Under the influence of methadone

By Lawrence Harmon

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WHILE THE early-morning South Shore commuters crawl along Southern Artery waiting for their coffee to kick in, the Habit OPCO methadone van pulls into the parking lot of a shuttered VFW hall in Quincy. Inside, a nurse pumps doses of liquid methadone for arriving opioid addicts, who range from burly workmen to young moms with kids in tow. Outside, a sharp-eyed guard swoops down on an unwelcome visitor. This and similar scenes at methadone clinics across the state have represented the gold standard in addiction treatment for 40 years. But it's looking more tarnished every day.

The synthetic narcotic in methadone binds to the same brain receptors as heroin, preventing cravings and withdrawal symptoms in addicts. Medically speaking, it's a "full agonist," meaning it packs a wallop. Methadone is strongly addictive and has been linked to an alarming increase in overdoses and poisonings in recent years. It's so susceptible to abuse that doctors can't prescribe it for addiction treatment in their private offices.

Something safer came on the market in 2002. Buprenorphine, sold under the brand name Suboxone, is a partial opioid agonist, meaning it activates receptors in the brain sufficiently to prevent cravings and withdrawal symptoms in addicts. But it does not produce the same high — which addicts describe as being wrapped in a narcotic blanket — as do full agonists such as methadone, OxyContin, or heroin. Suboxone also contains an opioid antagonist — naloxone — as a way to curb abuse. When taken as directed, the naloxone has no effect. But if Suboxone is crushed and snorted or injected, it causes immediate withdrawal symptoms, including cramping, vomiting, and muscle aches. Suboxone is gaining traction in academic medicine as the safest and most effective treatment for opioid addiction.

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THE PRESTIGIOUS McLean Hospital in Belmont now recommends Suboxone combined with counseling for most of its opioid-addicted patients. Stable patients are generally given a one-month, take-home supply of the drug, according to Dr. Kevin Hill, a psychiatrist at the hospital's alcohol and drug abuse treatment program. Suboxone has fewer side effects than methadone and minimal risk of overdose, said Hill. And that allows it to be prescribed for addiction from a physician's office.

Medical research that came out shortly after the introduction of Suboxone suggested that methadone may be more effective with long-term hardcore addicts. But the growing consensus now is that Suboxone should be the first choice for treating opioid addiction because it is highly effective and causes fewer side effects, a win-win for patients and their doctors.

So one might think that state public health officials would vigorously embrace the newer drug. They don't. Or that MassHealth — the government insurance plan for low-income residents — would give its recipients access to the safest formulation of Suboxone. It doesn't. Or that doctors, especially psychiatrists, would be lining up to learn more about the drug. They aren't.

How distorted is this picture? Consider that each of the 33,000 physicians and many of the 6,500 nurse practitioners in Massachusetts have authority to prescribe powerful narcotics that can lead to addiction. Yet only about 900 physicians in Massachusetts have taken the required course and sought the federal waiver needed to prescribe Suboxone, and only about 400 appear on a physician locator list — less than 2 percent of the total. And only about half of them are accepting new patients. The state spends liberally on methadone and sparingly on Suboxone for low-income addicts. Meanwhile, about 600 people die annually in Massachusetts of narcotic overdoses.

Dr. Hilary Smith Connery, the clinical director of the alcohol and drug abuse program at McLean Hospital, asked, "How do you have such a deadly disease and such an effective treatment, and the two aren't brought into proportion?"

MARIANNE TUCKER, 60, was 15 when she ran away from an abusive household in Albany and settled in Fall River, where she became addicted to heroin. She spent roughly 25 years in methadone treatment programs, including at the clinic now operated by Habit OPCO in Fall River, one of 10 methadone clinics in the state run by the Boston-based, for-profit company. She, like many addicts, describes her years on methadone as an endless cycle of daily dosing and methadone-related appointments. Tucker, who received state-subsidized treatment, said she sought to reduce her dosage, but staffers told her not to concentrate on the milligram number, just on how she felt.

"The for-profits keep you so high, you don't know what you're doing," said Tucker.

The worst part, she said, was the daily experience of being around other addicts who weren't committed to recovery. "This is the best place to hook up if you want to do dope," she said.

About five years ago, she walked away from the clinic and sought Suboxone treatment from Dr. Claude Curran, a

controversial addiction specialist in Fall River. Unlike with methadone, her Suboxone dose has gone down over time. And while methadone made her feel high, Suboxone makes her feel like the person she was before she started to use heroin — a feeling of freedom described by many addicts who switch from methadone to Suboxone.

Curran uses the term "nihilidation" to describe the loss of an addict's normal drives, interests, and goals. They become enslaved to opioids, he said. And it is the responsibility of treating physicians to give hobbled addicts "the lightest chains possible." That's what Curran said he was trying to do in 2005 when he was fingered by the federal Drug Enforcement Administration for prescribing Suboxone to hundreds more patients than allowable under a federal cap of 30 patients per year. Curran remains under scrutiny for his prescribing practices by the state Board of Registration in Medicine. But he also remains outspoken.

"Who ordained methadone as the standard of care for opiate dependence?" he asked.

SWITCHING TO Suboxone is no easy matter for methadone patients. The average therapeutic dose of methadone now stands at 80 to 120 milligrams, according to Dr. Christopher Lukonis, the chief medical officer for Habit OPCO. That's about double what it was a few decades ago. Lukonis defends the trend.

"People were under-medicated back then," he said.

Dosage strength is a big issue for patients. Going cold turkey off opioids practically guarantees a relapse into street drugs when the dope sickness sets in. Transitioning to Suboxone is a safer way than cold turkey to clear a patient's system of full opioid agonists such as heroin, oxycodone, hydrocodone, or methadone. But best practice requires patients to reduce their daily methadone intake to 35 milligrams to assure a safe changeover to Suboxone, a procedure that can be done in the privacy of a doctor's office. That leaves addicts and their advocates desperately, and often unsuccessfully, trying to convince methadone clinics to reduce doses.

Lukonis said that Habit OPCO not only honors requests for dose decreases, but informs patients about Suboxone as part of the medical admission process. But the drug isn't available at the company's Massachusetts clinics, which serve at least 4,000 addicts. And Habit OPCO makes no bones about what business it is in. Its website states as "fact" that "methadone, combined with life skills counseling, has been shown to be the best treatment available for opiate-dependent individuals." Like any other company selling a service, Habit OPCO depends on volume to make a profit. And weaning addicts can't be good for business.

MICHAEL BOTTICELLI, who heads the state's Bureau of Substance Abuse Services, gets testy at questions comparing methadone and Suboxone. He says that both drugs are important pieces in the state's "continuum of care" for opioid addicts, along with psychosocial services, detox beds, and long-term residential placements. But if one follows the public money, it's a lot more likely to lead to a methadone clinic than a treatment program offering Suboxone.

In 2007, MassHealth paid $325 million to treat 18,000 low-income addicts with either methadone or Suboxone, according to a 2009 legislative report. Of that amount, $276 million was spent on methadone programs for 14,000 addicts. The average cost per subsidized patient was $19,799 for methadone and $11,820 for Suboxone.

The same imbalance can be seen in other state agencies. The state Department of Public Health spent $6 million last year on methadone treatment for addicts whose insurance policies won't cover the drug. By contrast, the department provided only $1.5 million for Suboxone programs in 14 community health centers across the state.

MassHealth reimburses for Suboxone tablets, but not the thin, quick dissolving film that is placed under the tongue. The film has the advantage of coming in individually numbered pouches that are harder to divert into the illegal market. They can't be crushed for snorting or injection. And a spokesman for the manufacturer, Reckitt Benckiser, said the drug company can provide the film to the state at a lower contract cost than the tablet equivalent.

Medicaid officials aren't buying it, literally or figuratively. They say the Suboxone film is more a marketing strategy than a medical advance. And they remain focused on finding generic, therapeutic equivalents. Yet there is no generic equivalent. And Massachusetts is one of only five states where the product is not available to Medicaid patients. Private insurance companies here cover the film. By refusing to do so, MassHealth could exacerbate health disparities in Massachusetts.

Meanwhile, taxpayer money is spilling away on urine tests for illicit drugs. The Attorney General has uncovered all manners of scams, including straw companies, medically unnecessary screening, and kickbacks to drug treatment programs and sober houses from clinical testing labs. There would be a lot less opportunity for such monkey business if more doctors treated addicts in private offices, and monitored them with inexpensive and easily available urine testing kits. Monthly visits to a doctor's office would also eliminate much of the need for the subsidized vans and taxis now used by low-income addicts to get to methadone clinics for their daily doses. When asked, state health officials couldn't break out how much is spent annually on transportation to methadone clinics.

MCLEAN'S DR. CONNERY is studying barriers to the wider acceptance of Suboxone within the medical profession. Medical schools and residency programs, she said, focus too little attention on addiction. Historically, that left the field wide open to non-medical, peer-led groups, such as spiritual and 12-step programs.

How little interest is there in addiction medicine? In February, Connery offered a workshop on Suboxone at a psychiatric training conference in Austin, Texas. Only one person showed up.

Connery is pushing back. She requires psychiatrists-in-training at Massachusetts General Hospital and McLean to attend a one-day training session on Suboxone that makes them eligible for the federal waiver needed to prescribe the drug. Recently, she and her colleagues pored through case studies with about 20 trainees. They found Suboxone to be the right call in cases ranging from a 19-year-old college student who had been snorting heroin for 15 months to a 37-year-old school teacher who has been in a methadone maintenance program for nine years following a period of injecting heroin.

Those who complete the training can prescribe the drug to no more than 30 patients in the first year. After that, they must observe a patient cap of 100. Such caps and shortages of prescribers create opportunities for so-called "script docs" who insist on high cash payments for prescribing Suboxone, even though the drug is covered by most insurers. That won't change until more physicians seek the federal waiver needed to prescribe the drug and state officials get serious about funding Suboxone clinics in community health centers.

At McLean Hospital, at least, there were signs that young psychiatrists will be more willing to accept the concrete challenges of addiction medicine than their older colleagues who prefer the ambiguities of psychotherapy.

LIKE METHADONE, the long-term maintenance use of Suboxone doesn't address the underlying causes of addiction. But it does give addicts an opportunity to succeed in behavioral or talk therapy. Suboxone won't fill the "hole in the soul" of addicts, as identified by 12-step programs, either. But it could open up treatment to a lot of people — especially middle-class addicts — who wouldn't be caught dead in a methadone clinic or a peer-led program such as Narcotics Anonymous.

Opioid addiction is a chronic medical illness. Suboxone holds out the best hope for treatment in decades. But physicians and state health officials have fallen into the habit of thinking about methadone as the default treatment. And bad habits are hard to break.

Lawrence Harmon can be reached at harmon@globe.com.