Addiction is a Chronic Medical Illness

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Addiction is a chronic medical illness and needs to be viewed as such. For too long addiction has been viewed as episodic and has been treated in a 28-day inpatient rehab or 12-week outpatient program. That fact may explain why treatment outcomes for medication-assisted treatment (MAT) are better than short treatment episodes.

Addiction is a chronic medical illness and needs to be viewed that way if patients who suffer with addiction are to have a chance for proper treatment. DSM-V has changed the proper medical diagnosis of addiction from Substance Abuse or Dependence to Substance Use Disorder that can be considered mild, moderate, or severe. For the purpose of this commentary, I will use the term addiction. Like most chronic medical illnesses, there is no "cure" for addiction. It needs to be managed and mitigated by continuous treatment, usually requiring both behavioral and medication interventions. A common comparison that I have seen is between addiction and diabetes [1]. We want our patients who suffer with diabetes to have a consistent diet avoiding simple carbohydrates, choosing more lean meats and vegetables. Insulin and/or other medications are usually required to keep blood sugars under control. In addiction, we want our patients to avoid people, places, and things that might trigger their dependence and often medication is required to keep the threat of deadly relapses from occurring. For alcohol, the medications may be acamprosate, disulfiram, or naltrexone. For opioids, the medications may be methadone, buprenorphine, or naltrexone. For diabetes, there are physiological etiologies for the disease such as a of lack of insulin production or insulin resistance. For addiction, it is a heightened sensitivity and density of neuroreceptors for the addictive substance in the brain. Both have genetic predispositions. Both have elements of nature and nurture involved. Both have diagnostic criteria. Both have medications and other therapies indicated for treatment. Both have medication adherence issues [2].

The big difference might be the stigma involved in the false belief that addiction involves a moral shortcoming, that people "choose to use." Providers, even addiction specialists, have been known to "fire" patients who suffer with addiction when they relapse on drugs. Do we fire patients who suffer with diabetes when they relapse on donuts? The relapse rates for most addictions are 40-60%. For diabetes, the relapse rates are 30-50% [3]. And yet we look at relapses as treatment failures for addictions and not for diabetes.

Methadone maintenance for opioid addiction was approved by the federal government in the 1970s based on cost-effectiveness. For many years we have known that for every $1 we spend on addiction treatment, we save $6 from our criminal justice system and about $12 in other medical costs [3]. An ounce of prevention is worth more than a pound of cure. The same is true for diabetes. Primary prevention for diabetes involves reducing childhood obesity, reducing sugar-filled sodas and juices, and increasing exercise and movement. For addiction, primary prevention seems less clear. The Drug Abuse Resistance Education (DARE) program was not successful [4]. Primary prevention may start in the home with parents addressing alcohol and drug use, but there is little study on the topic.

For too long the standard treatment for this chronic disease was 28-day rehabilitation programs or 12-week intentsive outpatient programs, but treatment outcomes for medication-assisted treatment (MAT) are far better than short treatment episodes. To not offer MAT in short-term treatment centers, whether they be detox, rehab, or outpatient, is to not follow medical evidence and borders on malpractice. It would be comparable to treating a diabetic crisis until the patient's blood sugars are under 200 ng/mL with a return to their baseline mental status and discharging them without some sort of insulin. It would be a setup for disaster and that is often what we are doing in North Carolina for folks suffering with addictions. Most of the medications for addiction have gone generic, so cost is not as much of an issue. The challenge is a lack of education of prescribers, addiction clinicians, and the general public. The national outcome measures for success in terms of negative urine drug tests for MAT for alcohol and opioids range from 50-80% 6 months after initiating treatment, while self-report data from Alcoholics Anonymous, Narcotics Anonymous, intensive outpatient programs, and detox/rehabs (without MAT) range from 5-15% [5]. While it may be true that "it works if you work it," most people who suffer with addiction find it difficult to work it without MAT.

The most predictive measure of success in treatment for

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most addictions is length of treatment. That is because folks who stay in treatment usually recognize that their disease of addiction is a chronic medical illness.

We know that treatment for diabetes (even with the best compliance with diet and exercise, reducing the need for medication) is lifelong. Would you not check a hemoglobin A1C on somebody with a history of diabetes even if their last one was normal? People who are in recovery from addiction would still need to be checked on and given urine drug tests from time to time. You would not stop treatment for diabetes, nor should we for addiction. Relapse is not a completely dirty word. Relapse can be part of the recovery process if we learn from the relapse in all chronic medical illnesses, including diabetes and addiction. Relapse can be deadly, especially in the recent days of heroin mixed with carfentanyl derivatives. More than ever, we need to prevent relapse. The best way to prevent relapse is to remember that addiction is a chronic medical illness that needs to be treated as such, with the opportunity to remain on MAT indefinitely, as the patient and prescriber together deem it necessary. NCMJ

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