Balance Is Everything:

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Thoughts on Our Collective Approach to Opioid Addiction

People who are close to individuals with active addiction sometimes have to make high-stakes decisions. Desperate situations compel them to act, and then leave them hoping and praying for a positive outcome. Parents' decisions may be the toughest, regardless of the age of their child. "Will giving support right now save my child—or be enabling and ultimately destructive?" "Will withholding support right now save my child—or precipitate disaster?"

At such times it can be prudent to avoid all-or-nothing responses in favor of a sequence of limits and consequences. That way success or failure is not determined all at once. Success—safe recovery—then depends upon all concerned continuously making adjustments to maintain balance between clear-cut expectations and consequences.

Establishing and maintaining balance may also help this country work through the larger crisis of opioid misuse, opioid addiction, and overdose deaths. This crisis began with a rapid rise in opioid misuse in the late 1990s that was fueled by inflated availability of prescription pain medications and naïve thinking that pharmaceuticals are safe for recreational use. Multiple initiatives, including helping medical providers more effectively balance the risks of overprescribing against those of underprescribing, have steadily reduced the availability of opioid painkillers.

But, despite the reduced supply of prescription opioids and community efforts to make current and potential users more wary of their risks, demand for these drugs persists. And with pharmaceutical opioids in short supply, that demand is being met by abundant, cheap, and unpredictably potent

street heroin.

Adaptive responses to challenges presented by addiction usually involve hope and action, and the opioid crisis is no exception. This situation will become less threatening when we start taking full advantage of a major opportunity: *make treatment for active opioid addiction more accessible and more effective*. This can be done, but balance is critical.

No one disagrees with the need for effective treatment. It reduces demand because individuals who enter addiction recovery generally stop using drugs. Plus, if people in recovery were previously dealing drugs to finance their own habit, they stop supporting—and perhaps recruiting—other users. (The brains of people in active addiction are biased toward decisions that continue drug use, even when it means acting opposite to the person's own values. Common behaviors associated with addiction include neglect of family, theft, and drug distribution.) Future demand may also be curtailed when parents enter and continue in recovery because their children's risk of addiction likely goes down.

People do disagree, however, about what the treatment of opioid addiction should include. Advocates for "drug-free" treatment emphasize psychosocial (including behavioral) and spiritual tools for recovery. Advocates for "medication-assisted" treatment (MAT) emphasize opioid medications, especially methadone and buprenorphine. But the situation calls for balance, not dominance, by either point of view.

Research findings clearly demonstrate that many more individuals with opioid addiction stabilize with medication than without. But a fraction of people succeeds by applying psychosocial and spiritual tools alone—and many if not most who succeed on medication also apply psychosocial and spiritual tools in addition to taking medication. The two approaches are not mutually exclusive; they complement each other.

We need to outgrow dichotomized treatment approaches and balance interventions with and without medication according to the needs of each patient. Some parties will have to move beyond their belief that a medication-free state is the holy grail of recovery. Others, especially those in need of treatment, will have to move beyond their belief that medication alone is sufficient for recovery. We will all have to more completely accept addiction as a chronic disease and promote durations of medication management that are tailored to the individual. A recovering person's

need for medication may be temporary or lifelong—no different than another person's need for an antihypertensive or medication for diabetes.

MAT is a valuable treatment modality. But it threatens to add to our problems with opioids if it fails to balance treatment accessibility with patient accountability. Buprenorphine in particular is sometimes prescribed to individuals in early recovery at relatively high doses and with little patient accountability. That is, appointments, urine drug tests, and medication callbacks are at best infrequent. These lax practices have the unintended consequence of increasing the availability of buprenorphine (a popular drug of abuse, for example, among prison inmates) for misuse in the community.

Recovery is primarily an individual responsibility and treatment is primarily a professional responsibility. Successful recovery, and therefore successful treatment, depends upon all concerned continuously making adjustments to maintain balance between clear-cut expectations and consequences.

Defining the substances

In popular use, *opiates* and *opioids* are used interchangeably. In precise use, opioids is the more general term.

Opiates refer to a group of chemical substances derived from the seed juice of the opium poppy that includes opium, morphine, codeine, and heroin. For centuries, opiates have been used to treat ailments such as pain, diarrhea, and insomnia. The appeal of these substances has not been hurt by the fact that they also produce pleasure (euphoria).

Opiates exert their effects in the body because molecules of these substances closely resemble the size and shape of the body's own endorphins, chemical messengers in neural pathways of pleasure and response to pain. Opiates act in receptor sites on nerve cells that ordinarily recognize and admit only endorphins, a bit like a skeleton key that unexpectedly opens a random

lock.

Chemicals from the poppy have been modified into additional substances with similar effects (e.g., oxycodone), and scientists have synthesized more of these substances in their laboratories (e.g., methadone, fentanyl). All chemical substances that enter the endorphin receptors are termed *opioids*.

Not all opioids produce pleasure and relieve pain. Naloxone and naltrexone, for example, simply enter the receptor site—displacing other opioids—and sit there. Naloxone is used to wake people up from opioid overdoses; naltrexone is used to make it pointless for people with opioid addiction to try to get high with another opioid.

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