Is it really possible to fight addiction with medication?

America is facing an opioid epidemic. Drug overdoses are now the leading cause of accidental death in America, overtaking traffic fatalities at the beginning of this decade. According to the Centers for Disease Control and Prevention, more people died from heroin-related causes than from gun homicides last year (as recently as 2007, firearm homicides dwarfed heroin deaths by a ratio of more than 5-to-1).

As the statistics get more alarming, treatment experts are seeking out and finding more sophisticated solutions. And medication-assisted treatment — a combination of counseling, behavioral therapy and expertly prescribed medicines — is emerging as a powerful tool to combat addiction.

“This is a brain illness. Let us treat it with the respect it deserves and let us treat the illness like we treat the rest of medicine: in a manner that encompasses medication and non-medication modalities,” said Tonmoy Sharma, CEO of Sovereign Health Group, a San Clemente-based national provider of behavioral health services.

But medication-assisted treatment has a stigma attached to it: the idea that it doesn’t make sense to treat substance abuse with substances. The realities, however, aren’t so simple and, through the eyes of many experts, prove that individualized treatment plans containing medications can be the most effective strategy for many addicts.

“The focus should be treatment outcomes, not treatment ideology,” said David Mee-Lee, M.D., chief editor of the American Society of Addiction Medicine criteria and senior vice president of addiction information resource the Change Companies.

A 2004 paper by the World Health Organization, the United Nations Office on Drugs and Crime, and the United Nations Joint Programme on HIV/AIDS observed: “Substitution maintenance therapy can decrease the high cost of opioid dependence to individuals, their families and society at large by reducing heroin use, associated deaths, HIV risk behaviors and criminal activity.”

Medication-assisted treatment uses prescription medicines such as buprenorphine and methadone to prevent cravings for commonly abused opiates like heroin. “Assisted” is the operative word, as prescribed medicines are strictly used in combination with counseling and behavioral therapies. It mirrors treatment of diseases like diabetes, where insulin is prescribed along with counseling for weight and diet.

“Medication decisions in the treatment plan should be based on an assessment of a person’s needs and what combination of biopsychosocial-spiritual interventions will likely produce the best treatment outcomes,” Mee-Lee said. “Because manifestations of addiction-related problems are addressed in their biological, psychological, social and spiritual dimensions during addiction treatment, medication alone cannot address all aspects of treatment necessary for good treatment outcomes and full recovery.”

For some patients, just the idea of medicine can promote recovery because they're already convinced that their withdrawals will require real medicine. Knowing that they won't suffer the horrors of going cold turkey helps motivate them to get clean.

And it is by curbing these well-documented agonies of addiction withdrawal that medicines can perform their most valuable role in addiction treatment. Humans are naturally inclined to avoid pain. So the vomiting and seizures associated with some drug withdrawals make patients want to reach out for their substance of choice. In these cases, FDA-approved medicines can help a person safely and more comfortably manage drug and alcohol withdrawals.

"With opiates, for example, we've got opiate receptors in our gut, and that's why people vomit quite a lot when withdrawing," Sharma said. "You can decrease the discomfort of this [with medicine]. So medication can be helpful in the detoxification stage, easing cravings and other physical symptoms that often trigger a relapse episode."

Methadone, which was first approved for use in the United States in 1947 and is sold under a variety of brand names, can prevent an opiate addict from suffering the most negative physical effects of withdrawal and thus reduce their urge for an opioid in order to stop feeling sick.

"Prescribed at the correct dose for that person, and given in conjunction with other psychosocial-spiritual interventions, many [methadone users] can lead productive lives not possible without the medication," said Mee-Lee.

Buprenorphine can have the same benefits for other patients, Mee-Lee said. While naltrexone works by blocking the effects of opioids and diminishing the reward for taking those drugs, making them less appealing to the addict.

For patients addicted to alcohol, disulfiram, sold under the brand name Antabuse and as a generic, produces an acute sensitivity to alcohol that discourages drinking. The effects of disulfiram on alcohol consumption were first discovered by Danish researchers in the late 1940s. In short, by blocking the body's normal ability to break down alcohol into a harmless derivative, the influence of disulfiram is to produce an almost immediate "hangover" upon intake of alcohol.

"There's no one magic pill or one-size treatment that will banish a person who's drinking's desire to drink," said Sharma.

Naltrexone is also used to prevent alcohol abuse. It helps minimize the pleasure that alcoholics get from drinking and helps control the cravings that compel them to seek out more alcohol. It works so by blocking the receptor in the brain for endorphins — proteins produced by the body that elevate mood.

Marketed as Revia and also sold as a generic, naltrexone can be taken as a pill daily. Marketed as Vivitrol, it's a once-monthly, extended-release injectable.

Acamprosate, sold under the name Campral, can also reduce alcohol consumption or help achieve full abstinence.

Though the Food and Drug Administration has approved only disulfiram, naltrexone and acamprosate for the treatment of alcohol dependence, topiramate, branded as Topamax, has also had some success in treating heavy drinkers.

“The primary appeal [of topimarate] was for treatment of seizures,” Sharma said. “It has a mechanism similar to that of Campral and may similarly help patients avoid or reduce symptoms associated with long-term abstinence.”

Topiramate does not produce a sensation of euphoria. In the past, benzodiazepines such as chlordiazepoxide and diazepam had been used during periods of alcohol withdrawal, but patients sometimes developed a dependence on these medications in a phenomenon known as “replacement addiction.”

Though there are no FDA-approved medicines for the treatment of methamphetamine addiction, a study conducted by the University of Virginia School of Medicine found that topiramate minimizes the odds of meth relapse.

“The medication isn’t replacing the addictive drugs a person is using with just another addictive drug. It is treating biological and neurochemical aspects of addiction that for some patients cannot be effectively treated with psychosocial interventions alone,” Mee-Lee said. “Prescribed at the right dose, medications in addiction treatment are not making the patient ‘high,’ but correcting biological mechanisms to prevent a person from going into withdrawal, or helping a person deal with cravings and impulses to use substances and relapse.”

At the various stages of addiction treatment — detoxification, stabilization and maintenance — different medications in different doses may be appropriate for a patient. That means that individualized treatment must be based on the patient’s unique needs.

“Person-centered and individualized treatment is necessary for people with addiction, as it is with any other illness,” said Mee-Lee. “Not every person with diabetes, asthma, hypertension, schizophrenia, major depression or bipolar disorder gets exactly the same treatment and medications.”

—Paul Rogers for Sovereign Health Group

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