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SAFE Glen Cove Coalition: NIDA on the Opioid Epidemic and Views on Recovery

According to Dr. Nora Volkow, Director of the National Institute on Drug Abuse (NIDA), last year saw drug overdose deaths in the U.S. reach over 100,000 deaths. Historically, this is the highest number of drug overdoses and the numbers are increasing monthly. In order to combat this, a nationwide, coordinated response is required. 2020 shows that only 13 percent of people with drug use disorders received any treatment. Only 11 percent of people with opioid use disorder received one of the three safe and effective medications that could help them quit and stay in recovery.

The common assumption that abstinence is the sole aim and only valid outcome of addiction treatment is a grossly false and unsupported assumption about what treatment and recovery need to look like. While not using any drugs or alcohol poses the fewest health risks and is often necessary for sustained recovery, different people may need different options. Temporary returns to use after periods of abstinence are part of many recovery journeys, and it shouldn't be ruled out that some substance use or ongoing use of other substances even during treatment and recovery might be a way forward for some subset of individuals.

Reduced number of heavy drinking days is already recognized as a meaningful clinical outcome in research and medication development for alcohol addiction. Clinical endpoints other than abstinence, such as reduced use, are now being considered in medication trials for drug use disorders. This could facilitate the approval of a wider range of medications to treat addiction, as well as open the door to medications that address symptoms associated with it, such as sleep disorders and anxiety. The existing medications methadone, buprenorphine, and naltrexone have proven to be effective at reducing relapse risk and improving other outcomes in patients with opioid use disorder (OUD), but more options could benefit more patients and medications to treat other drug use disorders are needed.

Temporary returns to drug use are so common and expected during treatment and recovery that addiction is described as a chronic relapsing condition, like some autoimmune diseases. Yet these setbacks may still be regarded by family, friends, communities, and even physicians as failures, resetting the clock of recovery to zero. Patients in some drug addiction treatment programs are even expelled if they produce positive urine samples.

Dr. Volkow warns that healthcare and society in general must move beyond this dichotomous, moralistic view of drug use and abstinence and the judgmental attitudes and practices that go with it. There are still many unknowns about the different trajectories that recovery may take, but stereotypes should not guide us in the absence of knowledge. For example, research in the field of nicotine addiction shows that a person's first cigarette after a period of abstinence raises the risk of returning to their pre-treatment use pattern but does not always have that outcome. Research on the consequences of returning to opioid, stimulant, or cannabis use after a period of non-use is still needed, but there is little evidence to support the assumption—reinforced in movies and TV shows—that a single return to drug use following on a one-time loss of resolve will automatically lead the individual straight back to their former compulsive consumption.

Medical model practitioners often make a distinction between a one-time return to drug use, a "slip" or "lapse," and a return to the heavy and compulsive use pattern of an individual's active addiction—the more stereotypical understanding of relapse. The distinction is meant to acknowledge that a person's resolve to recover may even be strengthened by such lapses and that they need not be catastrophic for the individual's recovery. A return to substance use after a period of abstinence may also, in some cases, lead to less frequent use than before treatment. Such a trajectory has been identified in research on drug and alcohol treatment outcomes in adolescents. For some drugs, any reduced use is likely beneficial: Less frequent illicit substance use means less frequent need to obtain an illicit substance and fewer opportunities for infectious disease transmission or fatal overdose. It may also increase the likelihood that a person can be a supportive family member, hold a job, and make other healthy choices in their life.

But as long as treatment is only regarded as successful if it produces abstinence, then even one-time lapses can trigger unnecessary guilt, shame, and hopelessness. If an individual feels like they are bad, weak, or wrong for taking a drink or drug after a period in recovery, it could potentially make it more likely for those slips to become more serious relapses. As it now stands, even a slip can produce a positive urine sample or force the honest patient to self-report a return to drug use, which can then trigger the judgment and punitive policies of their treatment program or the law as well as trigger the personal sense that they have failed again and there is no hope for their recovery.

Another deleterious effect of equating treatment success with abstinence and drug use with treatment failure is that some people with SUDs are unready to give up substances completely. In fact, this is one of the main reasons people who could benefit from addiction treatment do not seek it. Although it may not be ideal or optimal, treating an opioid or methamphetamine use disorder even while a person continues to use cannabis or alcohol would be a net individual and public health benefit.

Offering supports for people with SUD that protect against the worst consequences of drug use. Syringe-services programs reduce HIV transmission and offer people an entry point into treatment; naloxone distribution to people who use opioids and their families reduces overdose fatalities. Neither of these measures increase drug use in communities that implement them, as critics often worry.

Other harm-reduction modalities being studied include personal drug-testing equipment like fentanyl test strips, as well as overdose prevention centers—places where people can use drugs under medical supervision, which are in operation in other countries and, as of late November, are available in New York City. Such services could potentially help mitigate some of the risks associated with lapses and relapses, such as heightened risk of overdose due to lost tolerance. The latter currently accounts for many fatal overdoses after people with an untreated opioid use disorder are released from prison, for example.

Dr. Volkow maintains drug addiction is a chronic but treatable disorder with well-understood genetic and social contributors. It is not a sign of a person's weakness or bad character. Continued or intermittent use of drugs, even by people who know they have a disorder and are trying hard to recover from it, must be acknowledged as part of the reality of the disorder for many who struggle with it. Just as we must stop stigmatizing addiction, we must also stop stigmatizing people who use drugs as being bad or weak, and instead offer them support to help prevent addiction's most adverse consequences.

The SAFE Glen Cove Coalition is conducting an opioid prevention awareness campaign entitled. "Keeping Glen Cove SAFE," in order to educate and update the community regarding opioid use and its consequences. To learn more about the SAFE Glen Cove Coalition please follow us on www.facebook.com/safeglencovecoalition or visit SAFE's website to learn more about the Opioid Epidemic at www.safeglencove.org.