

**STATEMENT OF ROBERT L. DUPONT, MD
PRESIDENT, INSTITUTE FOR BEHAVIOR AND HEALTH, INC
BEFORE THE
HOUSE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
REGARDING COMBATTING THE OPIOID ABUSE EPIDEMIC: PROFESSIONAL
AND ACADEMIC PERSPECTIVES**

April 23, 2015

Dear Chairman and Members of the Committee;

I appreciate the opportunity to offer suggestions on the nation's response to the current opioid epidemic focusing on "demand reduction," the needs of the thousands of people who now are dependent on the nonmedical use of prescription pain medicines and heroin.

I was the second White House drug chief, under Presidents Nixon and Ford, and the first Director of the National Institute on Drug Abuse (NIDA). Prior to that I created and led the Washington DC Narcotics Treatment Administration (NTA) which treated 15,000 heroin addicts in the nation's capital between 1970 and 1973, mostly with methadone. Since 1978 I have been the president of the non-profit Institute for Behavior and Health (IBH), an organization devoted to research and to identifying and promoting better drug policies. I have served as a Clinical Professor of Psychiatry at Georgetown Medical School since 1980. My CV is attached.

My presentation encourages greater access to treatment for opioid dependent patients. However it goes further. It insists on greater accountability from treatment, including public reporting of both the continued drug use that occurs during treatment and the rates of program retention. This is important because there are high levels of alcohol, marijuana and other drug use today by patients in many opioid treatment programs, and virtually all of these treatment programs have high rates of dropping out. By asking what happens to patients after they leave treatment I am proposing a New Paradigm for treatment evaluation, one that is focused on long-

term results. A clear statement of goals of treatments for opioid dependence – both those using medications and those not using medications – is necessary for the programs to be evaluated or improved.

Several facts set the stage for my suggestions. The nation is in the midst of its third devastating heroin addiction epidemic, this one seeded by the explosive increase in opioid prescriptions beginning in the mid 1990's. The first was at the start of the 20th Century, the second started in the late 1960's. While there is much yet to be done to reduce the supply of prescription opioids for nonmedical use and the supply of heroin, I am focused today on what can be done to reduce the nonmedical use of opioids.

This Committee in this hearing, and in its subsequent actions, has the opportunity to critically assess the current state of the treatment for opioid dependence and to demand a much needed public accountability, even as it also encourages a similarly much-needed increase in treatment capacity. I focus on Medication Assisted Treatment (MAT) because that is the mainstay of the current treatment for opioid dependence. However, the concerns I have for the limits of the current MAT apply fully to the non-medication, Abstinence-Oriented Treatment (AOT), of opioid dependence. I have no interest in adding to the long-running war between MAT and AOT. It is a war that undermines public confidence in all substance abuse treatment. Worse yet this internecine battle fails to recognize the reality that all substance abuse treatment needs to be improved.

Let us start with a few facts that underlie all evaluations of treatment efficacy. First, opioid dependence is seldom a brief episode in a person's life. Rather, it is a chronic disorder that lasts a lifetime in the sense that even after a long period of abstinence the risk of relapse is substantial, as was tragically demonstrated last year by the fatal heroin overdose of Phillip

Seymour Hoffman after two decades of sustained abstinence. We know this about former cigarette smokers – even a single cigarette can prove disastrous to a previously dependent smoker. That risk is lifelong. Second, there are few opioid dependent people who do not also have problems with alcohol, marijuana, cocaine and other drugs of abuse. Opioid dependence uncommonly exists as a single substance dependence. Third, all substance abuse treatment, including opioid dependence treatment, is short-term compared to the lifetime nature of the disorder. This universal mismatch is crucial for public health policy.

Three medications are widely used in the treatment of opioid dependence: methadone, buprenorphine, and naltrexone. MAT works only when the medicine is taken. The standard evidence of efficacy is reduced opioid use. In addition, MAT can reduce overdose deaths and reduce infections related to intravenous drug use (such as HIV-AIDS and Hepatitis C) while the patient is using the medicine. Consider how an episode of care ends and what happens to opioid patients when they leave MAT. One scenario for the end of MAT is for patients to gradually lower their doses of medication to zero and then to be monitored while still in the program to establish that they remain opioid (or drug) free for a period of time before they are discharged. An alternative scenario for MAT is lifelong use of the medicine. The actual experience of MAT is clear. Only rare patients taper to zero and are monitored for a period of time and then discharged. The percentage of patients who stay in the programs for many years is also relatively small; although, these multiyear patients are very common in MAT programs. The large majority of MAT patients drop out while still taking medicines. This virtually always means that they return to nonmedical opioid use. In a high quality methadone program we have studied, about 60% of patients left treatment within less than a year and 18% either stayed with the program or were readmitted to it five years after entering treatment. In a similarly high quality treatment

program using buprenorphine to treat opioid dependent patients, only 5% of newly admitted patients were still in the program a year later. In addition to the problem of retention is the problem of continued use of drugs of abuse during MAT which I have seen ranges from a low of about 20% to a high of more than 50%

These concerns can be summarized in three questions. First, what percentage of patients who enter MAT either stay in the program for life or successfully taper off and are then monitored for relapse before discharge? Second, what percentage of patients are continuing to use alcohol, marijuana and other drugs while they are in treatment? Third, what happens to patients after they leave MAT? Are they better off than they were when they entered treatment?

The public widely expects substance abuse treatment to “fix” the addict. No treatment, with or without medication, can “fix” the addict because the risk of relapse is lifelong and treatment is brief. The public – and apparently those who pay for substance abuse treatment – do not understand this reality about the prognosis of addiction after any treatment. It is hard to imagine that any families bringing a patient into treatment would consider a 20% reduction in opioid use for a few months to be a reasonable outcome of treatment.

To move forward we must define the goal for substance abuse treatment. What is the standard against which all substance abuse treatments, both those using medicines and those not using medicines, can be measured? This question led me nearly a decade ago to conduct the first national study of the nation’s state Physician Health Programs (PHPs). My colleagues and I looked at PHPs because I had treated many physician addicts in my own practice. I had seen their outstanding results. I had also participated with many others in the development of the Betty Ford Institute’s¹ landmark definition of “recovery” from substance use disorders, including opioid dependence. Recovery includes no use of alcohol and other drugs. Our PHP study

demonstrated that recovery could be the expected outcome of treatment rather than relapse. This PHP study also emphasized the importance of long-term random monitoring after leaving treatment and participation in community support programs.

We recently extended our analysis of our PHP data to compare the outcomes for physicians who were dependent on opioids to those who were dependent on alcohol alone, and to the physicians who were dependent on other drugs with or without alcohol. The physicians in all three groups were randomly monitored for any use of alcohol, opioids or any other drugs for five years. The opioid dependent physicians did not receive buprenorphine or methadone but a few used naltrexone (in many cases because of problems with alcohol rather than opioids). The opioid dependent physicians did as well as the physicians in the other two groups with 75% to 80% of all three groups never testing positive for alcohol or other drugs including opioids.ⁱⁱ Of course, the physician addicts are different demographically from typical MAT patients. Nevertheless, these data demonstrate that the biological disease of opioid dependence can – in this situation at least – be successfully treated without substitution therapy.

We are now conducting a study of these physicians five years after their mandatory monitoring ended to assess the stability of their recovery. While the study is ongoing, preliminary analysis showed that 97% of the physicians were licensed to practice medicine and a similar high percent reported that they considered themselves to be in recovery. When asked to rate their PHP experiences on a scale from “extremely hurtful” to “extremely helpful” only 3% said it had been hurtful to any extent, the remainder reported their PHP experience was helpful with nearly 50% reporting “extremely helpful.” When asked to rate which of the various components of the PHP program were most valuable to them the highest rating went to

participation in the 12-step fellowships, followed by their formal treatment experiences and their sustained random monitoring.

One controversial issue in defining recovery is whether a person can be considered to be in recovery while using medications including buprenorphine, methadone and naltrexone. I emphatically answer “yes” to that question – as long as the medication use is consistent with the prescribing physicians’ instructions, and as long as the patient is not also using alcohol other drugs of abuse.

I recognize that the ultimate goal of sustained recovery is difficult to achieve, and even controversial. I also recognize that there are many interim goals of treatment along this path to sustained recovery that are worthy of evaluation and support. In addition, I recognize that some opioid dependent people achieve sustained recovery without treatment.ⁱⁱⁱ Nevertheless, I am convinced that failure to define this (or some other ultimate goal of treatment) means that the entire treatment enterprise lacks focus. In addition, it is difficult to compare the outcomes of alternative treatments in the absence of a shared definition of the goal of treatment.

My hope is that this Committee will encourage all substance abuse treatment programs, both those that do and do not use medications, to keep track of two numbers and to routinely make them public: what is the retention rate of the treatment? And what is the drug use of patients during treatment? Beyond that, it is my hope that this committee will request that the National Institute on Drug Abuse (NIDA) and Substance Abuse and Mental Health Services Administration (SMHSA) fund several pilot programs to establish practical strategies to assess the Five-year recovery outcomes for various substance abuse treatments.

My testimony today is focused on the need to improve substance abuse treatment, especially but not only the treatment for opioid dependence. In this context I return to our decade long study of the state PHPs which I believe set the standard for achieving sustained recovery. This is a standard toward which all substance abuse treatments can usefully aspire. While the PHPs use high quality treatment, the treatment itself is brief, often one to three months of residential treatment or several months of intensive outpatient treatment. The PHPs also address other issues which contribute to addiction including comorbid mental and physical disorders. They insist on active, sustained participation in community support programs, mostly but not only Alcoholics Anonymous and Narcotics Anonymous. This unique system of care management also includes continuous random monitoring for any alcohol or drug use linked to serious consequences for even a single use. The PHP model is a not a model of substance abuse treatment. It is instead a model of care management. The PHPs do not themselves do any treatment or monitoring, all of that is done by others under the supervision of the PHPs.

PHP care management could hardly be more different not only from MAT but also from typical abstinence-oriented treatment. Skeptics say the PHP model is utopian and thus irrelevant. But the fact is that some treatment programs, including the Caron Foundation, are now experimenting with PHP-like contracts for patients leaving treatment that include active random monitoring and vigorous supervision of the patient participation in community support as well as early identification of any relapse. I see similar new thinking in the courageous model being developed at Hazelden, the distinguished source of all modern AOTs, as it has added buprenorphine and naltrexone to its armamentarium for opioid dependent patients. This experiment holds the promise of helping to break down the counterproductive wall between MAT and AOT. Our study of an exemplary methadone program asked about the experiences of

patients with Alcoholics Anonymous and Narcotics Anonymous because one of my colleagues complained of the harm done by the 12-step fellowships to patients in MAT. What we found surprised me. “More than three quarters of respondents (77.2%) currently participating in NA said that it was very or extremely helpful to them; 72.4% of current AA participants rated this activity as very or extremely helpful. Only about 3.5% of each group said that NA or AA was not helpful.”^{iv} This methadone program staff had not known of this widespread involvement with AA and NA until our study. This too is an example of new thinking about treatment, thinking that is outside the old paradigm of MAT vs AOT.

Once the goal of sustained recovery is established for opioid treatment and once the disorder of opioid dependence is defined as a serious, chronic and often fatal disease there is new hope for the widespread application of the PHP-like long-term care management in the new direction of health care. Health-care is moving away from brief and expensive episodes of care to long-term, even lifelong, disease monitoring and management. This effort is devoted to the prevention of relapse and to early intervention when relapses do occur. This is increasingly the case for diabetes, coronary artery disease, and asthma. In the not too distant future, I expect that opioid dependence will be added to that list of serious chronic – and high cost – diseases. When that happens the PHP model of care management for opioid dependence will become the standard of care.

In conclusion, the concerns I have expressed for MAT are no different from my concerns for AOT. Both need to shift their focus away from relatively brief episodes of treatment to the long-term goal of sustained recovery. That means shifting the focus from only what happens to the patients in treatment to include what happens to them when they leave treatment. There is plenty of room for improvement in all forms of substance abuse treatment. Having a measurable

goal will help all treatments achieve their full potential as important parts of the nation's response to the current, devastating opioid epidemic.

ⁱ The Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, 33, 221-228.

ⁱⁱ McLellan, A. T., Skipper, G. E., Campbell, M. G. & DuPont, R. L. (2008). Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *British Medical Journal*, 337:a2038.

ⁱⁱⁱ Humphreys, K. (2015). Addiction treatment professionals are not the gatekeepers of recovery. *Substance use & Misuse*, 1-4.

^{iv} White, W. L., Campbell, M. D., Shea, C., Hoffman, H. A., Crissman, B., & DuPont, R. L. (2013). Coparticipation in 12-step mutual aid groups and methadone maintenance treatment: a survey of 322 patients. *Journal of Groups in Addiction & Recovery*, 8(4), 294-308.

Other Relevant Publications

1. DuPont, R. L. (1990). Saying 'no' to heroin use: A dilemma in a free society [Foreword]. In W. H. McGlothlin & M. D. Anglin (Eds.), *The Compulsory Treatment of Opiate Dependence*. New York: Haworth Press.
2. DuPont, R. L. (1990). Benzodiazepines and chemical dependence: Guidelines for clinicians. *Substance Abuse*, 11, 232-236.
3. DuPont, R. L. (1990, October). Benzodiazepines and chemical dependence: Clinical guidelines. In *Practical Clinical Management: Drug Abuse Education for the primary Care Physician* (Monograph of Conference Proceedings, pp. 51-59). Baltimore Medical and Chirurgical Faculty of Maryland.
4. DuPont, R. L. & Humphreys, K. (2011). A new paradigm for long-term recovery. *Substance Abuse*, 32(1), 1-6.
5. White, W. L., Campbell, M. D., Spencer, R. A., Hoffman, H. A., Crissman, B., & DuPont, R. L. (2014). Participation in Narcotics Anonymous and Alcoholics Anonymous and abstinence outcomes of 322 methadone maintenance patients. *Journal of Groups in Addiction & Recovery*, 9(1), 14-30.
6. White, W. L., Campbell, M. D., Spencer, R. D., Hoffman, H. A., Crissman, B., & DuPont, R. L. (2014). Patterns of abstinence or continued drug use among methadone maintenance patients and their relation to treatment retention. *Journal of Psychoactive Drugs*, 46(2), 114-122.