**Pharmacotherapy and Recovery**



*“Never doubt that a small group of thoughtful, committed, citizens can change the world. Indeed, it is the only thing that ever has.”*

*~ Margaret Mead*

**Overview**

The use of medication during treatment, and as a part of recovery, is highly debated and controversial. Recovery communities, families, and treatment professionals have long-standing debates about involving medication in recovery. This information is designed to challenge personal ideas and perceptions in order to assist students in becoming stronger clinicians who provide all evidence-based options to clients.

Use of medication can prove beneficial for Alcohol Use Disorder and Opioid Use Disorder. This module will explore both disorders and the FDA approved medication used to treat both.

**Objectives**

* Recall 3 of the myths and facts about medication management and Opioid Use Disorder;
* Review FDA approved medications for Opioid and Alcohol Use Disorder; and
* Recall 3 definitions provided in this material.

**Opioids**

Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone (OxyContin), hydrocodone (Vicodin), codeine, morphine, and many others (NIDA, n.d.).

**Overview of Use**

The National Institute on Drug Abuse (NIDA) conducts an annual survey obtaining information on substance use trends across America. The 2017 survey differentiated the use or heroin versus pain relievers by age. Use was reported by respondents for the 12 months prior to the survey. The results are reported in percentages.

|  |  |  |  |
| --- | --- | --- | --- |
| Drug | 12 – 17 years old | 18 – 25 years old | 26 years and older |
| Heroin | 0.10 | 0.60 | 0.30 |
| Pain relievers | 4.10 | 3.10 | 3.70 |

The National Institute on Drug Abuse (NIDA) explains, of the people who are prescribed opiates for pain:

* 21 – 29% misuse the medication
* 8 – 12% develop Opioid Use Disorder
* 4 – 6% move on to use heroin

Other Opioid Use [research findings](https://www.drugabuse.gov/drugs-abuse/opioids/opioid-research-findings-funded-by-nida) funded by NIDA

**How Opiates Work**

Opiates can be injected, smoked, snorted, inserted rectally, and taken orally. Smoking or injecting heroin is the fastest route of administration for the substance to reach the brain.

When a person consumes an opioid, that opioid binds to the opioid receptors in the brain signaling a release of dopamine.

View the NIDA [slide presentation](https://www.drugabuse.gov/publications/teaching-packets/neurobiology-drug-addiction/section-iii-action-heroin-morphine/1-action-heroin-morphine) for a simply detailed account of heroin binding to opioid receptors.



This NIDA Graphic shows

a close-up view of a synapse in the nucleus accumbens. Three types of neurons participate in opiate action: one that releases dopamine (on the left), a neighboring terminal (on the right) that contains a different neurotransmitter (probably GABA for those who would like to know), and the post-synaptic cell that contains dopamine receptors (in pink). Show that opiates bind to opiate receptors (yellow) on the neighboring terminal and this sends a signal to the dopamine terminal to release more dopamine (NIDA, 2007).

**Opioid Overdose**

In 2016 The Centers for Disease Control (CDC) reported opioid deaths had quadrupled since 1999 to an estimated 40 per day. Many states began programs addressing this issue thereafter.

View the United States [map](https://www.thenationalcouncil.org/opioid-map/) to see state-initiated programs for Opioids.

In March 2018 the National Institute on Drug Abuse (NIDA) indicated 115 deaths per day related to opiates. The rate of deaths and the speed at which the deaths occurred increased dramatically between 2016 and 2018. This is likely the reason many now refer to this news as the Opiate Epidemic.

**What is MAT?**

The Substance Abuse and Mental Health Services Administration([SAMSHA](https://www.samhsa.gov/)) provides a description about Medication Assisted Treatment:

Medicated-Assisted Treatment (MAT) is the use of FDA- approved medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders (SAMHSA, 2018).

In a 2018 study of the impact of the words used on bias, Ashford, Brown, and Curtis found that the term “Pharmacotherapy” was positive and significantly different from the terminology “Medication Assisted Treatment”. The same study found the terminology “Medication Assisted Recovery” and “long-term recovery” as positive and appropriate, as well as terms not promoting stigma.

Methadone Maintenance and Methadone clinics are antiquated and should not be used by professionals.

**What is MAR?**

The National Council on Alcohol and Drug Dependence ([NCADD](https://www.ncadd.org/)) explains there are many pathways to recovery, medication being one:

“The phrase “Medication-Assisted Recovery” is a practical, accurate, and non-stigmatizing way to describe a pathway to recovery made possible by physician-prescribed and monitored medications” (NCADD, 2018).

**Medication**

Medications are used to treat disease or disorder. Medications are taken for all other needs. What is the reason for discrimination related to addiction?

Smoke-free licensed residential treatment centers treating adults in Texas are required to provide smoking cessation to their clients. Smoking cessation is provided through inhaler, lozenges, and patches. This type of medication is often viewed by addiction professionals in a positive light.

The medication used for smoking cessation is Bupropion and goes by the brand name Zyban.

Consider the reason other medications are not viewed in a similar fashion as smoking cessation medication.

**Medications for Opioid Use Disorder**

There are 4 medications are FDA-approved for Opioid Use Disorder.

The four medications are:

* Methadone
* Naltrexone
* LAAM
* Buprenorphine

**Methadone**

One of brand name for Methadone is Dolophine.

FDA approved in 1964.

Taken daily orally.

Can be taken as pill, liquid, or wafer.

Acts as an opioid agonist.

Seen as a benefit to maintaining recovery due to decreasing unpleasant withdrawal symptoms.

Methadone has been used for decades to treat people who are addicted to heroin and narcotic pain medicines.

SAMHSA's [TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs – 2008](http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214)shows that methadone is effective in higher doses, particularly for heroin users, helping them stay in treatment programs longer.

June 2000 [Methadone Treatment Outcomes in the National Treatment Improvement Evaluation Study (NTIES)](http://datafiles.samhsa.gov/study-publication/methadone-treatment-outcomes-national-treatment-improvement-evaluation-study-nties)

**Naltrexone**

The brand name for Naltrexone is ReVia and Depade.

FDA approved in 1984.

Acts as an Opioid antagonist.

Blocks the effects of opioids if they are taken.

Taken in pill form once each day.

Seen as a benefit to maintaining recovery due to the person taking the medication being unable to achieve the desired results if opioids are used.

**LAAM**

This medication is no longer used in Europe or the United States due to life-threatening consequences.

Levacetylmethadol, LAAM, was FDA approved in 1993.

Works similarly to methadone.

Long acting, lasting one to two days.

**Buprenorphine**

The brand name for Buprenorphine is Suboxone or Subutex.

FDA approved in 2002.

Acts as a partial agonist, combining medication decreasing withdrawal effects with medication blocking the pleasurable effects of taking an opioid.

Decreases withdrawal symptoms.

Taken in pill form once each day.

Taken under the tongue.

Seen as a benefit to maintaining recovery due to low potential for addiction, misuse, or side effects. This medication can be written as a prescription and taken at home.

Review SAMHSA’s pdf [The Facts About Buprenorphine](https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine)

**Alcohol Trends**

The National Institute on Drug Abuse (NIDA) conducts an annual survey obtaining information on substance use trends across America. The 2017 survey shows alcohol use of adults and people under 18 years old.

The results are reported in percentages.

Respondents reported having consumed alcohol 8th Graders; 10th Graders; and 12th Graders:

|  |  |  |  |
| --- | --- | --- | --- |
| Time Period | 8th Graders | 10th Graders | 12th Graders |
| Lifetime | 23.10 | 42.20 | 61.50 |
| Past Year | 18.20 | 37.70 | 55.70 |
| Past Month | 8.00 | 19.70 | 33.20 |

Respondents reported having consumed alcohol:

|  |  |  |  |
| --- | --- | --- | --- |
| Time Period | 12 – 17 years old | 18 – 25 years old | 26 years and older |
| Lifetime | 27.10 | 81.10 | 87.10 |
| Past Year | 21.90 | 74.00 | 69.50 |
| Past Month | 9.90 | 56.30 | 55.80 |

**Alcohol Use Disorder**

NIDA estimates 16 million Americans have Alcohol Use Disorder (AUD).

Clinicians use the DSM – 5 to diagnose Alcohol Use Disorder.

The Eleven Symptoms of Alcohol Use Disorder listed in the DSM – 5 are:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which it is physically hazardous.
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following: a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect b) A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for alcohol (refer to criteria A and B of the criteria set for alcohol withdrawal) b) Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Having 2 or more symptoms indicate an Alcohol Use Disorder. The DSM grades severity as mild, moderate, and severe.

* Mild: The presence of 2 to 3 symptoms.
* Moderate: The presence of 4 to 5 symptoms.
* Severe: The presence of 6 or more symptoms (American Psychiatric Association, 2013).

**Alcohol’s Effect on Neurotransmitters**

To better understand the benefit of medication, first review this [diagram](http://www.ablongman.com/html/psychplace_acts/addiction/neuro.html) of how neurotransmitters are impacted by alcohol. **Alcohol Cost**

The Centers for Disease Control (CDC) reports

* 88,000 alcohol related deaths in the United States, between 2006 – 2010;
* Excessive drinking responsible for 1 in 10 adults (age 20 – 64 years) deaths;
* Excessive alcohol consumption in 2010 resulted in $249 billion economic cost (CDC, 2018).

Excessive drinking most often is not done by those with Alcohol Use Disorder.

Excessive drinking is considered heavy drinking, binge drinking, and drinking by women who are pregnant (CDC, 2018).

**Binge and Heavy Drinking**

Binge drinking is defined by the CDC as 4 or more drinks for women and 5 or more drinks for men during a single occasion.

The CDC’s 2015 Youth Risk Behavior Surveillance System and Behavioral Risk Factor Surveillance System shows binge drinking:



One in six adults binge drinks four times each month.

Most common among young adults, aged 18 – 34 years old.

Twice as common in men than women.

Most of those under 21 who drink, binge drink (CDC, 2018).

Review the NIH (National Institute on Alcohol Abuse and Alcoholism) [fact sheet](https://pubs.niaaa.nih.gov/publications/CollegeFactSheet/Collegefactsheet.pdf) about college drinking. Pay close attention to the consequences of harmful and underage drinking.

Heavy drinking is considered having 8 or more drinks per week for women and 15 or more drinks per week for men (CDC, 2018).

**Medications for Alcohol Use Disorder**

There are 4 medications are FDA-approved for Alcohol Use Disorder.

The four medications are:

* Disulfiram
* Naltrexone
* Naltrexone extended release
* Acamprosate

**Disulfiram**

The brand name for Disulfiram is Antabuse.

Disulfiram is the oldest pharmacotherapy medications used to help treat Alcohol Use Disorder, approved by the FDA in 1951.

Taken in the form of a pill and must be taken daily.

Can be taken for years, if needed.

Is an alcohol antagonist.

The antagonist effect of Disulfiram causes an unpleasant reaction in a person who is taking this medication if they drink alcohol.

Some of the unpleasant reactions can be:

* Vomiting
* Nausea
* Headache
* Flushed face
* Sweating
* Uneasiness
* Weakness

Disulfiram has a half-life of 60-120 hours and can create this unpleasant reaction for up to 14 days after the last dose.

A person taking Disulfiram would likely desire to avoid the unpleasant reactions and this can act as an obstacle to drinking.

**Naltrexone**

The brand name for Naltrexone is ReVia/Depade.

Approved by the FDA in 1994.

Taken in pill form once each day.

Decreases the pleasurable effects of alcohol consumption.

An alcohol antagonist, as substance is unable to bind to the receptors.

**Extended Release Naltrexone**

The brand name for the extended release Naltrexone is Vivitrol.

Approved by the FDA in 2006.

Discourages the pleasurable effects of alcohol.

Injected into the muscle every 4 weeks.

This medication is seen as more attractive than the Naltrexone oral tablets for those not wanting to take a medication daily.

This medication is also seen as more beneficial than the Naltrexone oral tablets due to the amount of time it stays in the system, thus, prolonging the amount of time a person remains free of alcohol consumption.

**Acamprosate**

The brand name for Acamprosate is Campral.

Approved by the FDA in 2004

Taken to reduce the desire to drink.

Taken in pill form.

Has a half-life 30-hours, therefore, must be taken three times each day.

Taken to decrease Post-acute withdrawal symptoms.

Likely the most used medication in the United States as a pharmacotherapy to Alcohol Use Disorder.

Reacts with neurotransmitters in the brain.

During repetitive/addictive alcohol use, the brain will suppress glutamate activity and cause an increase in NMDA receptors. When a person with Alcohol Use Disorder stops drinking, the increased glutamate activity can cause symptoms such as:

* Anxiety
* Insomnia
* Hallucinations
* Seizures

These symptoms can create a desire to drink again, therefore, use of Acomprosate can assist a client with staying in treatment and/or remaining abstinent.

**Other Medications**

There are other medications that are used in the treatment of Alcohol Use Disorder. These medications were not originally developed to treat AUD, but have shown to be of some benefit.

**Topiramate** (brand name Topamax) can be used to reduce cravings.

**Gabapentin** (brand name Neurontin) was created to treat seizures. This medication is not currently FDA approved for use to treat Alcohol Use Disorder, but has been shown to decrease the impact of withdrawal symptoms.

**Selective Serotonin Reuptake Inhibitors** (SSRI) is an anti-depressant and has shown to help decrease depressive symptoms in the newly sober.

**Post-Acute Withdrawal Symptoms**

PAWS, Post-Acute Withdrawal Symptoms, is a topic often given to clients in treatment as education to decrease the recurrence of use.

Physical withdrawal lasts a few days to a couple of weeks. PAWS is the stage after physical symptoms are gone. These refer to the emotional or psychological symptoms.

Many clinicians believe PAWS is a physiological result of the brain returning to life without substances.

Each person in recovery is different, as are the symptoms of PAWS.

Some common symptoms could be:

* Anxiety
* Irritability
* Difficulty sleeping
* Mood swings

In early recovery the presences of PAWS are more frequent. The longer a person is in recovery the more likely the symptoms will diminish and cease altogether.

Many clinicians believe PAWS can last up to two-years. This could be the reason the potential is greater for a recurrence of use in early recovery.

SAMHSA’s [July 2010 Advisory](https://store.samhsa.gov/product/protracted-withdrawal/sma10-4554) discussed Protracted Withdrawal, which is similar to PAWS. The Advisory can be ordered for free.

**Myths**

Medications are drugs and you cannot consider yourself clean if you use drugs.

Medications are a crutch.

Medications are just another way to get high.

Alcoholics Anonymous is against the use of medication.

**Facts**

If medications are used to treat all other disease or disorder, what is the reason they cannot be used to treatment Substance Use Disorder?

Changes that occur in the brain of a person actively using substances can be helped through the use of medication.

Length of time in treatment is the single most accurate factor for successful treatment outcomes. Medication can assist a person to remain in treatment longer.

Alcoholics Anonymous does not speak against the use of medication.

**Decreasing Stigma**

The AMA (American Medical Association) [Task Force](https://www.end-opioid-epidemic.org/) recommendations for reversing the Opioid epidemic:

Change the conversation and include the science behind Pharmacotherapy as an option for clients.

Use PDMP (Prescription Drug Monitoring Programs). PDMP’s help identify people who see multiple doctors, or “doctor shop” and may provide an alert that could lead to intervention for those with Substance Use Disorder.

Improve prevention (AMA, 2017).

**Ask Yourself**

* Is a person in recovery if they are taking medications to assist?
* Does a person have to be totally abstinent from all mood and/or mind-altering substances in order to lead a quality life in recovery?
* Are my thoughts and beliefs about the use of medication in the treatment of addiction and recovery discriminatory?
* On what do I base my view of recovery?

**Challenging Myths**

Believing myths only perpetuates the stigma associated with Pharmacotherapy and Recovery, thus, moving people further away from help.

It is important for clinicians, and those studying to enter a clinical field, differentiate between personal opinion and clinical interventions. Personal disagreement with the use of medications to assist treatment or recovery is simply a personal opinion. Clinicians must base their decisions on knowledge of facts related to the profession. Clinicians must offer clients all possible options, rather than eliminate those with which he or she disagrees.

Review the pdf, Myth Challenging [Fact Sheet](https://www.thenationalcouncil.org/wp-content/uploads/2016/10/MF_1_30.pdf), provided by the National Council for Behavioral Health.

|  |  |
| --- | --- |
| **Myth** | **Fact** |
| **MAT JUST TRADES ONE ADDICTION FOR ANOTHER** | MAT bridges the biological and behavioral components of addiction. Research indicates that a combination of medication and behavioral therapies can successfully treat SUDs and help sustain recovery ([10](http://www.integration.samhsa.gov/clinical-practice/mat/mat-overview)). |
| **MAT IS ONLY FOR THE SHORT TERM** | Research shows that patients on MAT for at least 1-2 years have the greatest rates of long-term success. There is currently no evidence to support benefits from stopping MAT ([11](https://www.congress.gov/bill/114th-congress/senate-bill/524/text)). |
| **THE CONDITION IS NOT SEVERE ENOUGH TO REQUIRE MAT** | MAT utilizes a multitude of different medication options that can be tailored to fit the unique needs of the patient ([2](https://www.whitehouse.gov/sites/default/)). |
| **MAT INCREASES THE RISK FOR OVERDOSE IN PATIENTS** | MAT helps to prevent overdoses from occurring. Even a single use of opioids after detoxification can result in a life-threatening or fatal overdose. Following detoxification, tolerance to the euphoria brought on by opioid use remains higher than tolerance to respiratory depression (14). |
| **PROVIDING MAT WILL ONLY DISRUPT AND HINDER A PATIENT’S RECOVERY PROCESS** | MAT has been shown to assist patients in recovery by improving quality of life, level of functioning and the ability to handle stress. Above all, MAT helps reduce mortality while patients begin recovery |
| **THERE ISN’T ANY PROOF THAT MAT IS BETTER THAN ABSTINENCE** | MAT is evidence-based and is the recommended course of treatment for opioid addiction. American Academy of Addiction Psychiatry, American Medical Association, The National Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration, National Institute on Alcohol Abuse and Alcoholism, Centers for Disease Control and Prevention, and other agencies emphasize MAT as first line treatment ([8](http://www.samhsa.gov/medication-assisted-treatment/%20training-resources/support-organizations)). |
| **MOST INSURANCE PLANS DON’T COVER MAT** | As of May 2013, 31 state Medicaid FFS programs covered methadone maintenance treatment provided in outpatient programs ([4](http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final)). c). Extended-release naltrexone is listed on the Medicaid PDL in over 60 percent of states. ([5](http://store.samhsa.gov/shin/content/%20SMA14-4854/SMA14-4854.pdf)) |

**Rise in Deaths**

This rise in opioid overdose deaths can be outlined in three distinct waves.

1. The first wave began with increased prescribing of opioids in the 1990’s, with overdose deaths involving [prescription opioids](https://www.cdc.gov/drugoverdose/opioids/prescribed.html) (natural and semi-synthetic opioids and methadone) increasing since at least 1999.
2. The second wave began in 2010, with rapid increases in overdose deaths involving [heroin](https://www.cdc.gov/drugoverdose/opioids/heroin.html).
3. The third wave began in 2013, with significant increases in overdose deaths involving synthetic opioids – particularly those involving illicitly-manufactured [fentanyl](https://www.cdc.gov/drugoverdose/opioids/fentanyl.html) (IMF). The IMF market continues to change, and IMF can be found in combination with heroin, counterfeit pills, and cocaine.

**Stigma and Discrimination**

Substance Use Disorder is wrought with discrimination to the many myths still believed in society. The level of stigma and discrimination in the realm of SUD recovery and treatment pales in comparison to those accessing services for MAT or MAR. The recovery community and addiction profession are some of the biggest offenders when it comes to being discriminatory.

Some of the issues faced by people with SUD undergoing treatment or in recovery with the assistance of medication are many:

|  |  |
| --- | --- |
| Unable to be admitted to “typical” residential treatment.  | Unable to live in most recovery housing.  |
| Not welcome at 12-step meetings. | Even when welcomed at 12-step meetings, are told they are not in “real” recovery.  |
| Difficulty if justice involved due to medications being seen as the same as “street drugs”.  | MAR being referred to as a “substitution” of substance used prior to recovery.  |

Read this personal story. The title alone likely speaks volumes about the views of MAT[. There’s a Highly Successful Treatment for Opioid Addiction. But Stigma is Holding it Back.](https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone)

**Language is important**.

Reiterated in module after module, language impacts stigma and access to treatment services.

The table below, based on comments in a Journal of the American Medical Association (JAMA) article, offers a few additional examples.

|  |  |  |
| --- | --- | --- |
| **Subject** | **Terminology** | **Implication** |
| Urine Test Results | Urine is termed “clean” or “dirty,” rather than “positive,” “expected,” “negative,” or “unexpected” | The test result is “positive” or “dirty” if an unexpected substance, such as an illicit opioid, is identified |
| Evaluation of Opiate Use Disorder (OUD) Patients | Patients are considered “clean” if in recovery or if managing their symptoms | Patients showing symptoms are considered “dirty” |
| Dosage Decreases of Methadone or Buprenorphine | Tapering often is called “detoxification” | Methadone and buprenorphine are toxic (poisonous) |
| Treatment That Doesn’t Involve Medication | Treatment often is considered “drug-free,” or patients “abstinent,” only if patients are not taking any medication | A person cannot be drug-free if taking methadone or buprenorphine |

**A Look at the Inner-Discrimination**

In this [New York Times article](https://www.nytimes.com/2018/01/17/opinion/treating-opioid-addiction.html), the author says, “this widespread rejection of proven addiction medications is the single biggest obstacle to ending the overdose epidemic.”

In her opinion piece written for STAT, Elizabeth Brico shares her thoughts, [By shunning medication-assisted therapy, 12-step meetings are making the opioid crisis worse.](https://www.statnews.com/2017/10/04/medication-assisted-therapy-12-step/)

**SAMHSA and HRSA**

The Substance Abuse and Mental Health Services Administration (SAMHSA) with The US Department of Health and Human Services (HRSA) made available a comprehensive resource bank of information regarding Medication Assisted Recovery.

One resource made available is a [list](https://www.integration.samhsa.gov/clinical-practice/mat/Helpful_Resources_to_Address_Discrimination.pdf) of helpful resources to address discrimination against people using medication in conjunction with treatment for addiction.

**Evidence of Effectiveness**

Professionals must use evidence to support their referrals and actions related to client interventions. There is evidence to support the effectiveness of MAT. To continue to base recommendations for others on personal beliefs is discriminatory and

In 2015 The National Institute on Drug Abuse (NIDA) released an article related to the success rates of MAT. A bit of that information is below. You can view the information in entirety by reading [the report](https://www.drugabuse.gov/longdesc/long-term-follow-up-medication-assisted-treatment-addiction-to-pain-relievers-yields-cause-optimism) *Long-Term Follow-Up of Medication-Assisted Treatment for Addiction to Pain Relievers Yields “Cause for Optimism*

**From a Professional**

Rick Bingham, Clinic Director of [The Anti-Aging and Longevity Center](https://www.addictioncareclinic.com/) provided the slides for this module. Rick has worked in the treatment field over 40-years. He openly shares about the discrimination he has personally faced in the addiction profession by other professionals who do not believe in Medication Assisted Treatment or Recovery. Rick explains the increase in quality of life of patients served who were once using opioids to the extent of not being able to maintain employment and having other consequences enter treatment and are able to have the life they only once dreamed possible.

**MAR and the 12-Steps**

Included are comments from people who have had negative experiences taking medication while trying to attend 12-step support.

|  |
| --- |
| *I didn’t know what to do when I wanted to stop heroin the first time. I heard about AA from a friend, so I went to a meeting. As soon as I said I was an “addict” a lady came from across the room and asked me to talk with her outside of the meeting. After we were outside, she explained to me that AA was only for alcoholics and since I was an addict, I was not in the right place.*  |
| *I tried more than 20 times (I am not exaggerating) to get clean from opiates. I would go to detox and even treatment for long periods of time, but I could not do it physically. I wanted recovery. I really did. There are so many counselors that would tell me I must not really want recovery if I kept going back to drugs. That really was not true. I didn’t want to live the way I was living. I didn’t have a home. I lost my job. I couldn’t really function.* *Then, I found a program that provided Medication Assistance. They explained to me that recovery was not black or white. It was about improving the quality of my life. If I have to use medication to do that, I will. I cannot attend NA because they consider the medication I am taking the same as if I was using. There is not a lot of support outside of the treatment center for me. Even counselors I have seen tell me they will only work with me if my goal is to get off of the medication. I do not know when (or if) I am going to get off the medication.* *Today I am married. I have two kids. I have a great job. My spouse and I are buying our first house. I have mended the relationship with my family. I am not in debt. I have a real life today, I am not just surviving day to day. I believe in MAR. I know if I kept going from treatment center to treatment center and kept thinking I had to be “clean” to be in recovery, I would either be dead or still using. This is what works for me and I wish I could find peer support like NA or AA, but I would rather have what I have today than forcing my way into a program that doesn’t want me as a member.*  |

**12-Steps and Medication Assisted Recovery**

There is now a program specifically for those who haven’t “fit” or been welcome in traditional 12-step meetings. The program is called Medication-Assisted Recovery Anonymous (MARA).

|  |  |
| --- | --- |
| **Twelve Steps of Narcotics Anonymous (NA)** | **Twelve Steps of Medication-Assisted Recovery Anonymous (MARA)** |
| 1. We admitted that we were powerless over our ***addiction***, that our lives had become unmanageable. | 1. We admitted we were powerless over our ***disease*** of addiction and that our lives had become unmanageable. |
| 2. We came to believe that ***a Power*** greater than ourselves could restore us to sanity. | 2. We came to believe that ***powers*** greater than ourselves could ***help*** restore us to sanity.  |
| 3. We made a decision to turn our will and our lives over to the care of ***God*** as we understood Him. | 3. We made a decision to turn our will and our lives over to the care of ***a Higher Power or*** GOD, as we understood ***GOD.*** |
| 4. We made a searching and fearless moral inventory of ***ourselves.*** | 4. We made a searching and fearless inventory of ***our defects and assets***.  |
| 5. We admitted to God, to ourselves, and to another ***human being*** ***the exact nature of our wrongs.*** | 5. We admitted to GOD, to ourselves, and another ***person*** ***the contents of our inventory.*** |
| 6. We ***were*** entirely ready to have God remove all these defects of character. | 6. We ***became*** entirely ready to have GOD remove our defects of character. |
| 7.   We humbly asked Him to remove our shortcomings. | 7. We humbly asked GOD to remove our shortcomings.  |
| 8. We made a list of all ***persons we had harmed*** and became willing to make amends ***to them all***. | 8. We made a list of all ***the harm we have done*** and became willing to make amends. |
| 9. We made ***direct*** amends ***to such people*** wherever possible, except when to do so would ***injure them or others***. | 9. We made amends wherever possible, except when to do so would ***cause more harm.*** |
| 10. We continued to take personal inventory and when we were wrong promptly admitted it. | 10. We continued to take a personal inventory and when we were wrong promptly admitted it.  |
| 11. We sought through prayer and meditation to improve our conscious contact with God as we understood ***Him, praying only for knowledge of His will for us and the power to carry that out***. | 11. We sought through prayer and meditation to improve our conscience contact with GOD, as we understood GOD.  |
| 12. Having had ***a spiritual awakening*** as a result of these steps, we tried to carry ***this message to addicts***, and to practice these principles in all our affairs. | 11. Having had ***an awakening of our spirit*** as a result of these steps, we tried to carry ***a message of recovery to those who still suffer*** and to practice spiritual principles in all our affairs. |

The differences in the steps for the two programs seems minor, however, this seems to create a distinction many members of other 12 step groups wanted.

[Jillian Bauer-Reese](https://slate.com/author/jillian-bauer-reese) writes about MARA in this Slate [article](https://slate.com/technology/2018/04/theres-a-new-12-step-group-for-people-in-recovery-who-are-prescribed-medications-like-methadone.html).

Review the [12-Steps, 12-Traditions, and How it Works](http://www.vamarp.org/%40/RecoverySupport/_files/1/file.pdf) for MARA.

**UNT Professor Dr. Rachita Sharma’s Video**

[**Lessons learned from Portugal’s War on Drugs: Social Policy and Reform**](https://www.youtube.com/watch?v=5-XcOiV3JTE&feature=youtu.be)

Presented by Rachita Sharma, Ph.D., LPC-S, CRC

In 2001, Portugal radically changed its drug policy by decriminalizing drug possession and use. Until 1999, Portugal had the second-highest rate of drug abuse in Europe, with nearly 1% of its population at the time using or known to have already experienced heavy drug use. With consumption and trade rising, drug related crimes were seen as a major national security problem, and prisons were being flooded with people convicted of drug-related offenses. The government shifted from a traditional punishment approach to a revolutionary treatment model that serves as a case study on drug policy. Participants in this seminar will learn about the complexity of this issue through a lecture presentation and personal anecdotes of the presenter who engaged in a 10-day seminar accessing the institutions, charities, and specialists who helped navigate the many different sides of the war on drugs in Portugal.

Watch this video.

**Glossary**

**AMA** American Medical Association

**APA** American Psychological Association

**AUD** Alcohol Use Disorder

**Agonist** A medication acting as an agonist binds to the same receptors in the brain as the addicted substance and provides a similar euphoria. This is meant to decrease the desire of the substance to which the person is addicted.

**Antagonist** A medication that binds to the same receptors as the addicted substances to prevent the substance being treated for from producing pleasurable effects.

**Binge drinking** defined by the CDC as 4 or more drinks for women and 5 or more drinks for men during a single occasion.

**Buprenorphine** Partial opioid agonist used in the treatment of Opioid Use Disorder

**CDC** Centers for Disease Control

**DSM** Diagnostic and Statistical Manual of Mental Disorders

**Disulfiram** Alcohol antagonist used in the treatment of Alcohol Use Disorder.

**FDA** Food and Drug Administration

**Glutamate** Excitatory neurotransmitter.

**Heavy drinking** defined by the CDC as having 8 or more drinks per week for women and 15 or more drinks per week for men

**MAR** Medication Assisted Recovery

**MARA** Medication Assisted Recovery Anonymous

**MAT** Medication Assisted Treatment

**Methadone** Opioid agonist used in the treatment of Opioid Use Disorder.

**NCADD** National Council on Alcohol and Drug Dependence

**NCBH** National Council for Behavioral Health

**NIDA** National Institute on Drug Abuse

**NIH** National Institute of Health

**NMDA** N-methyl-D-aspartate, a glutamate receptor.

**Naltrexone** Opioid and Alcohol agonist used in the treatment of Opioid and Alcohol Use Disorder.

**OUD** Opioid Use Disorder

**Opioid** a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl,

and pain relievers available legally by prescription, such as oxycodone (OxyContin), hydrocodone (Vicodin), codeine, morphine, and many others.

**PAWS** Post-Acute Withdrawal Syndrome

**PDMP** Prescription Drug Monitoring Program

**Partial Agonist** A medication that binds to the receptors providing a bit of euphoria, but not to the extent an agonist.

**Post-acute withdrawal** Symptoms of withdrawal lasting after physical detoxification.

**SAMHSA** Substance Abuse and Mental Health Services Administration

**Resources**

*Information*

[2018 Annual Surveillance Report](https://www.cdc.gov/drugoverdose/pdf/pubs/2018-cdc-drug-surveillance-report.pdf) of Drug-Related Risks and Outcomes issued by the Centers for Disease Control (CDC)

Visit the National Alliance of Advocates for Buprenorphine Treatment (NAABT) for, which provides: [Free Printed Resources, a pdf about the importance of language, and](https://www.naabt.org/documents/NAABT_Language.pdf)

[Laws concerning opioids](https://www.naabt.org/laws.cfm)

*Support*

[Opiates Anonymous](http://www.opa12.org/home.html) is an existing 12-Step program; however, it does not explicitly support the use of medication.

*Treatment*

Buprenorphine Treatment information provided by SAMHSA and the Center for Substance Abuse Treatment (CSAT) 866-BUP-CSAT (866-287-2728) or infobuprenorphine@samhsa.hhs.gov

Medication Assisted Treatment information provided by SAMHSA Division of Pharmacologic Therapies at 240-276-2700 or otp-extranet@opioid.samhsa.gov

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