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Sobriety a Poor Treatment Option? One Hundred Years of Opioid Treatment Re-visited

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In my previous role of Vice Chairman of Psychiatry, and Director of Substance Abuse Services at Nassau University Medical Center, I was given the task of developing a strategy that would address the rising number of addicted individuals, while decreasing poorly funded inpatient beds. Reviewing the literature I found.

1. There is no evidence to suggest that short term detoxification or 28 day rehab services are effective in the treatment of opioid dependence
2. There is evidence that continued opioid abuse changes the neurobiology of the individual, and these changes create a pattern of relapse.
3. Previous models that have allowed for improved quality of life, were those where opioid agonist treatment was the mainstay of treatment.

The model that was developed was to continue to have a small number of inpatient beds for complicated detox patients, however, the mainstay would be Medication Assisted Treatment on “demand”, rather than with the long waiting lists. The model would also allow for access to care for the uninsured and the underinsured. All in all, we felt that the model was a good one, and dealt with the various issues in addiction. It was met by hostility and panic in the community by addiction treatment providers.

I became curious as to why the hostility and began looking at the historical accounts of drug addiction in the United States. Over the 100 years of opiate epidemics in the United States, there have been attempts to "medicalize" addiction, however each effort was met with social and legal pressures. Eventually, physicians themselves gave over control to government, special interest groups and regulators.

As per the APA code of ethics which reads;
Section 5

- A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

We are ethically obliged to study and advance knowledge. We are obliged to educate the public, yet what we find is that the regulatory or legal response supersedes all these attempts. The present opiate epidemic started 15-years ago, and it is not the first epidemic. What makes this epidemic different is the demographics. The community response has also been different in that during the era of 24 hours news cycles and social media, awareness is broader than in previous epidemics. However, there are falsehoods that drive the narrative.

The first falsehood is that this is the "worst" or "only" epidemic of its kind. If we look at historical records we know that in the later 1800's, the United States had an epidemic which had a similar rate as the present epidemic. In 1900 there were 250,000 opiate addicts in the United States with a then population of 75,000,000. We now estimate 1,000,000 with a population of 325,000,000. In fact, there were several opiate epidemics in the United States, with the only "clean" period being during WWII due to disruption of the trade routes. There was a lack of public awareness of these epidemics which had to inner cities becoming the place for the epidemic in 30's and the 40's and later the 70's. As such it was more the connection with crime, and later AIDS. This created the belief that drug was a problem of the "not us" or the "them". The present epidemic has as its face the "suburban child", focusing on the white, middle to upper middle-class communities. It has thus become the epidemic of the "us". Again, this is not unique as we see with the epidemics in the late 50's into the 60's. These epidemics became connected with the "Beats" and later the "Hippies". This therefore became an epidemic of "our children". Even Richard Nixon became involved with the increase in Vietnam vets having tried heroin overseas.

The second falsehood is that blame rests on physicians, rather than looking at the interplay of a variety of forces. The first epidemic had its connection to physicians, but it was broader than just the use of morphine. Opiates became a part of many over the counter formulations, and the rates became as high as the present rates. Although physicians were unaware in the late 1800's, there was a shift in knowledge and more responsible prescribing became the norm, and the removal of opiates from over the counter formulations occurred. Much like the present day however, government regulated use of opiates, closed the Morphine Clinics that were caring for those already addicted to opiates, and were able to live functional lives. True to form, the government closed the stable doors after the horses ran out, and further drove the epidemic underground into the illicit opium and heroin trade where it remained until the 90's. In the present epidemic we have been "educated" and "regulated" to use opiates. In the 1980's through the early 90's opiate pain relievers were to be avoided at all costs aside from cases of cancer pain, and post-operative pain. Yet with the various reports from Pain Management, JCAH and Purdue pharmaceutical, the regulators opened the barn doors again, allowing the horses to leave. The provider was now using opiate medication with the blessing of regulators, to deal with the "5th vital sign".

In fact, satisfaction surveys became the norm and the addressing of pain became central to the questionnaire. However, high satisfaction does not correlate with better outcomes as research from UC Davis shows us. These various forces all are connected to the present epidemic. This is not to say that the physicians were not involved at all, but it is more complex than this. Meanwhile the interventions are designed in such a way that it might limit access to appropriate care and creates a group that is driven underground once again to obtain their drug.

The third and final falsehood is that we provide the "needed" treatment for those addicted. The present model is to enforce sobriety and creating an environment where medical professionals feel that providing opioid medication can lead to serious consequences. These consequences are focused on the physician's exposure to risk, rather than the patient receiving quality care. Creating a forced sobriety model often goes against the obligation of the health care provider to "do no harm". To begin with, there is a difference between physical dependence which is common with individuals on long term maintenance of opiates, and "addiction" which is in fact a relatively rare event as noted by Volkow and McClellan. As physicians grapple with how to tell the difference, patients go into withdrawal and are driven to continued use in order to avoid the discomfort. Rather than looking at options which include maintaining on medication for chronic pain, or finding evidenced base treatment of addiction, the physician, reacting to fear, will choose discontinuation or outside referral. The referral tends to be to traditional modalities of care which are heavily based on inpatient and 12 step programs. There to take away the drug, and send the patient into a setting where they will suffer withdrawal, only to discharge them symptomatic with a decreased tolerance, ready to overdose on previously "safe" doses of heroin etc. Relegated now to the world of "junkies" we incarcerate or mandate into treatments which do not take into account the neurophysiological changes that have occurred and as such, leave the individual vulnerable to relapse. As the epidemic grows we continue to invest in services that as McClellan points out are based on 12 step models, which although useful for some, are not the gold standard of care.

A more "humane" and "ethical" model will include the following components;

1. Removal of oversight by the criminal justice system and the offices of professional misconduct.
2. A formal ownership of Addiction as a medical illness, with physicians playing a vital role in treatment.
3. The creation of programs that can provide agonist therapies early in the course of illness, while also providing the needed psycho-social treatments to assist individuals.
4. Continuous study of the modalities utilized and rapid dissemination of the information. This would involve expansion of the National Institute of Drug Abuse role in the CSAT initiative which creates partnerships between academic and community providers.