

The Wrong Way to Treat Opioid Addiction

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Before Joe Thompson switched treatments for his opioid addiction, he was a devoted stay-at-home father, caring for his infant son after his wife returned to work. His recovery was aided by the anticraving medication buprenorphine. But after over two years free of heroin, Mr. Thompson, a former United Parcel Service worker from Iowa, relapsed and decided to try another kind of treatment program.

Unfortunately, his new counselors insisted that continuing his buprenorphine, though it was approved by the Food and Drug Administration, was just as bad as using heroin, according to his wife, Deborah. He wasn't even allowed to start therapy until he'd been abstinent for several weeks. Stressed by withdrawal, he went to a third center. It, too, banned medication. Within a week of entering the program, he was dead from a heroin overdose. He was 35.

Buprenorphine is one of only [two treatments](#) proven to cut the death rate from opioid addiction by half [or more](#). But the programs Mr. Thompson tried viewed abstinence as the only true recovery — even though abstinence treatment has not been shown to reduce mortality and is less effective than medication at preventing relapse.

Unfortunately, Mr. Thompson's experience is more the rule than the exception. Only [about one-third](#) of American addiction programs offer what many experts worldwide see as the standard of care — long-term use of either methadone or buprenorphine. Most programs view medication as a crutch for short-term use and provide only talk therapies.

This widespread rejection of proven addiction medications is the single biggest obstacle to ending the overdose epidemic. Funding isn't the barrier: Outpatient medication treatment is both [more effective and significantly cheaper](#) than adding inpatient beds at rehabilitation centers. The problem is an outdated ideology that views needing a medication to function as a form of addiction.

Rather than defining addiction as destructive, compulsive behavior, this ideology focuses on physical dependence. If you need a drug to avoid being physically ill, you are considered addicted. So Prozac would be considered addictive, but not cocaine, because quitting Prozac abruptly can cause flu-like symptoms while stopping cocaine doesn't, even though it elicits extreme craving.

In the 1980s, crack cocaine made clear just how addictive cocaine could be, even without physical withdrawal symptoms. Today, both the National Institute on Drug Abuse and the Diagnostic and Statistical Manual of Mental Disorders reject the idea that addiction is synonymous with dependence. Unfortunately, many clinicians, including doctors, haven't caught up.

What is addiction, then? The root problem is craving, which drives a compulsion to use drugs despite the harm they cause. That's what makes crack addictive, while Prozac can be therapeutic.

Because methadone and buprenorphine are opioids themselves, it's easy to assume that using them is "substituting one addiction for another." However, the pattern of taking the same dose every day at the same time means that there is no high or intoxication. Patients on maintenance doses are able to nurture a baby, drive, work and be a loving spouse.

In these patients, addiction is replaced by physical dependence. And that's not a problem for those who have health care coverage: It's no different from needing antidepressants or insulin. When a drug's benefits outweigh its risks, continued use is healthy, not addictive.

Sadly, though, there's another reason for widespread skepticism about addiction medication. It comes from the fact that many patients will continue to misuse opioids. Medication reduces relapse more than abstinence does — but relapse is still common, as in Mr. Thompson's case. In abstinence treatment, however, relapsers drop out and are invisible; with medication, they often remain in treatment.

And remaining in treatment is important because it cuts overdose risk, even during relapse. Many highly traumatized people also need the continued health care support before they are able to quit street drugs.

When we fail to understand that these medications can be used both to reduce harm and stabilize people in recovery, we risk letting the perfect be the enemy of the good. For some, medication is a way to reduce risk while drug use continues. For others, it's a path to rapid recovery. Often, people will need to take the first route to survive long enough to reach the second.

For harm reduction to work, maintenance drugs need to be almost as accessible as street drugs. Whenever people take buprenorphine rather than heroin, their risk of dying is lowered, especially since so much heroin these days is tainted with deadly strong fentanyl. For stabilization, people need empathetic counseling that doesn't view dependence as continuing addiction.

Change will require innovative measures. The government should stop funding and insurers should stop covering any program that does not use all the F.D.A.-approved anticraving medications and does not provide informed consent about their effectiveness. While abstinence can work for some, we need many options. We also need to rethink our regulations for methadone and buprenorphine prescribing.

Then we need to publicly recognize that recovery on medication is every bit as valid as any other treatment. What matters is whether, as Freud put it, you can love and work, not the chemical content of your brain or urine.

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