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ADDICTION

Hazelden Introduces Antiaddiction Medications into Recovery for First Time

Recovery from opioid addiction may no longer mean complete abstinence from drugs

By Maia Szalavitz @maiasz | Nov. 05, 2012

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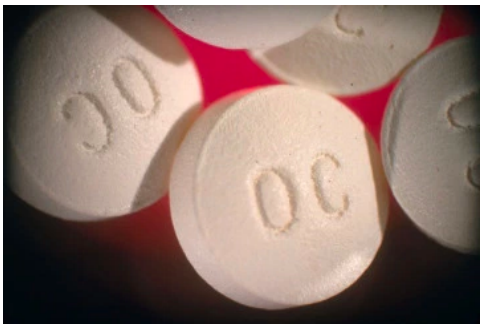

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Founded on the idea that abstinence is the bedrock of any recovery from drug or alcohol addiction, Hazelden will now incorporate anti-addiction medications in its rehabilitation programs.

Treating drug addiction is as much about addressing why people become hooked on substances like alcohol, painkillers or illegal drugs as it is about weaning them off of their habit— at least that's the core of the Hazelden recovery approach. From its founding in a Minnesota farmhouse in 1949, the program has championed the 12-step method, with its roots in the principles of Alcoholics Anonymous. That philosophy is anchored by the belief that true recovery can only start with addicts admitting they need help from others. Abstinence from all potentially addictive substances has always been the cornerstone of this strategy, which has become known as the "Minnesota Model." Some 90% of American addiction counselors rely on Minnesota Model principles.

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But for the first time, Hazelden will begin providing medication-assisted treatment for people hooked on heroin or opioid painkillers, starting at its Center City, Minnesota facility and expanding across its treatment network in five states in 2013. This so-called maintenance therapy differs from simply detoxifying addicts until they are completely abstinent. Instead, it acknowledges that continued treatment with certain medications, which can include some of the very opioid drugs that people are misusing, could be required for years.

"This is a huge shift for our culture and organization," said Dr. Marvin Seppala, Hazelden's chief medical officer, who pushed for the new practice. As the program's first adolescent patient, and someone who has been in recovery from multiple drug addictions for 37 years, Seppala is keenly aware of how dramatic this decision is for the organization, which once debated whether or not coffee was acceptable in its abstinence-based program. "We believe it's the responsible thing to do," he says.

Driving the need for change is the sobering reality of what happens to patients addicted to prescription pain relievers— a growing segment of those in need of drug recovery— once they leave the Hazelden program. Within days of leaving the residential treatment facility, most were relapsing— and at least half a dozen have died from overdoses in recent years. It was time, Seppala argued, for a radical change.

In the coming months, Hazelden will begin to prescribe the drug buprenorphine (Suboxone) for some people addicted to opioids — the class of drugs that includes prescription pain relievers like Oxycontin and Vicodin, as well as heroin. At low doses, buprenorphine acts like methadone or heroin, which helps addicts to avoid severe withdrawal. But at higher doses it prevents opioids from working. That means it's much harder to misuse or to overdose on buprenorphine, making it safer than methadone, the other commonly used anti-addiction medication.

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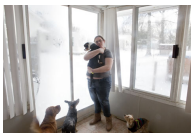

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the latest research, which has documented the effectiveness of such strategies for decades. But it's taken longer for the leading treatment providers in the community, including Hazelden and Betty Ford, to accept the idea that giving drug addicts medications similar to those to which they were addicted can be part of recovery.

The science, however, is getting harder to ignore. Studies show that people addicted to opioids more than halve their risk of dying due to their habit if they stay on maintenance medication. They also dramatically lower their risk of contracting HIV, are far less likely to commit crime and are more likely to stay away from their drug of choice if they continue maintenance than if they become completely abstinent.

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The first maintenance drug, methadone, was introduced in 1964 after studies supported its effectiveness in fighting heroin addiction. Based on that data, leading health organizations — including the Institute of Medicine (an independent U.S. body of experts authorized by Congress to study health-related issues), the World Health Organization and the U.S. "drug czar's" office — recognized the importance of medication-assisted treatment for opioid addiction.

"The evidence shows much, much better outcomes," says Dr. Nora Volkow, director of the National Institute on Drug Abuse.

But to a treatment program based on the 12-steps of Alcoholics Anonymous—whose first step involves admitting "powerlessness" over one's addiction— the idea of maintenance on a potentially mood-altering drug has always been suspect. For an alcoholic, substituting vodka for gin or even beer for wine wouldn't really represent progress: so why would replacing an illegal opioid like heroin or non-prescribed painkillers with a legal one be better for recovery?

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The answer lies in the different ways that opioids and alcohol act on the brain. In alcoholism and other addictions, pleasure areas in the brain get misdirected as addicts continue to chemically activate the system in order to achieve greater "highs." The repeated behavior leads to tolerance, and over time, larger and larger doses are needed just to feel normal, let alone "high."

But where drinking alcohol is always accompanied by some degree of physical impairment— like loss of motor coordination and reduced cognitive ability, with opioids, there is no significant mental, emotional or physical impairment if someone regularly takes the exact same dose. In fact, research shows that patients addicted to opioids who are on maintenance doses of anti-addiction drugs like buprenorphine can drive safely, work productively and engage emotionally like those who aren't addicted.

"For most people using opioids daily, they are no longer getting high, even when they are still using. It's just become maintenance," Seppala says. The effect is similar to the tolerance people experience with caffeine. "If you drink caffeine on a daily basis, after a while, you don't notice the effect of one cup of coffee," he says, "But if you drank two, you would."

New Beginnings

Still it wasn't until the FDA approved buprenorphine in 2002 that Hazelden even began considering lifting its ban on medication-assisted recovery. Unlike methadone, buprenorphine can be prescribed by family doctors (although there are still some limits on the number of prescriptions physicians are allowed, in an attempt to prevent "pill mills" from dispensing the drug without proper supervision). Like other medications, it can be picked up monthly at pharmacies, not daily at clinics.

Watching many Hazelden patients leave the facility only to overdose soon afterwards, Seppala realized change was needed. "This is a place of healing," he says, "To have people die after treatment is just horrible." Buprenorphine, he realized, might help to avoid some of those deaths.

To his surprise, he found far less resistance than he expected when he approached Hazelden officials to consider using buprenorphine. Over a period of 10 months, the facility's experts analyzed the available data and in September, the group's full board approved a plan for change, which involved integrating medication-assisted therapy thoroughly into treatment, not just handing out drugs.

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Hazelden will start using buprenorphine maintenance cautiously at first. The drug will not be provided to people

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be needed. And the rehab will now consider people who are taking maintenance medications in their program as being "in recovery" from the day they start these drugs and stop taking non-prescribed drugs. The program will define relapse as any drug use outside that provided by medical advice. Those changes will be integrated into the counseling and even the 12-step meetings offered onsite.

And because clinicians expect that a single treatment strategy won't be enough to address the recovery needs of all of those addicted to opiates, for some patients the program will also provide Vivitrol, a time-release injection of naltrexone that prevents opioids from from being effective for about a month. Although this approach may seem like a better option than maintaining people on an opioid medication indefinitely, studies so far have not shown that naltrexone reduces mortality in opioid addiction in the same way that maintenance drugs like methadone and buprenorphine do. The National Institute on Drug Abuse is currently conducting the first trial to compare Vivitrol directly with opioid maintenance to determine its long term effectiveness.

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As for Hazelden, "We will never change from being a solid, 12-step based program," Seppala says. "But I am a physician and we look at the research and want to use evidence-based treatment."

The reaction among academic addiction experts to the change has been, not surprisingly, positive. "I was delighted," says Volkow of Hazelden's decision. "This was a change that I've been waiting for. I would predict that as data emerges as to how this change improves the outcome of their patients, then others may realize that this is beneficial for patients and not harming them in any way."

The ultimate test, of course, will be with the patients, whom Hazelden will study closely. And already, they have been encouraged by a success story. J, who failed to overcome multiple addictions during seven different attempts at rehab, including at Hazelden, finally took the first steps toward recovery after a doctor prescribed buprenorphine. J's mother, Cheryl, a former heroin addict who recovered at Hazelden and became a counselor and supervisor there, witnessed the difference that the anti-addiction medication made for her daughter, and realized that recovery, and recovery treatments, have to be flexible.

What worked for her, she now knows, may not work for everyone. Now free of illegal drugs and alcohol for more than a year, J has regained custody of her son, which she had lost due to her addiction. "I'm as proud as I can be of her," says Cheryl, "She's responsible and reliable. I don't get these calls any more where she has frantic mood swings or is feeling so down and desperate that she is threatening suicide. Without that Suboxone, I don't think my daughter would ever have been able to develop these sober living skills. The oldtimers are just going to have to accept it."

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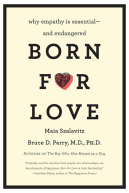
Maia Szalavitz is a neuroscience journalist for TIME.com and co-author of ***Born for Love: Why Empathy Is Essential — and Endangered***.



Szalavitz's latest book is *Born for Love: Why Empathy Is Essential — and Endangered*. It is co-written with Dr. Bruce Perry, a leading expert in the neuroscience of child trauma and recovery.

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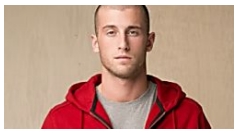

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