No Blame, No Shame: Treating Heroin Addiction As A Chronic Condition

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BOSTON Ever heard of a diabetic patient who ate a large muffin before having a blood glucose test, was scolded for giving in to temptation, and then told to just say no to carbs?

How about a cardiac patient who has a worrisome stress test and is shown the door when she admits to eating a few Big Macs?

That kind of response is all too familiar for patients whose brains have been altered by heroin or other opiates.

"We blame patients for their disease," says Dr. Sarah Wakeman. "We also kick people out of treatment for having symptoms of their disease with addiction, which would honestly be malpractice if we did that with other conditions."

Wakeman runs the Substance Use Disorders Initiative at Massachusetts General Hospital, where treating addiction as a chronic condition, like diabetes or asthma or high blood pressure, is the norm.

Patients are screened using questions that determine if they are at risk for addiction. There's an assessment. Then Wakeman and her patients work on lifestyle changes, decide what medication will help break the addiction, and meet frequently to monitor progress.

A 20-Year Struggle With Addiction

"So what's been happening?" Wakeman asks Michael Cavallo, 37, who she began seeing about 19 months ago. Cavallo, who grew up on the South Shore, shifts in his chair, twisting the fingers of one hand. He typically sees Wakeman every two weeks, but it's been three and too long. August was a tough month.

"I don't know what's working, what's not," Cavallo says. "Trying to solve the problems with the same head that created the problem is one of my biggest weaknesses."

Michael Cavallo, pictured, typically meets with Dr. Sarah Wakeman every two weeks to discuss the challenges he faces in his more than 20-year battle against addiction. (Hadley Green for WBUR)

Cavallo has been working a lot of hours in construction and getting back to his music career. He records and performs as "Skinny" Cavallo, often writing about his 20-plus year struggle with addiction. But performing in clubs and bars puts Cavallo back in the settings where he drank, took meth and shot heroin.

"It sounds like that was a challenge, being in bar settings and playing music again," Wakeman says, leaning toward Cavallo. "So do you have more shows coming up?"

"Yeah, I have one tomorrow night," he says.

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Wakeman asks Cavallo if he'd like to increase his daily dose of Suboxone, a medication that helps block heroin cravings. Patients with diabetes, high blood pressure or other chronic diseases are typically on some type of medication. But many patients addicted to heroin scorn the idea of using a drug to treat a drug problem. Cavallo is on Suboxone, and it's working for him, but still, he says he obsesses about whether he's doing the right thing.

"When someone says things like, 'We turned our will, our life over to the care of God, not over to the care of Suboxone,' that, that makes me second guess what I'm doing," Cavallo tells Wakeman.

"No one would say those things to you about insulin," Wakeman responds. "Medication that's prescribed by a doctor for a disease and taken appropriately is what modern medicine is."

"Yeah," Cavallo says, "but there's no chance of somebody misusing insulin."

Cavallo shakes his head. He tells Wakeman he struggles with both the idea of becoming dependent on another drug and with the fear that he'll be perceived by others in recovery as weak. But Cavallo has no doubt that he has a disease. And he's tired of fighting the perception that addiction is a moral failing or a weakness. Cavallo had worked his way onto a top college hockey team when the disease hit.

"I know the difference between right and wrong, I had a great upbringing," Cavallo says. And if you want to talk about willpower, "most people don't compete and train on the level that I did as far as an athlete. You have to have a very strong will to do that."

Medication-Assisted Treatment: 'A Cultural Transformation'

Cavallo has felt shamed by his disease. He's been kicked out of treatment programs for showing traces of drugs in his urine. He's been in hospitals where he caught the look of pity or disgust before a nurse or doctor glanced away. And he's left emergency rooms with nothing more for recommended care than a 1-800 number on a slip of paper.

"That's not how you would expect a health care provider to react if, let's say, you had a mini-stroke," says Dr. Melinda Campopiano, branch chief for regulatory programs at the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). "They wouldn't just say, 'Oh well, you should probably call this 800 number and get evaluated so that you don't have another stroke that disables you or kills you next time.'"

Recent Coverage Of The Opioid Addiction Crisis In Mass.

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Complete Coverage

Campopiano says significant parts of the country still see substance abuse as a character flaw. In health care, an overdose is routinely treated as a crisis, not the signal of a chronic illness.

"We respond to crises, and we provide an intervention that's time limited, and then we're done and don't do anything until there's another crisis," Campopiano says.

Which helps explain, she says, why there's a shortage of treatment programs, restrictions on insurance coverage of Suboxone and other medications that help patients stay off heroin, special waivers required for doctors who prescribe Suboxone, and limits on the number of patients they can treat.

In Massachusetts, 568 physicians have completed training required to prescribe Suboxone and are certified by the federal government to treat up to 100 patients each. That's 1.8 percent of the 31,722 active doctors in the state.

Cavallo is on MassHealth, the state's Medicaid plan. Wakeman must take steps to reauthorize his prescription every six months. Sometimes Cavallo has to skip a few days of Suboxone, and feel the heroin cravings return, while he waits for the prescription to be renewed.

"That can be really scary for patients," Wakeman says, "and can lead to relapse in some cases."

Coverage of Suboxone varies by insurer. Blue Cross Blue Shield, the state's largest private insurer, requires physicians to reauthorize use of Suboxone yearly. There is no lifetime limit for the drug.

"The centrality of medication-assisted treatment is a new concept in the field of opiate addiction," says Dr. Ken Duckworth, medical director for behavioral health services at Blue Cross. "That's a cultural transformation that's happening."

It's a tranformation that could save a lot of money.

Getting patients into treatment with Suboxone, methadone or naltrexone could save $2 for every $1 spent, according to a report that analyzed research on opioid dependence at the Institute for Clinical and Economic Review.

"That was just thinking about health care costs alone," explains Dan Ollendorf, the report's lead author. "The return on investment would be much larger if you expanded that thinking to include legal costs, costs of lost education and reduced employability."

Understanding Addiction As An Ilness

Cavallo says he's used heroin twice in the last 14 months, "kind of giving up on myself for a day." A sense of shame lingers. Few patients with diabetes describe a setback as giving up on themselves.

Cavallo's last overdose was in July 2014, a few days after he was kicked out of a residential treatment program.

"I got $20 worth of heroin, and I put it my veins and I died," he says. "I was at a set of lights. Luckily, somebody pulled me out of the car and EMTs came and brought me back to life."

Some residential treatment programs send patients home if they show traces of alcohol, an illegal drug or a prescribed opioid treatment such as Suboxone.

"Historically there's been a strong emphasis on abstinence, but I think that the field is moving in more and more recognition that [addiction] is a chronic condition," says Vic DiGravio, president

of the Association for Behavioral Healthcare, a trade group representing mental health and addiction treatment organizations in Massachusetts.

DiGravio says residential programs that send patients home when they relapse do so because they worry about the effect active heroin or other substance use would have on other patients.

“Some providers may feel that allowing somebody to remain in a program who’s tested positive or who’s actively using may undermine the integrity and ultimately the effectiveness of the program,” DiGravio says.

Wakeman acknowledges that addiction patients can be more difficult to manage for providers and for families.

“Your loved one with diabetes isn’t going to rob you or steal from you,” Wakeman says, “and yet addiction really can change the person, does change the person and those behaviors can be really unpleasant. That can make it really hard for people to understand this as an illness.”

Dr. Sarah Wakeman, pictured, speaks with her patient, Michael Cavallo, about his struggles with heroin addiction. As they decide whether to increase his daily dosage of Suboxone, Wakeman asks Cavallo to talk about things that trigger his drug cravings. (Hadley Green for WBUR)

Dr. Wakeman monitors Cavallo’s sobriety and drug use. At the end of this visit, she snaps open a package, pulls out two blue plastic swabs and hands them to Cavallo.

“I sort of think of it like checking blood sugar in a patient with diabetes,” she says, smiling.

Cavallo is relaxed as he adjusts the swabs, one inside each cheek. “This used to be the time in my visit where I would be, ‘Should I tell her, should I not tell her?’”

If the drug test was positive, Wakeman would just ask Cavallo what happened, what triggered the relapse.

“That has helped me immensely,” he says, “to bring the periods of sobriety longer and the periods of relapse shorter.”

“That’s the goal of any chronic disease treatment,” Wakeman says, “to make the periods of remission longer and the relapses farther apart and shorter when they do happen.”

With help from Wakeman, AA and his family, Cavallo is sober after more than 20 years. He's waking up to day 78 and counting.

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