

Monmouth Behavioral Medicine, LLC
Psychiatry, Behavioral & Addiction Medicine

2517 State Hwy 35, Bldg J, Suite 103
Manasquan, NJ 08736
732-477-4470 v 732-818-0050 f
monmouthbehavioralmedicine.com

The Truth About Opiates And Treatment For Opiate Addiction

Russell Ferstandig, M.D., Medical Director

Diplomate of The American Board Of Addiction Medicine

© Copyright 2013 Russell Ferstandig, M.D., All Rights Reserved

There is no mystery about how opiates affect humans because their impact on animal brains, especially human brains is well known. However there is an abundance of misinformation about their use in medicine, their addictive potential and effective treatment options. The purpose of this article is an attempt to set the record straight about the basics of how opiates affect humans and what is needed to recover from opiate dependence and addiction.

The Unavoidable Effect Of Opiates On Humans

All opiates affect the human brain in essentially the same way regardless of the reason for their use. Said another way, you can become addicted to opiates just as easily if they are prescribed by your doctor as if you used them recreationally. Your brain does not know why opiates are present. It only knows that they are present.

What matters to your brain is which opiate and how much is present. It is also important how the opiate is taken and for how long. A simple rule of substances that have potential for abuse is that the faster they can be transferred into the brain, the more addictive they are. Therefore, IV use and smoking of a drug is way more addictive than if the drug is taken by mouth, with snorting the drug falling somewhere in the middle. It is my belief that when the same substance is either injected IV or smoked compared to taken orally, that the perceived quantity of the substance by the brain can be as much as 50% more because of the sudden and elevate spike in the blood levels of the substance at the brain.

Many of the problems caused by opiates can be best understood when one understands how the brain responds to internally produced opiates. The animal and human brain has a natural opiate system for short-termed emergencies to help the animal/human survive. This system is triggered by naturally occurring opiates called endorphins and enkephalins, which are produced and released by the brain in minute quantities for short periods of time (seconds) to produce an opiate response to help an animal/human deal with pain, especially to override pains in life-threatening situations. When opiates are present in small amounts for short periods of time, there is essentially no chance of addiction.

Problems with opiate addiction occur when opiates are present in large quantities for hours, days, if not months or years, as is the case with heroin, opium and pharmaceutical opiates, both real and synthetic. The part of the brain that regulates the natural opiate system starts to become less sensitive to the opiate stimulus as an adaptive mechanism to keep the animal/human alive and not succumb to opiate overdose. People experience this reduction of sensitivity as “tolerance”, where they need more opiate to achieve the same effect that they once achieved with less opiate.

Typically most people will start to experience this protective adaptation/tolerance starting around 4-5 weeks of constant opiate use, although the problem can manifest after just 2 weeks, with the magnitude of the problem becoming much worse as the duration of time on opiates increases. If the dose of the opiates continues to increase, the animal/human will eventually reach a point, “the wall”, where additional opiates no longer produces any benefit, although many negative side-effects like respiratory suppression continue to worsen as the dose increases. It is usually at this point that many people either start to contemplate stopping their use of opiates due to the lack of desired result, or they engage in an irrational escalation of dose in a desperate attempt to reinstate a formerly present opiate effect.

Opiate Dependence/Addiction and Withdrawal

Most people are used to being able to control their behaviors. Therefore it is not surprising that initially people expect that they will be able to control their personal opiate use. Due to the natural protective brain responses to sustained opiate presence, the brain progressively adapts to the prolonged presence of opiates by becoming less sensitive to them, thus starting the mechanism of opiate dependence. Consequently, only a small percentage of people who takes opiates for longer than several weeks actually succeed in ceasing their use without professional treatment due to their inability to tolerate the unavoidable and extremely unpleasant opiate withdrawal symptoms.

Those who experience withdrawal of varying degrees typically revert back to taking opiates to “maintain” a non-withdrawal state by using enough opiates to prevent withdrawal symptoms, which in turn actually worsens their dependence on the opiates. Even the smallest amounts of opiates taken for several months, as is the case with most pain management treatment programs, can produce withdrawal symptoms upon cessation that will lead all but the strongest and most determined to resume their intake of opiates or seek professional treatment, typically within 3-4 days of onset of the unavoidable progressive withdrawal symptoms.

Sadly due to the stigma of opiate use, most people are reluctant to admit to others their fears about their use of and potential emerging problems with opiates. This avoidance of disclosing opiate problems increases markedly once a person realizes that they can no longer control their opiate use due to dependence on the substance and the discomfort from the opiate withdrawal that occurs when they try to reduce their dose.

Consequently, upon realizing that one's use of opiates is beyond their control, most people opt to try to solve the problems quietly and by themselves. This almost always produces a scenario where the individual quietly, if not secretly, continues their use of opiates with the belief and hope of reducing their intake. Sadly almost no one succeeds in being able to reduce their dose of opiates on their own. In fact, instead of being able to reduce their opiate dose, almost always this approach leads to a progressive increase in daily consumption of the opiate.

Depending on an individual's magnitude and duration of opiate consumption, their withdrawal symptoms can easily last as long as a year and almost always last at least a month or two. Typically the withdrawal is divided into two phases, the "acute" and the "chronic". As the name suggests, the acute phase is when the symptoms are the most severe and constant. The acute phase almost always lasts at least a month.

The chronic phase of withdrawal is somewhat more tricky than the acute phase because the symptoms come and go, creating an illusion during phases of no symptoms that the withdrawal is over. Of the people who do not go to a rehab for the first 28-30 days, probably less than 10% of people ever get to the chronic phase because most have great difficulty abstaining beyond the third or fourth day of opiate withdrawal because the nature and severity of the symptoms become too uncomfortable to tolerate by day three or four. Sadly around the third or fourth day of withdrawal, most falsely conclude that if they can make it to three or four days, they could stop their opiate use any time they wish and thus "choose" to return to using opiates because they convince themselves that they can continue to use opiates without significant risk. Ironically, realizing the huge inaccuracy of this false belief that it is their choice to return to opiates, rather than the withdrawal forcing them to return seems to be one of the steps necessary for someone to be able to truly recover from opiate abuse.

The people who spend 7-14 days in an opiate detox program are discharged in the midst of the acute phase of withdrawal and thus the norm is for them to rapidly relapse. Those who attend a 28-30 day rehab frequently manage to make it all or most of the way through the acute phase of withdrawal and frequently leave the rehab feeling as if the withdrawal, and thus their opiate use, is behind them. Unfortunately most of them "mysteriously" relapse within the next 1-3 months with no clear reason other than an unexplained resumption of craving, which of course signals the return of the withdrawal symptoms.

While the physical symptoms of opiate withdrawal are well known (severe flu-like symptoms, joint and bone pains, hot and cold flashes, muscle spasms, etc.), probably the most difficult symptom to tolerate from opiate withdrawal is opiate craving. Craving should be distinguished from cue-behavior where something reminds an individual of their previous opiate use.

Opiate craving is physiologic and sadly one of the first symptoms of withdrawal to appear and the last to stop with withdrawal treatment. It manifests as a constant thought about using opiates, almost like a little devil on one's shoulder with a bullhorn coaxing one to use. Sadly craving is so powerful that most people will ultimately succumb to their craving, regardless of logic, especially when life's pressures accumulate.

Equally problematic to craving's ability to drive addictive behavior is that craving from opiate addiction persists throughout the duration of withdrawal and thus can easily be present for up to a year if an individual had serious opiate dependence issues, regardless if it was due to prescribed opiates from a doctor or from illicit sources.

Opiate Treatment

Medications

While treatment for addictions is one of the most difficult behavioral health tasks, treatment for opiate addiction is particularly complex, and almost always requires pharmacological agents that control opiate withdrawal symptoms to have any realistic chance of lasting success. Currently, the two best pharmacologic agents are Suboxone[®] or generic buprenorphine, and methadone.

Properly used Suboxone is a way to eliminate withdrawal symptoms both initially and as the brain heals till the withdrawal symptoms are no longer present in the absence of withdrawal controlling substances like suboxone. At this point, Suboxone is no longer necessary because the brain has reverted back to its pre-opiate state, with the individual feeling like they have never taken opiates. Only one symptom persists at this point and, sadly for the rest of the individual's life, a hypersensitivity to opiates. This hypersensitivity is much like an allergy although the actual cause is unknown. Basically this hypersensitivity means if an individual is re-exposed to opiates, the reinstatement of their previous levels of tolerance and dependence occurs within several days. Said another way, if one goes back to even a small amount of opiates following a full recovery at any time in their life, they will almost certainly fall back to at least their previous worst opiate dependence unless there is professional intervention almost immediately with a total cessation of the opiate intake. Therefore, it is important that these individuals try to avoid for the rest of their lives, opiate intake of any amount if at all possible, even a Percocet or Vicodin from their dentist for a root canal or tooth extraction.

Methadone, on the other hand, when used as part of opiate withdrawal treatment and not being used for pain management, is purely used for transferring a patient from an opiate to an equivalent dose of methadone in an effort to hold the person at that dose rather than continue to experience the dose escalation that occurs as a result of tolerance when someone is on opiates.

In my professional opinion the two medications provide completely different results and thus should not be considered similar treatments. Suboxone provides a true exit from opiate dependence while methadone shifts the problem from opiates to methadone dependence. In addition, methadone can and typically does produce more lasting and significant side effects. Another negative of methadone treatment is that one must attend a methadone clinic daily and thus must encounter a population that can be less than desirable because of the high prevalence of individuals who are still actively using and possibly selling opiates.

Medication and Drug Screens

Sadly random supervised medication and drug screens are needed to insure that the medications (Suboxone and methadone) are actually being taken by the patient as prescribed and to insure that they are not being diverted from legitimate use to illegitimate/illegal use, especially being sold to or traded with drug dealers who then sell them to drug abusing individuals.

Since Suboxone is so effective and rapid at stopping withdrawal, it is very popular amongst opiate abusers on days when they do not have enough funds to purchase the opiate that they are addicted to in the quantities necessary to prevent the onset of withdrawal. Therefore, in an attempt to prevent diversion of Suboxone from legitimate usage to illegitimate usage, it is necessary to conduct random drug screens for substances of abuse and for Suboxone metabolites using either urine or oral fluids. This is the only way to insure that the Suboxone is being used by a patient and not being sold for cash or swapped for opiates with a drug dealer.

It is my experience that patients who are attempting to divert Suboxone for illicit use are much more likely to go to doctors and lie to obtain Suboxone if the doctor is not using sophisticated drug screens that identify the actual drug being used and its metabolites. These sophisticated drug screens make it much harder for the patient to succeed with their lies to obtain unnecessary Suboxone that is likely to be diverted to illicit use than a simple basic 6 test urine screen that is much easier to “beat” or to offer a “plausible” explanation for a positive test.

Therapy and Behavior Change

Repeatedly and consistently outcome studies of opiate treatment programs demonstrate that there is a huge difference in recovery rates between programs that focus merely on ceasing the usage of opiates compared to programs that combine opiate use cessation with highly focused therapy and frequently cognitive behavioral therapy aimed at helping the individual shift their coping skills with life’s daily challenges. The addition of therapy to treatment with a sole focus on ceasing use of the opiates can increase the rate of long-term sobriety (measured at 6 months following completion of treatment) up to 300%.

The role of the therapy is to teach the individual healthier and more adaptive lifestyle behaviors to replace their prior highly maladaptive behaviors that tend to promote ongoing opiate addiction. Fortunately, the substitution of healthy beliefs and behaviors for the lies and maladaptive behaviors of addiction becomes much easier with repetition.

Probably the most important of these behavior shifts is how an individual copes with the unavoidable stresses of daily living. While most people actively addicted to opiates have a number of “explanations/rationalizations” for why they continue to use opiates, difficulty coping is almost universally the actual reason for their ongoing opiate use. Therefore, any gains in their coping skills greatly helps the addicted individual with their recovery.

Inherent in their ongoing use is the string of extensive lies that any addicted individual tells themselves in order to continue to engage in addictive behaviors that clearly, at least to those other than the addicted individual, cause many more problems than they solve. Helping an individual realize that their opiate usage actually makes it harder for them to cope with the stresses of daily life than facing them head on and sober is a critical step in their early recovery.

Through repeatedly showing them that they actually cope better sober and produce less secondary problems that ongoing opiate use always brings, many people start to realize the true cost of their opiate dependence. Sadly prior to this realization, most people calculate the cost of their opiate use by how much money they spend on the opiates and the discomfort that arises when they go into withdrawal.

Unfortunately, most opiate treatment programs focus on getting people off of the medications with little or insufficient effort spent on the needed behavior changes and coping skills that will help insure a long and healthy recovery. Also many of the counselors who are charged with addressing the needed behavior changes of the opiate addict are overworked and typically insufficiently skilled for the very difficult task at hand. If the treatment program is not located where the individual lives, then there is the additional problem of finding the appropriate and highly needed follow-up treatment once they complete the initial phase of their treatment and return home.

Twelve-Step Programs and Meetings

Twelve-Step programs are readily available throughout the world and especially in the United States. Like all self-help programs, the efficacy of 12-Step programs varies from meeting to meeting and is largely dependent on who are the key people behind each individual meeting. While opiates are clearly a type of narcotic, many opiate addicts find that they benefit more from attending Alcoholics Anonymous than attending Narcotics Anonymous because AA meetings tend to have more people than NA meetings with long term sobriety, less “war stories” and no drug dealers preying on individuals in early recovery or still actively using. Many report that NA is stronger and healthier in general,

The Dr. Russ Two-Prong Approach To Opiate Treatment

During the time that I have been treating patients with opiate dependence issues I have experimented with a number of treatment designs to determine the best treatment design to provide the highest percentage of long-term (at least one year post treatment) sobriety. Clearly the most effective approach that I have explored I call the "*Dr. Russ Two-Prong Opiate Treatment*".

Prong One

The first prong of the *Dr. Russ Two-Prong Opiate Treatment* is to initially restore the patient's physiology to some semblance of normality. Obviously with opiates the first physiologic abnormality that must be addressed is opiate withdrawal, which is both incredibly uncomfortable and can mimic many other medical and psychiatric problems, especially severe anxiety and/or depression.

Fortunately, Suboxone, when taken properly and in sufficient doses is capable of 100% elimination of all symptoms of withdrawal. It is critical to eliminate all of the withdrawal symptoms including the most difficult to eliminate, craving for opiates. It is my strong professional opinion, that unless opiate craving is eliminated by eliminating all symptoms of withdrawal, it is essentially impossible to cease use of opiates without incarceration or with restricted access to public places as occurs in a long-term rehab.

As the opiate user's brain starts to heal, the amount of Suboxone needed to stop the withdrawal symptoms decreases until Suboxone is no longer necessary when the brain has reverted back to its pre-opiate state. The reduction of the Suboxone dose as the brain heals is called the "Suboxone Taper" and takes as long as it takes for the body to recover from withdrawal, typically 6-12 months. Attempts to taper the Suboxone dose faster than the body will allow is guaranteed to precipitate a return of withdrawal symptoms until the proper Suboxone dose is reinstated. This return of "withdrawal" always means the return of craving, the first of the withdrawal symptoms to occur, which as I have already stated several times, almost always leads to a resumption of active opiate use.

Sadly the majority of Suboxone providers do not use Suboxone properly, producing a less than optimal result for the patient and thus exposing them to unnecessary risk or relapse by allowing their withdrawal symptoms to return. This also has contributed to many people believing that Suboxone is not effective, rather than realizing it is the best option available assuming that the prescriber is sufficiently educated and skilled with Suboxone prescribing.

There are three main reasons for poor Suboxone results:

- 1. Improper technique when taking the Suboxone films**

If the films are not taken properly the optimal transfer of the medicine from the films to the opiate receptors in the brain does not occur. This can result in markedly less of the medicine (10% instead of 90%) being absorbed from under

the tongue and actually attaching to the opiate receptors in the brain.

2. Insufficient dosing of Suboxone to totally stop withdrawal symptoms

Suboxone treatment is a “numbers game” because efficacy is based on the number of opiate receptors that have a molecule of buprenorphine (the main active ingredient in Suboxone) attached to them. Any receptors that do not have a molecule of buprenorphine attached and quieting it are susceptible to the type of receptor excitation that occurs during withdrawal and thus contribute to the production of withdrawal symptoms. The more excited receptors, the worse the withdrawal symptoms. Since craving is the first withdrawal symptoms to return is likely to produce relapse, any withdrawal symptoms greatly increases the chance of relapse. I find that almost all patients need between 24-32 mg of Suboxone at the beginning of their treatment to insure no withdrawal symptoms, and therefore no craving, thus helping insure a chance of lasting recovery from opiates.

3. Suboxone must be used in the appropriate dose till the patient’s brain has healed back to its pre-opiate state and withdrawal is totally over

Suboxone “fools” the brain into thinking that the brain alteration from long-term opiate exposure is not present. This alteration, or neuro-adaption, results from the brain’s natural tendency to become less sensitive to the presence of opiates with time as a survival mechanism, thus causing dose tolerance to opiates which in turn forces the individual to take more opiates to achieve the same effect that they once achieved at a lower dose.

The amount of Suboxone necessary to fool the brain into thinking that there is no neuro-adaptation to opiates (opiate insensitivity) occurring in the brain varies with the state of brain sensitivity to opiates. As the brain heals, the brain’s neuro-adaptation reduces as it reverts back to its pre-opiate state. As this adaptive insensitivity to opiates decreases, the opiate receptors become less excitable and thus a single molecule of buprenorphine can now control more than one receptor at the same time, with the number of receptors controlled by a single molecule of buprenorphine increasing as the receptor excitability reduces. The net result of this process is that the amount of Suboxone necessary to keep the individual from reverting back into withdrawal decreases as the brain heals until the healing process is over. At this point Suboxone is no longer needed to prevent the return of withdrawal symptoms.

Most of the patients who come into my offices who are addicted to opiates are addicted to either oxycodone (a semi-synthetic codeine product roughly equivalent to morphine in its opiate strength) or heroin. Almost all heroin dependent people start on oxycodone (Roxy’s or Blue’s) and then convert to heroin because it costs about a third as much and produces a somewhat different type of high.

Almost everyone I treat is addicted to at least 6 30 mg Roxy's per day, with most snorting the ground up pills, and thus creating a more intense, but shorter high. The highest dose of oxycodone I have seen is 150 Roxy 30 mg pills snorted per day. If the patient is using heroin they typically come into my offices using somewhere between 5 "bags" and 30 "bags", with most snorting the heroin initially and then many shifting to IV injection. The highest dose of heroin use I have seen is 123 bags IV per day.

The typical duration of withdrawal for the low end of my patients' use of oxycodone or heroin is 6 months minimum with those patients using the higher doses withdrawal lasting at least a year. Said another way, the duration of the Suboxone taper for my patients using the lower doses is a bare minimum of 6 months and for those using the higher doses at least a year and possibly two if they were using the opiates IV.

Another important part of the first prong is attempting to correct any biological or physiologic imbalances that might be present in the patient possibly from their genetics, diet, some other medical problem and/or as a consequence of some life stressors that are impacting them. By addressing these problems and trying to normalize them there is a high probability that the individual will have fewer triggers like depression and/or anxiety that probably formerly played a role in their using opiates to feel better emotionally. Conversely, failing to address these problems greatly increases the chance of opiate relapse when the depression, anxiety, etc. symptoms are severe.

Prong Two

The second prong of the *Dr. Russ Two-Prong Opiate Treatment* is to address an individual's reflex thoughts, perceptions and behaviors that dictate most of their daily functioning. This prong is essentially a highly customized individual behaviorally oriented therapy to help an individual better understand how certain stressors and cues impact their thoughts and behaviors. Hopefully, they will realize that have developed a pattern of using drugs and/or alcohol to numb their awareness of their emotional discomfort with their current real-life scenarios.

As they better understand the true cost of hiding in drugs and alcohol and the undeniable fact that with opiates, if use continues, things always get worse. Ironically, it is also important to remind them that since they are on Suboxone and not experiencing any withdrawal symptoms, that the real world options available to them are quite different and more positive than when they try to stop their opiate intake and attempt to endure their withdrawal symptoms, which almost always fails within days or weeks.