

Opioid maintenance and recovery-oriented systems of care: it is time to integrate

An independent commentary by A. Thomas McLellan and William White on the RODT Expert Group's 'Medications in recovery: re-orientating drug dependence treatment'

There is international interest in recovery as an organising construct for addiction-related public policy; and for the redesign of addiction treatment. England's Recovery Orientated Drug Treatment Expert Group, established by the NTA to explore and integrate the recovery construct, is an important milestone in these international efforts.

A recovery orientation in public policy and in treatment systems is a particularly refreshing approach to problems of addiction. Many public policies seek to punish addictive behaviors and remove the addicted from view. Some treatment systems focus only on remitting the most obvious and problematic symptoms of addiction. In contrast, recovery-orientated treatment systems offer an integrated approach to promoting the health of the addicted individual as well as the improved function of the family and community through a focus on social contribution. Emerging recovery definitions emphasise that recovery is more than the removal of destructive alcohol and/or drug use from an otherwise unchanged life. Recovery is a broader process that involves a radical reconstruction of the person-drug relationship, progressive improvement in global health and the reconstruction of the person-community relationship.

Recovery and opioid maintenance treatment

It is in the context of a recovery-orientated treatment approach that the treatment of heroin addiction with an opioid medication has been so clinically controversial and politically divisive. Synthetic opioids were introduced over 60 years ago to help physicians reduce mortality, pain and fear of withdrawal among heroin-addicted individuals. From that day to this there have been political battles between those who favor and those who oppose the long-term (maintenance) use of methadone or buprenorphine in the treatment of heroin addiction. These 'methadone wars' have been waged largely on ideological and political grounds questioning the morality of 'substituting one opiate for another' or the political cruelty of 'forcing societal values about abstinence on those who are struggling with a brain disease'. The results have been polarisation within the treatment and policy fields, stigmatisation of individuals who need care and confusion among the public. The emotional charge and the moralistic nature of these battles have also constrained the nature of the scientific evaluation, prevented rational discussion and ultimately retarded progress in our field.

In this divisive and corrosive context the work of the Expert Group has been refreshing. It is progressive and valuable to ask practical, sensible questions regarding whether, how and under what conditions opioid maintenance medication can promote recovery – and to address those questions through empirical examination of the evidence. Several conclusions emerge from an unbiased, unemotional examination of the large body of data reviewed in this report.

First, the original clinical purpose of opioid medications was simply to provide metabolic stabilisation as a means of engaging seriously and complexly addicted individuals into a therapeutic process and a personal recovery process that involved far more than just medication. There is no doubt that these medications are effective in achieving these ends and are often life-saving. It is also clear that these initial medication effects are not synonymous with recovery. Recovery is more than physiological or even emotional stabilisation. It has been defined in various ways but one recent version describes recovery as a "voluntary lifestyle characterised by sobriety, health and citizenship". The most ardent proponent would not claim that the simple administration of even significant doses of any opioid maintenance medication should be expected – by itself – to reliably induce this type of lifestyle. There is no type of treatment yet that can reliably induce recovery. Even 12-step treatment, the treatment most widely associated with recovery, cannot claim successful, sustained recovery in more than 25–30% of those who enter such treatment. The important point in the above definition is that recovery is not defined by a particular method by which one comes into recovery – only by the qualities of the life itself.

So, does being maintained on an opioid medication prevent an addicted individual from entering into a recovery lifestyle? The answer from the data reviewed is a qualified 'no'. The qualifications come from both the desires of the patients who enter and the therapeutic goals of the programs that provide opioid maintenance care. Many of the seriously addicted patients who enter opioid maintenance treatment do not want a recovery lifestyle. Data reviewed from large-scale studies in three continents show that many long-term opioid maintained patients continue alcohol and drug use and unemployment, and thus would not be considered by the above definition to be 'in recovery'. But these same data also show that a significant proportion of opioid maintained patients eliminate

all substance use, obtain employment, care for their families and eliminate criminal activity – results which are quite consonant with recovery. Thus, it is neither the presence nor the absence of an opioid medication that defines recovery – it is other important qualities of the lifestyle.

But is the quality of ‘medication-assisted recovery’ really the same; and is it as enduring as recovery without the assistance of an opioid medication? There is no empirical answer to this question at this time, but it is an important issue for study. At a conceptual level, few would argue that an otherwise abstinent opioid-addicted person who took statins for high cholesterol, insulin for diabetes, SSRIs for depression or a nicotine patch to prevent return to smoking would still be considered ‘in recovery’. Is that same, otherwise abstinent, individual who takes maintenance doses of methadone or buprenorphine as prescribed so different?

An important question addressed in the report from the Expert Group is whether there are clinical services and administrative practices that can increase the likelihood of recovery within opioid maintenance treatment? Here again, the answer from the data reviewed is a qualified ‘yes’. Opioid maintenance programs that set recovery goals, offer supportive services and promote pro-social behavioral change facilitated by individual and family counselling – are more likely to produce or perhaps attract – patients who ultimately meet the definition of recovery. Again the qualification is that not all patients want a recovery lifestyle and not all providers accept recovery as a requirement for effective opioid maintenance treatment. Should there really be only one acceptable treatment goal and only one approved form of care? Recall that proper dosing with an opioid medication has been proven to protect individuals from withdrawal, overdose and also to reduce many of the associated public health and public safety behaviors (e.g. injection-related infections, drug-related crime, etc.). Many patients and providers believe that these benefits are adequate in themselves. It seems clear again that being maintained on an opioid maintenance medication neither assures nor eliminates the potential for a patient to be in recovery – his/her recovery status is best defined by the other lifestyle qualities.

In turn, this leads to the final set of questions which also cannot be answered by the evidence thus far available and assembled by the Expert Group. Does a treatment program have the obligation or the right to demand recovery from its patients? Many opioid maintenance providers are hesitant to make demands on patients for recovery-orientated behavioral changes under fear of jeopardizing the significant gains already achieved through ‘low threshold’ treatments. Other providers of abstinence-orientated treatments believe

it is better to discharge patients who lapse to drug use, in order to protect and preserve an abstinence-orientation for the remaining individuals in treatment. Are the public health benefits from medication-alone threatened by clinical or administrative requirements for recovery-orientated changes? These empirical questions have not been asked, perhaps because of the charged political climate in this field. In this context, the work of the NTA and its advisors may have helped us move toward a time when different therapeutic philosophies are accepted and even matched to the needs of patients; and research can help each type of provider examine these issues in an empirical manner with the objective of better matched and balanced treatment/rehabilitation options in the future.

Conclusion

Recovery status is best defined by factors other than medication status. Neither medication-assisted treatment of opioid addiction nor the cessation of treatment by itself constitutes recovery. Recovery status instead hinges on broader achievements in health and social functioning – with or without medication support.

Rather than seeing addiction treatments with and without medication as philosophically incompatible, the Expert Group suggests it is more useful to consider medications and all other therapeutic components of contemporary care as a menu of medical and non-medical recovery support options that can be combined, separated and sequenced to meet individual/family needs over the course of the recovery process. Why would we deny any patient attempting to recover from any disease the ability to access an effective medication to aid their recovery? At the same time, the way to get the most from opioid maintenance treatment is by continuing to motivate patients receiving the pharmacological benefits of craving reduction and overdose protection toward the broader but harder-earned benefits of full recovery.

Recovery-focused systems of care have the potential to significantly elevate the quality of addiction treatment and the quality of life in individuals, families and communities affected by addiction to alcohol and/or other drug problems. But our scientific knowledge about addiction-related pathology has not yet been extended to understanding the pathways, stages and styles of long-term recovery across diverse clinical populations and promoted in different ways. It is our expectation that, as the work of the Expert Group moves forward, a recovery-focused research agenda will emerge to guide and refine research, treatment and policy. Such an agenda is emerging in the US as we go through our own process of exploring how to increase the recovery orientation of addiction treatment. We look forward to international collaboration on pursuing such an agenda.