

A journal on ADDICTION RESEARCH & PUBLIC POLICY

PERSPECTIVES

Recovery support, MAT focus of Newark trends conference

August 2009
Vol. 20, No. 4



Dr. R. Douglas Bruce of the Yale University School of Medicine discusses medically assisted treatment during a panel at a recent conference in Newark. Also on the panel are (at rear, from left) Liliane Cambraia, assistant professor at the Rutgers University; Jude Iheoma, manager of the state's Medication Assisted Treatment Unit; and Anthony Jenkins, clinical supervisor at the Lennard Clinic in Newark.

Newark, the city in New Jersey with the greatest concentration of cases of addiction, hosted a Substance Abuse Trends and Treatment Conference on Aug. 13. The event, jointly sponsored by the University of Medicine and Dentistry of New Jersey and the New Jersey Community Research Initiative, urged the redoubling of resources in two areas shown to sustain recovery: support services and medically assisted treatment.

The two prongs of sustaining recovery were presented by Division of Addiction Services Director Raquel Mazon, who talked about support services, and by Dr. R. Douglas Bruce of Yale University, who briefly reviewed addiction as a brain disease and how it responds positively to pharmacological treatments. These treatments, he said, include medications such as methadone and Buprenorphine. Methadone is the forerunner of Buprenorphine and other medications now used to treat opiate and other addictions.

Jeffers described addiction's pervasiveness in the state, noting that 817,000 adult residents – 11 percent of the adult population - meet the criteria for addiction to drugs or alcohol. The heroin found in New Jersey is both the most potent and the cheapest, creating a perfect storm of opiate addiction. She quoted a statistic about the state having more admissions to treat addiction to heroin, an illegal drug, than for alcoholism.

Of those adult residents who demand addiction treatment, approximately 54,000 receive treatment but 31,000 are unable to access the care they need. An initiative, Closing the Addiction Treatment Gap-New Jersey, has pressed for more treatment resources to meet that shortfall. Furthermore, a large percentage of addicts – between 40 and 60 percent – have co-occurring mental illness.

Treatment for addiction must be done on a chronic care continuum, Jeffers stressed. She likened it to other chronic illnesses, such as diabetes and asthma. She noted that when a diabetic has a slip and eats a donut, that patient's doctor does not withhold care or say that the care given to date has been a failure. With addiction, however, a relapse is generally met with condemnation by the provider and certainly by societal mores.

To illustrate the idea of support services she referred to a graph created by recovery advocate and historian William White. The graph traced the course of recovery from acute care to stable recovery. The steep cost of acute care was represented on the graph by a peak in resources expended on detox and intensive inpatient care. Farther into recovery, the graph dipped into a 'valley' representing sustained recovery and the services that promote it. Those support services, which consume considerably fewer resources, merit greater investment, the goal being to widen the recovery valley.

"Right now," Jeffers said, "there are not a lot of resources supporting recovery." The idea is to "minimize acuity and build resilience. Recovery support services, she noted, could be considered a form of prevention in that it prevents relapse. The key components of the state's recovery-oriented system of care include being client-centered, advancing a chronic care model, recovery supports that include housing, something that is available through the syringe access pilots. Also being implemented are phone outreach, recovery mentoring, and recovery support centers.

Several presenters noted that the Obama Administration had lifted the ban on federal funding for needle exchange programs, opening the door for states to do

likewise. The state's syringe access program, which is being piloted in Newark and four other sites, was also reviewed at the conference. Assistant Commissioner, Division of HIV/AIDS Laurence Ganges of Trenton spoke about the long fight to have syringe access included in the battle against HIV. He recalled a time when the term "harm reduction" had been verboten within the Department of Health and Senior Services. That term is applied both to needle access programs and methadone maintenance.

The legislation that enacted syringe access included a \$10 million in treatment allocation (\$1.2 million per site). In Newark, the syringe access program has had 670 clients, 30 percent of whom have sought treatment through the program.

Dr. Bruce's presentation argued for increased use of MAT. What MAT provides his addicted patients, he said, is "clarity of mind" to work on whatever behavioral or emotional problems contributed their becoming addicted to alcohol or drugs. MAT, therefore, is not meant to replace counseling but used in concert with it.

Bruce reviewed how Buprenorphine works on dopamine, the brain's neurotransmitter that governs pleasure and that is fundamental in addiction to opiates. When the dopamine receptors are filled by Buprenorphine, the euphoric effect normally supplied by heroin is suppressed.

Methadone has a long history, having been introduced around the middle of the last century as a painkiller in the same class as morphine. It was later discovered to Bruce noted that Buprenorphine is extremely safe. The Food and Drug Administration classifies it as a Class three drug, the same category as Tylenol. Medications are critical in treating addiction. Among the recent advances in pharmacology, Bruce noted the gains seen with Topamax in treating alcoholism.

When it comes to relapse, Bruce stressed that having one does not negate all the time a patient was clean. The strides made toward thinking clearly and toward improving one's physical health do not vanish because of a relapse. He stressed that it is important for both the treatment provider as well as the individual who relapsed to understand and accept this.