EDITORIAL

Make methadone easier to get

Lexi sat under a highway overpass where she sleeps near a stretch of Massachusetts Avenue nicknamed "Methadone Mile."

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THE ARGUMENT AGAINST using drugs like methadone and Suboxone to kick heroin usually gets whittled to a cliched, and inaccurate, phrase: It’s trading one addiction for another. But ask Dr. Jessie Gaeta about some of the clients she treats in the heart of Boston’s so-called Methadone Mile and she’ll describe regimens that are about trading despair for hope. Gaeta, who is chief medical officer at Boston Health
Care for the Homeless, knows all about the doomsday scenarios that often play out on the grimy blocks around Massachusetts Avenue and Albany Street, where a mix of shelters, treatment centers, and methadone clinics years ago created a subculture of people desperate to get help or get high. Sometimes both.

The state’s opioid crisis, compounded by the 2014 closing of the 700-bed Long Island shelter and its recovery programs, has made the Methadone Mile scene more pronounced. But Gaeta still sees reason for optimism. One example: the story of a woman in her early 20s who had surrendered everything to heroin, including her three children. “She came in absolutely ravished by homelessness,” says Gaeta. It wasn’t her first try at detox and treatment, but this time it took. Gaeta credits Suboxone — a combination of buprenorphine and naloxone that blocks the effects of other opiates if taken regularly, and eases withdrawal symptoms. After a year on Suboxone, the woman had gone through a personal revolution. Heroin and a violence-prone boyfriend were gone, replaced by a home, a job, and a rekindled relationship with her family. “There are a lot of people like her,” says Gaeta. “People who are doing well.”

Their success, however, hinges on consistent Medication-Assisted Treatment, or MAT, which most addiction specialists agree is safer and more effective than other approaches, including abstinence. Methadone, which dates to the 1930s, is the most commonly used MAT. It works differently than Suboxone, but serves the same purpose — substituting a lethal addiction with a manageable dependence. But methadone is easier to abuse, which is why it’s tough to get a prescription that eliminates the need for daily visits to a specially-licensed clinic. As a July 17 Globe story
by Nestor Ramos and Evan Allen graphically illustrated, that can worsen the odds of a methadone user staying free of heroin’s grip. On Methadone Mile — people who work there loathe the label — patients have to navigate a gantlet of sidewalk dealers to get their methadone, putting themselves on a path of temptation over and over again. An increased police presence might periodically roust dealers and tamp down petty crime.

What’s needed here is a patient-centered strategy that would make it easier for addicts well into the recovery process to avoid Methadone Mile. In Europe, for example, methadone sometimes is dispensed at pharmacies. Why not do that here? There’s also the promise of better ways to deliver MAT. Earlier this year, the Food and Drug Administration approved an implantable version of buprenorphine that contains six months’ worth of doses. It could discourage misuse and eliminate the possibility of someone selling buprenorphine for street drugs.

Improved access to methadone is just one piece of the confounding puzzle that is addiction. There’s a need for additional residential treatment beds, better reimbursement rates, more behavioral health therapy — it’s a long list. But significant progress won’t come until there is wider acceptance of addiction as a brain disease. Dr. Michael F. Bierer, an addiction specialist at Massachusetts General Hospital and president-elect of the Massachusetts Chapter of the American Society of Addiction Medicine, envisions a day when people managing addiction “sit in a doctor’s waiting room with people going in for an annual wellness visit, as though they were actually getting treated like a person with any other disease.”
As a society, we still attach a special ignominy to substance addiction, especially heroin. It’s an affliction of the down and out, inexorably connected with crime and disease. We’d prefer it to be relegated to a sketchy part of town. But addiction does not discriminate. It permeates all social strata. Imagine people suffering from other chronic illnesses being similarly shunned. Imagine a Diabetes Drive.

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