methadone was the only medication used to promote long-term recovery in opiate-dependent clients. We need a term that refers to a range of pharmacotherapy that encompasses a variety of medications that are available to stabilize clients and treat addiction, including prescription drug, alcohol, and tobacco addiction. This broader definition should reflect an important change because it sets the stage for a new vision of substance use treatment; both in terms of the role that medications can play in client recovery and the quality of care that substance use providers deliver.

The use of addiction medications requires defined medical protocols and, often, modifications in program processes and communication to integrate these protocols with behavioral treatment. Further, it will be necessary for treatment providers and patients to accept that: 1) these are medications, not drugs; and 2) psychological treatment, pharmacological treatment, and support groups are complementary, rather than competitive, and can be combined effectively to improve treatment outcomes.

Developing an ongoing therapeutic alliance between counseling and medical staff that works toward effectively sharing the treatment of these patients is critical.

CONTINUED ON PAGE 3
Vivitrol and Suboxone: Two New Approaches for Treating Opioid Dependent Patients

Anna Pecoraro, Psy.D, postdoctoral fellow in addictions at the University of Pennsylvania, and George Woody, M.D., Professor of Psychiatry, University of Pennsylvania School of Medicine

HIGHLIGHTS:

- Vivitrol is a sustained release injectable version of the antagonist naltrexone which lasts 30 days. Since its FDA approval in 2010, Vivitrol has been shown to reduce the patient adherence problems associated with the daily tablet form of naltrexone. Russia has approved a 60-90 day antagonist injection and other countries are researching similar treatments.
- Suboxone® is a sublingual preparation of buprenorphine (a partial opioid agonist) that is combined with naloxone (a drug used to counter the effects of opiate overdose). Approved by the FDA in 2002, it has been particularly useful for those unable or unwilling to be treated at methadone clinics.
- A 2008 study showed that extended treatment with Suboxone® is safe and efficacious for adolescents and young adults and that clinicians should be in no hurry to stop treatment with it.

The Big Book says that members should take advantage of medical advances. Somehow, the 12-step message has often been interpreted as a “no medication” philosophy, probably based on observations that abusable substances often precipitate relapse even if used in small amounts, ambivalence about addiction as a personality/social/motivational problem rather than a medical disorder, and the historical absence of the medical profession from addiction treatment. As a result, except for detoxification, many programs have come to avoid all medication, even ones with no addiction risk (e.g., lithium, antidepressants, etc), and treatment has become almost entirely based on psychosocial therapies and 12-step participation. Things have been changing slowly for Medication Assisted Treatment (MAT) due to research and evidence-based medicine. As of now, medications to assist longer-term treatment are available for opioids, alcohol, and tobacco. Two new approaches for opioid dependent patients include Suboxone® for detoxification and maintenance treatment, and the sustained release naltrexone formulations Vivitrol® for those interested in non-agonist treatment.

Vivitrol®

Vivitrol® is a sustained-release injectable form of naltrexone. Originally a daily oral medication, naltrexone is an opioid antagonist that blocks opioid effects and does not cause euphoria, thus eliminating the “rewarding” effects of opioids so long as the patient takes it. Tolerance to these effects does not occur and no withdrawal symptoms result when it is stopped. In the US and other countries where agonist treatment is available, daily oral naltrexone for opioid dependence has been associated with poor compliance and retention except with highly motivated patients. Despite this, a systematic review shows that oral naltrexone alone or with psychosocial treatment is more effective than placebo alone or with psychosocial treatment in reducing heroin use during treatment, and that naltrexone with psychosocial treatment is more effective than psychosocial treatment alone to prevent re-incarceration during treatment. There are also other benefits. For example, a case report showed that naltrexone can render heroin overdose suicide attempts ineffective. Better compliance has been demonstrated in Russian studies, probably because agonist treatments are not available there, inpatient detoxification is common (thus it is easy to start patients on naltrexone), and family members are often available to monitor medication adherence.

Sustained-release naltrexone formulations such as Vivitrol® are significant advances because they eliminate the adherence problems associated with the oral formulation that must be taken every day. For example, one Vivitrol® injection lasts 30 days, and in 2010 the FDA approved it for preventing relapse to opioid dependence. It is important to keep in mind that patients must be detoxified before receiving naltrexone; otherwise it will precipitate opioid withdrawal. Another sustained release formulation is currently approved in the Russian Federation, Prodetoxon®. It is an implant that blocks opioids for 60-90 days; other implants are undergoing clinical trials in Australia, China, Germany, Egypt, and England. In the US and other places where agonist treatments are available, Vivitrol® may be useful for patients and settings not interested in agonist treatment, such as the criminal justice system.

Suboxone®

Suboxone® is a sublingual preparation of buprenorphine (a partial opioid agonist) that is combined with naloxone to prevent IV misuse and diversion. It was approved by the FDA in 2002 for detoxification and maintenance treatment of opioid dependence for persons aged 16 and over. It is a Schedule III controlled substance, and unlike methadone, it is available in primary care settings from physicians who have completed an 8-hour training program and have been licensed to prescribe it. Buprenorphine’s physical dependence and withdrawal are less than with full agonists like methadone, and its safety margin is greater. A systematic review found that at medium (8-15 mg) and higher (16-32 mg) doses, it is more effective than a placebo for reducing heroin use, but somewhat less effective than methadone doses of 60-120 mg. Many patients have done very well on Suboxone®, and it has been particularly useful for those unable or unwilling to be treated at methadone clinics.

CONTINUED ON PAGE 3
The NIDA Clinical Trials Network (CTN) recently published a study of buprenorphine-naloxone treatment for opioid dependent youth aged 15-21. This study compared a group who received Suboxone® for nine weeks followed by a three-week taper to a group who received a two-week Suboxone® detoxification; patients in both groups were offered weekly group and individual counseling for 12 weeks. Patients in the extended treatment group reported significantly less opioid use, better retention, less injecting, less use of cocaine (p<.001) and marijuana (p<.001), and less use of non-study addiction treatment. The authors concluded that extended treatment with Suboxone® was safe and efficacious for adolescents and young adults and that clinicians should be in no hurry to stop it.

REFERENCES


GLOSSARY OF TERMS (continued from page 1)

Methadone is a synthetic opioid that has been used to treat people with opioid addiction for more than 40 years. It has also been used as an approved narcotic painkiller. Methadone is available in liquid or tablet form. The SAMHSA Substance Abuse Treatment Advisory, “Emerging Issues in the Use of Methadone” (Spring 2009, Vol.8, Issue 1) stresses that “methadone is effective and safe in the treatment of opioid addiction and chronic pain when it is used appropriately.”

Naltrexone, acamprosate, and disulfiram can be prescribed by nurse practitioners and physician assistants. Buprenorphine can be prescribed only by a physician who has taken an eight-hour training course and received a special DEA license number.

For complete information on physician requirements for prescribing buprenorphine, visit: http://buprenorphine.samhsa.gov/waiver_qualifications.html

Vivitrol®, which is now approved to treat opioid as well as alcohol addiction, the injectable form of naltrexone, is usually administered by a nurse or other qualified practitioner.
Interview with Dr. Adam Gordon

Dr. Adam Gordon, MD, MPH, FACP, FASAM, CMRO, is an internal medicine physician with a specialty in addiction medicine and an Associate Professor of Medicine at the University of Pittsburgh School of Medicine. He is core faculty for the Veterans’ Affairs (VA) Mental Illness Research, Education and Clinical Center and leads health services investigations to improve access to medical, mental health, and substance abuse services for vulnerable populations. Dr. Gordon serves as a national mentor for physicians using office-based treatment of opioid dependence and appropriate methadone medication prescribing. He leads the Buprenorphine in the VA project, a national consulting service to assist providers in treating opioid dependent veterans.

Dr. Gordon sat down with Resource Links to discuss the unique integration of medication-assisted treatment services at the VA, stigma, and why he likes treating patients with co-occurring chronic pain.

RESOURCE LINKS: What has the VA’s attitude/policy been historically toward pharmacotherapy for the treatment of opioid addiction?

ADAM GORDON: The VA has an aggressive policy that encourages pharmacotherapy for patients with addictions. Nationally, in the VA, there are 42 methadone treatment centers and as many as 10 other VA facilities that officially contract out methadone treatment to local, non-VA, methadone facilities. Since 2002, VA providers have been prescribing buprenorphine in office-based practices for opioid dependence. Today, there are over 600 VA providers who have prescribed buprenorphine to veterans.

The VA and VA investigators were important to the availability of buprenorphine for the treatment of opioid dependence. VA investigators were important in crafting the DATA 2000 legislation which allowed office based treatment of opioid dependence as well as investigations supporting its FDA and legislative approval for use.

Nationally, VA and Department of Defense guidelines indicate that buprenorphine or methadone should be offered to every patient with opioid dependence. In addition, common mental health services benefit packages for veterans indicate that every veteran patient with opioid dependence must be offered either methadone or buprenorphine.

Importantly, criteria for use and best practice guidelines suggest that optimum benefit of the medications are achieved when in combination with non-pharmacologic treatment for veterans’ addictions.

RL: How long has the VA been prescribing medications for alcohol addiction?

AG: The VA has a long history of supporting the use of adjunctive medications for the treatment of alcohol dependence. VA practitioners have been using the four approved medications for the treatment of alcohol dependence since their inception. Oral naltrexone, injectable naltrexone, disulfiram, and acamprosate have all been available in the VA.

RL: How effective are the medications for alcohol compared to the medications used to treat opioid addiction?

AG: All medications for the treatment of addictions have varying treatment efficacy and effectiveness depending on the patient population and/or support surrounding the patient. It is hard to compare medications for alcohol dependence to medications for opioid dependence. History suggests that the disease processes are quite different between the disorders. In addition, treatment responses (not just medication responses) may vary between patients.

Researchers in the VA are examining patient genotypes that may predict a response to one medication for alcohol and opioid dependence, naltrexone. It appears that persons with a specific gene will have better outcomes on this medication than others without the gene.

RL: Has there been resistance to this move toward medication assisted treatment from medical staff or administration at the VA?

AG: There is always resistance to change—this is not peculiar to the VA. Costs of medications tend to be more than costs of other types of therapy, so there may be a general belief that administrators, insurers, or systems of care prefer non-pharmacotherapy to medication assisted treatments. In our research in the VA (and consistent with research outside the VA), we’ve found several factors that can facilitate medication-assisted treatment in large health systems. One important factor is having a “champion” facilitate change on the local level and “start using medications” for the treatment of addictions. Once a practitioner starts using medication-assisted treatment, it tends to encourage other practitioners to try medications on their patients.

RL: What response do you receive from the patients themselves when you recommend pharmacotherapy?

AG: The response to pharmacotherapy for addictions on the patient level has been fabulous. Patients seek care because pharmacotherapy exists. For instance, for buprenorphine, patients often “try” it on the street, get a response, and then seek care from practitioners who can prescribe it. It is rare for me to see a patient for opioid dependence treatment who has not tried, illicitly, a pharmacotherapy. Patients who are on buprenorphine often feel “normal,” but this “normality” tends to be difficult for them—they are not used to it. In general, patients respond great to pharmacotherapy, but there are always patients who don’t. Other therapies work for them. Medications are not the answer for everyone. There is no “miracle drug” for addiction, at least not yet.

CONTINUED ON PAGE 5
**RL:** How important do you think integrated onsite care is for medication-assisted treatment?

**AG:** Simply put, integrated onsite care is essential. There are different types of integrated care. For example, coordinated-, multidisciplinary-, and co-located care are not the same things. In my experience, co-located, interdisciplinary care is the best model. We are seeing a move toward a systematic “medical home” approach to addictions and this is a good thing. Because addiction treatment has traditionally been outside of mainstream healthcare, the more integrated and coordinated addiction care becomes, the more, I think, patients will benefit.

**RL:** Is care more integrated at the VA (concurrent counseling, other recovery support services) than in a PCP’s office?

**AG:** The VAs do have primary care providers (like me). The VA also has co-located and integrated clinics, much more than systems of care outside the VA or individual primary care practices in non-VA settings. In my own VA primary care clinic, when I see a patient with addiction, down the hall I have a social worker, a psychiatrist, a psychologist, and a motivational counselor that I can quickly refer the patient to ... this is unusual in environments outside the VA.

**RL:** Do VA staff members or patients generally feel there is stigma attached to MAT?

**AG:** I think the staff at the VA is fabulous. It is my experience that the staff and patients at the VA have LESS stigma about addiction than staff I interact with outside the VA. Because we routinely screen for addiction, including hazardous drinking, addiction diagnoses and alcohol and other drug use problems are not thought of as behaviors, but as medical disorders. In my experience and opinion, VA practitioners are committed to help patients with a host of addictions—and the patients feel the VA provides the best care for these conditions.

**RL:** Do patients receiving medication assisted treatment meet regularly with a behavioral health counselor? How often?

**AG:** This depends on the setting of the treatment engagement and whether the patient requires a counselor. Some patients do best with an addiction psychiatrist or an addiction medicine physician without additional counseling. If, as an addiction medicine physician, I am seeing the patient weekly, or monthly, and during those sessions with the patient, I provide counseling that is individualized for the patient, additional counseling may not be required. If the patient has seen me for ten years and is doing well in his/her recovery, outside counseling may not be required, and potentially could be detrimental.

For the vast majority of patients on medication assisted treatment, they should (and do) receive treatments outside of the physician office. That being said, if the goal is not abstinence, for example from alcohol, some counseling mechanisms do not tailor to a harm reduction model of treatment.

**RL:** Does the VA recommend 12-step involvement or provide for other recovery supports for patients on pharmacotherapy?

**AG:** Yes, all the time. It is not required, however.

**RL:** How often does a patient interact with the doctor or other medical staff while he or she is being stabilized on medication?

**AG:** This depends on the patient. I see patients at least weekly when they are being induced on medication assisted treatment, and often more than that. But this also depends on the type of medication. It is likely not needed to see someone weekly who is started on naltrexone, for instance, with a goal of reducing alcohol consumption.

I often give my patients my cell phone number so they have a means to contact me daily if they want to.

In the VA, we often see patients much more frequently than non-VA clinicians. Our integrated clinics and facilities provide much greater opportunities for this.

**RL:** Is there a point at which you discontinue pharmacotherapy if a patient is not complying? What process do you go through as a practitioner when a patient repeatedly relapses?

**AG:** In my opinion, relapsing is not an indication of poor outcomes on the patient side, it means that I am not providing the best possible care for the patient. If the patient relapses, that patient requires more intensive and/or different therapy.

In my opinion, the addiction field is ripe with health care professionals who think that someone should be “kicked out of a program” if they are not compliant with a specific treatment plan. Perhaps that treatment plan is not good for that specific patient? Practitioners would be aghast if I kicked out patients out of diabetic counseling and/or insulin if patients routinely ate cupcakes and candy. Similarly, we all should be aghast if I kicked out patients who have addiction disorders who have started using again.

I have discontinued pharmacotherapy for patients when it is not working for patients, not because they are not “complying.”

**RL:** Does it impact your approach to medication-assisted treatment if patients are addicted to prescription medications, especially pain medications?

**AG:** Not really. The most glaring example of when it could be is when patients are prescribed opioids pain medications—obviously buprenorphine and naltrexone would not be appropriate for that patient.

As an aside, I enjoy taking care of patients with addictions who have co-morbid pain syndromes. Most have not had good communication from prior treatment providers. Some have been in the addiction treatment world and been told that they should not take medications for pain, others have been in the pain-treatment world, and been “kicked out of care” because they have a problem with addiction. These patients have two disorders: pain and addiction. They can be concurrently treated! Communication, goal setting, and evidence based treatment strategies need to be applied. Particularly for the chronic pain patient, that patient should be treated for life for their pain and addiction. We need providers who can engage that patient and, over the long term, work to manage both problems. Chronic pain cannot be cured—neither can an addiction.

In this interview, Dr. Gordon does not represent the views of the Department of Veterans Affairs or the VA Pittsburgh Healthcare System.
Reflections on Medication-Supported Recovery

William L. White, MA, Senior Research Consultant at Chestnut Health Systems

HIGHLIGHTS

• Recovery-oriented approaches to MAT are alternatives to acute and palliative care. They offer a sustained menu of options to assist individuals and their families maintain long-term recovery. They draw from some practices that begin in the early years of methadone maintenance.

• The revitalization of recovery-oriented MAT has come about as science has recognized its efficacy, MAT patient advocacy has increased, MAT has increased nationwide and pharmacotherapy options have expanded, and efforts have been made to increase and standardize the quality of opioid treatment programs.

In 2010, Lisa Mojer-Torres and I authored a monograph entitled Recovery-Oriented Methadone Maintenance (ROMM). It reflected on the confluence of new advancements in Medication-Assisted Treatment (MAT) and called to reconnect addiction treatment to the larger and more enduring processes of addiction recovery. It also was the outcome of the new recovery advocacy movement’s unequivocal declaration that “There are multiple pathways of long-term recovery, and all are cause for celebration.”

Recovery-oriented approaches to opioid addiction MAT combine pharmacotherapy and a sustained menu of professional and peer-based recovery support services to assist patients and families in initiating and maintaining long-term addiction recovery. This approach extends the focus on remission of primary and secondary substance use disorders and their related consequences (what is deleted from one’s life) towards a focus on enhancement of personal/family health and functioning and positive community reintegration (what is added to one’s life). Recovery-oriented MAT is a person-centered model of long-term recovery management that provides an alternative to acute care (detoxification or short-term maintenance) and palliative care (prolonged medication maintenance as a strategy of personal pacification and social control).

Recovery-oriented approaches to MAT include practices that characterized the early years of methadone maintenance and that have since been linked to elevated long-term recovery outcomes:

• rapid access to treatment
• patient involvement in clinical decision-making
• adequate and personally optimal medication doses
• therapeutic responses to any continued drug use
• no arbitrary limits on duration of treatment
• emphasis on creating a strong therapeutic alliance with each patient

• the use of recovering staff as role models and recovery coaches
• access to programs for populations with special needs
• broader mobilization of community resources to support long-term recovery

Although some of these practices declined through the 1970s and 1980s, there has been a subsequent revitalization of MAT in the United States.

This revitalization process has included: 1) the scientific reaffirmation of the effectiveness of MAT by prominent scientific, professional, and governmental bodies; 2) increased advocacy efforts by MAT patients; 3) an expansion of national MAT treatment capacity; 4) national efforts to professionalize and elevate the quality of accredited Opioid Treatment Programs (OTPs); and 5) an expansion of pharmacotherapy choices in the treatment of opioid addiction. These developments have occurred amidst renewed efforts to publicly and professionally portray opioid addiction as a brain disease that can be medically managed with competently supervised pharmacotherapies and ancillary support services. This revitalization is unfolding in the midst of two trends that will profoundly influence the future of MAT in the United States: 1) a clearer articulation of addiction as a chronic disorder that is best treated through methods used to manage other chronic primary health problems, and 2) the emergence of recovery as an organizing paradigm for the addictions field.

Achieving this vision of recovery as remission, global health, and citizenship for the mass of MAT patients will require expanding and elevating the range and quality of clinical and peer-based recovery support services available to MAT patients and their families. It will also require creating the physical, psychological, and cultural space in local communities within which medication-assisted recovery can flourish.

Put simply, recovery-oriented MAT seeks to:

• attract people at an earlier stage of problem development via programs of assertive community education, screening, and outreach;

• ensure rapid service access for individuals and families seeking help;

• resolve obstacles to initial and continued treatment participation;

• achieve safe, individualized, optimum dose stabilization;

• engage and retain individuals and families in a sustained, recovery-focused service and support process;

• assess patient/family needs using assessment protocols that are global, family-centered, strengths-based, and continual;

• transition each patient from a professionally directed treatment plan to a patient-directed recovery plan;
• **expand the service team** to include primary care physicians, psychologists, social workers, peer recovery support specialists, and indigenous healers;

• **shift the service relationship** from a professional/expert model to a long-term recovery partnership/consultation model marked by mutual respect, hope, and emotional authenticity;

• **ensure minimum (at least one year) and optimum (individualized) duration of treatment** via focused retention strategies and assertive responses to early signs of disengagement;

• **shift the treatment focus** from an episode of care to the management of long-term addiction/treatment/recovery careers;

• **expand the service menu** to include ancillary medical/psychiatric/social services and non-clinical, peer-based recovery support services;

• **extend the locus of service delivery** beyond the OTP to non-stigmatized service sites (physician offices) and neighborhood-based, church-based, work-based, home-based, and technology-based (phone/Internet) recovery support services;

• **assertively link patients/families** to recovery community support resources;

• **engage the community** through anti-stigma campaigns and recovery community development activities;

• **provide post-treatment monitoring and support** and stage-appropriate education, support, and (if and when needed), early re-intervention for all patients regardless of discharge status for a minimum of five years; and

• **evaluate methadone maintenance treatment** using proximal and distal indicators of long-term personal and family recovery.

Care will need to be taken to avoid potential unintended consequences of this heightened recovery orientation within MAT, e.g., the abandonment of patients who do not share this vision of a recovery-transformed life.

Recovery-Oriented Methadone Maintenance is what I hope will be the opening salvo in an extended conversation about the role of medication in long-term addiction recovery and how MAT can be infused with a greater understanding of the stages, the styles and critical mechanisms of change, and the critical supports that mark the process of long-term recovery from opioid addiction.

**WHAT’S IN A NAME (continued from page 3)**

There are several promising benefits of the use of addiction medications. Pharmacological interventions have shown an ability to improve behavioral treatment retention. In addition, the use of these medications fosters the concept of addiction as a medical condition and can promote individualized treatment planning. One hope is that with the change to a disease concept and available medications, more physicians will enter the field. At the very least, the primary care physician can now see the value of treating substance-using patients with a wide range of available tools.

There are absolutely barriers to incorporating addiction medications, though they can be overcome. Education is a large hurdle and clinicians—both counselors and physicians—need more exposure to the neuroscience of addiction and available medications. Funding plays a role as the medications can be costly and more physician and nursing time may be needed in treatment facilities. The biggest barrier may be a knowledge gap, as we do not currently have the exact science to tell us who will do best on which medication and for how long the person should be maintained on it.

Organizational shifts are needed to fully embrace the ability of a medication to support an individual in his or her recovery. Some ideas include:

• Improve cross-training/communication/collaboration between medical and counseling staff (e.g. in the creation of treatment plans) to ensure an on-going therapeutic alliance that is responsive to patient needs and concerns.

• Provide training to all staff about addiction medications that includes the science of addiction as well as medical signs, symptoms and consequences of substance use. These aid in understanding the changes in a patient’s brain that contribute, in part, to relapse.

• Encourage counselors to increase their awareness of the patient’s physical symptoms and to work closely with medical staff to change medications or dosage.

• Modify program processes (e.g. scheduling) to address both addiction medications and specific patient needs when using medications. For example, a program might consider briefer/fewer group and individual sessions during the very early phase of treatment if a patient is adjusting to an addiction medication and/or is in withdrawal.

• Continue to recognize and promote the importance of secular and 12-step-based mutual aid groups.

• Increase understanding of how and why some patients’ substance use may mask psychiatric symptoms.

• Teach patients about emerging addiction medications and the changes in their brains that addiction causes.

• Many patients are not compliant in regard to taking medication: include medication adherence as part of the treatment plan to increase compliance.

The definition of recovery is being expanded to include individuals successfully maintained on an addiction medication and free of illicit substance use. Medication Assisted Treatment or similar terms should be phased out of the addiction treatment language. The treatment plan for the substance using individual should be one that recognizes the lifelong course of the disease. The New York Office of Alcoholism and Substance Abuse Services (OASAS), along with others in the field, propose to use the term MEDICATION-SUPPORTED RECOVERY (MSR) to embrace not only treatment with medications, but the continued recovery of the person.
Resources Links

Medication Supported Recovery - What's in a Name?
New York Office of Alcoholism and Substance Abuse Services (OASAS) Medication-Supported Recovery Resources: www.oasas.state.ny.us/GSI/BP/resources.cfm#MAT

Vivitrol and Suboxone: Two New Approaches for Treating Opioid Dependent Patients

An Interview with Adam Gordon
VA Pittsburgh Healthcare System: www.pittsburgh.va.gov/
The VA Mental Illness Research, Education and Clinical Centers (MIRECC): www.mirecc.va.gov/index.asp
Physicians’ Clinical Support System - Buprenorphine: www.pcssb.org/

Reflections on Medication-Supported Recovery
Selected Papers of William L. White: http://www.williamwhitepapers.com/

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