Once Bitten Twice Shy - the Recovery Community and the False Promise of Harmless Drugs

"*Pay no attention to the man behind the curtain*!" — **Noel Langley, The Wizard of Oz Screenplay**

On March, 18th, 1898, Heroin was introduced to the world as a cough suppressant by its maker, Friedrich Bayer & Co, now known principally as a producer of Aspirin. Bayer marketed Heroin as a cough suppressant with weaker narcotic properties than morphine. Time and evidence have proven otherwise. In respect to highly addictive drugs being produced and marketed as aids to minor ailments or "cure all" elixirs, it was not unique. It occurred in the heyday of patent medications and even occurs now in our own times. This was how the modern medical market in America was born and in some respects continues to operate. To move forward with greater efficacy and to reduce iatrogenic harm, we must do better in how addictive drugs are marketed to persons at risk for addition or those of us in recovery.

We have examples from our modern era, Valium (diazepam) was the miracle drug first introduced in 1963. Initial reviews into the addictive potential of benzodiazepines quickly dismissed any concerns, the safety profile was taken for granted. Patients were irresponsibly given greater doses for longer durations than necessary. More thorough critiques of the clinical and preclinical literature suggested dependence was a substantial factor, although mostly in cases of higher dosage and duration. By the 1990s, the scope of benzodiazepine addiction had been expanded to not only dosage escalation, but even chronic low-level administration. Earlier in our history, cocaine was billed as a treatment for alcoholism and morphine addiction. Time and evidence now show us that these some drugs carry a great deal of risk.

In America, drug marketing has long portrayed harmful drugs as harmless, non-addictive and beneficial since the inception of the industry. Consider the tobacco industry executives testifying under oath in front of Congress in 1994 and lying through their teeth. Decades earlier they marketed cigarettes as a safe health aid to reduce stress. One reason that there is deep distrust in the recovery community is how drugs are marketed as beneficial and non-additive in ways that are proven wrong over time. It takes time for the bloom to fade and the truth to be evident. It has long been the case that the promises of a drugs benefits fail to match the real-world experiences of persons at risk for addiction.

A mentor in recovery with a pharmacy background once noted to me that the only safe drug is a new drug. This is not to say that these drugs are not beneficial, they are. However, it is to highlight how they are often presented as having few risks or downsides, particularly in respect to addictive qualities. These historic tendencies of overpromising safety and efficacy and hiding or minimizing consequences is why there is such profound distrust for medications in the recovery community. Understanding these dynamics is critical for changing how the recovery community views medications that are safe and effective when taken as prescribed and combined with proper treatment and support. It is a subject that has received scant discussion at the policy level but should get significant focus.

The Example Gabapentin aka Neurontin

The drug that for me most recently illustrates this distrust in the recovery community for prescription medications is Gabapentin. It was approved by the FDA for use by Parke Davis in 2000 as an adjunctive therapy for epileptic seizures. As highlighted in this AMA Journal of Ethics, Neurontin and Off-Label Marketing (2006) Parke David illegally marketed it for over a dozen off label uses, including neuropathic pain. The company hired ghost writers to talk about how effective it was to drum up sales. As this STAT news piece New on the streets: Gabapentin, a drug for nerve pain, and a new target of misuse (2017) notes, one of the claims was that it was non-addictive. This of course was also not true.

This misrepresentation of Neurontin for which the company legally settled for 430 Million Dollars and pled guilty to resolve civil and criminal charges is burned into my memory. It is for me an experience of moral wounding. I told dozens if not hundreds of clients of mine that this drug was non-addictive as this is what the doctors were telling us. They were following what they learned as the ghost writers misrepresented the drug nationally. We all trusted what we were being told. It had tragic consequences for many of my clients. Some experienced terrible consequences as addiction took hold starting with this drug and the false claim it was safe and not habit forming for people in recovery. Probably about a third of all the clients in the program I was responsible for were on this drug. A painful lesson I will never forget.

We now of course know that Gabapentin was being used recreationally on the street and in this paper it was directly involved in the death of users in just under half of the cases reviewed. Gabapentin: Abuse, Dependence, and Withdrawal (2016) found addictive use of the drug and all the cases of addiction were in patients who had a previous history of alcohol, cocaine, or opioid abuse, conditions it was also marketed off label to treat.

In our current era, we see drugs like Kratom and Ketamine being used in some ways that people see as helpful, and others have found harmful. I know people who have gotten into trouble with these drugs even as others have claimed they were beneficial for them. In my mind the jury is still out on their safety and efficacy. I doubt my sense or reticence here is unique. Our experience is often in conflict with what we are told is true in respect to a lot of drugs in our space. Time and observation are our way of knowing. This makes our world even more challenging to navigate.

While there is a great deal of vilification of communities of recovery who have been hesitant to accept medication supported recovery, to fully understand their reticence, we must also understand the context of their concern and their distrust for what they are told by the purveyors of addictive drugs. This community has been lied to so many times by the drug industries. We have watched people die because of assurances that drugs in the market were claimed to be safe, effective and non-addictive later to learn that this is not the case by watching people we loved die.

One of the consequences of this dynamic is that there has been a great deal of distrust in respect to medications such as buprenorphine. I had reservations and doubts in no small way based on my experience described above with gabapentin and with other overhyped drugs claiming safety and efficacy. The evidence I tend to believe in is what I can see with my own eyes. Years later, I now know many people who have used and in some cases are still using buprenorphine as part of their recovery pathway. It is working when used as part of a comprehensive recovery program. People I know describe it as a lifesaver for them in many instances. Evidence which is now broadly available to our recovery community.

Being entirely candid here, because of what I have learned about the misrepresentation of drugs that have impacted our community, I had to see recovery with medication pathways with my own eyes to believe the presented evidence. I suspect that this was not uncommon for many other evidence base oriented members of the recovery community. The paradox here is that skepticism, at times born out of experience, can also make people on medication pathways not feel very welcomed or supported in the recovery community. The result here is in no small part a result of the historic misrepresentation of drugs in the marketplace as it also inhibits their effective use it is valid and beneficial.

One parallel here to illustrate the point is the Drug Abuse Resistance Education (DARE) program. It started in 1983 under the premise that if you tell kids drugs are bad and show them the very worst consequences, they would be too scared to use drugs. We know now that much of what young people were told was overblown hype. Kids were told things that they could see with their own eyes were not fully true, so they discounted all the risks and decided that the adults were lying to them. This is exactly how I perceived these messages as a kid. These dynamics are in parallel in the recovery community in respect to how the pharmaceutical industry has historically operated with overhyped claims of safety and efficacy. To effectively move forward, we must properly account for the misrepresentation of drugs to the recovery community if the trust of this community is to be gained.

While it is far easier to brand the recovery community as misguided or ignorant when they are distrustful of drugs presented as safe, perhaps the best path forward, in parallel to what has happened in the DARE program is to insist on more accurate representations of both benefits and potential risks of medications to the recovery community. If we actually do trust that people can make good decisions and support people in the community to make good decisions, we must provide true and accurate information. We should not let companies overhype their products until the truth catches us with them (and us), paid for by members of our community in far too often tragic ways. We must acknowledge that distrust for medication can come from valid experience in our community and seek to correct the

origins of this mistrust, the false assertions of the industries that profit off us by harming us in order to more fully experience their benefit where applicable.

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