For Mark Willenbring, Substance Abuse Treatment Begins With Research
Profiles in Science
By GABRIELLE GLASER FEB. 22, 2016

On the rainy fall morning of their first appointment, Dr. Mark Willenbring, a psychiatrist, welcomed a young web designer into his spacious office with a firm handshake and motioned for him to sit. The slender 29-year-old patient, dressed in a plaid shirt, jeans and a baseball cap, slouched into his chair and began pouring out a story of woe stretching back a dozen years.

Addicted to heroin, he had tried more than 20 traditional faith- and abstinence-based rehabilitation programs. In 2009, a brother died of an OxyContin overdose. Last summer, he attempted suicide by swallowing a fistful of Xanax. When he woke up to find he was still alive, he overdosed on heroin.

At a boot camp for troubled teenagers, he said, staffers beat him and withheld food. After he refused to climb a mountain in a team-building exercise, they strapped him to a gurney and dragged him up themselves.

The young man in the psychiatrist’s office paused, tears sliding down his cheeks.
“Sounds like a prison camp,” Dr. Willenbring said softly, leaning forward in his chair to pass a box of tissues.

He began explaining the neuroscience of alcohol and drug dependence, 60 percent of which, he said, is attributable to a person’s genetic makeup. Listening intently, the young patient seemed relieved at the idea that his previous failures in rehab might reflect more than a lack of will.

Dr. Willenbring, 66, has repeated this talk hundreds of times. But while scientifically unassailable, it is not what patients usually hear at addiction treatment centers.

Rehabilitation programs largely adhere to the 12-step principles of the 80-year-old Alcoholics Anonymous and its offshoot, Narcotics Anonymous. Addicts have a moral and spiritual defect, they are told; they must abstain from alcohol and drugs and surrender to a higher power to escape substance abuse.

This treatment is typically delivered through group therapy led by counselors whose main qualification is their own completion of the program. In some states, drug counselors with only a high school degree may treat patients, according to a 2012 study by the National Center on Addiction and Substance Abuse at Columbia University.

Dr. Willenbring says he believes this approach ignores the most recent research on the subject, a judgment he is well qualified to make. From 2004 to 2009, he was the director of treatment research at the National Institute for Alcohol Abuse and Alcoholism, and he oversaw dozens of studies proving the efficacy of medications and new behavioral therapies to treat drinking problems.

But he grew frustrated at the failure of most traditional rehabilitation facilities to take advantage of the findings.

“The taxpayers had paid for them,” he said of the studies, “but nobody was paying attention.”

When the National Heart, Lung, and Blood Institute, another federal research facility, publishes a major study on blood pressure, he said, cardiologists and other...
physicians in the field often move quickly to integrate the new drug or behavioral approach into their practices.

But the $35-billion-a-year treatment industry has proved far more resistant.

“When the facts change — and they’ve changed a lot — the minds have not,” Dr. Willenbring said.

“When we publish studies in our field, nobody who is running these centers reads them. If it counters what they already know, they discount them,” he continued. “In the addiction world, the knee-jerk response is typically, ‘We know what to do.’ And when that doesn’t work, we blame patients if they fail.”

And so in 2009, after five years in Washington, D.C., Dr. Willenbring returned to his home state, Minnesota, the birthplace of traditional inpatient rehab, to open a private clinic called Alltyr that treats people with alcohol and drug problems on an outpatient basis.

Unlike many rehabilitation concepts, in which treatment may be limited to a few weeks or months, Dr. Willenbring’s clinic, whose name was inspired by a stone with healing properties in Russian folklore, treats addiction as a chronic medical condition. After he makes an initial evaluation, his diagnoses may include a wide range of substance and psychological disorders.

His treatment plans can involve antidepressants; medication for anxiety, A.D.H.D. and chronic pain; anti-relapse medications; psychotherapy; and family training. Patients may come for a single consultation, or be treated for years.

The question of effective treatment for alcohol- and substance-use disorders is more pressing than ever. According to a recent article in The New England Journal of Medicine, the number of Americans admitted to treatment programs for prescription opioids more than quadrupled from 2002 to 2012. Deaths from heroin overdoses nearly quadrupled from 2002 to 2013, the Centers for Disease Control and Prevention reported.
In addition, an estimated 18 million Americans have alcohol use disorder, according to the N.I.A.A.A., and a study published in *JAMA* last year found that the number of Americans who drank to excess was rising.

Last month, President Obama proposed $1.1 billion in new federal spending to fight the growing epidemic of heroin and prescription opioid addiction. His 2017 proposed budget designates $920 million for states to expand access to drug-assisted treatment over the next two years. It also calls for more prescription-drug monitoring programs and increasing the use of the opioid-reversal treatment naloxone.

Only 10 percent of those with alcohol- and substance-use disorders ever seek treatment, said Brad Stone, a spokesman for the Substance Abuse and Mental Health Services Administration. The Affordable Care Act covers treatment for alcohol- and substance-abuse disorders, but many who need it fear they will be stigmatized if they ask for help.

**A Range of Therapies**

Many people in need of treatment believe that the only way to recover is to spend time at a rehab facility, which can cost as much as $50,000 a month. Yet there is no reliable evidence that intensive inpatient treatment is more effective than continual outpatient care, Anne M. Fletcher, the author of the 2013 exposé of the treatment system, “Inside Rehab,” said in an interview.

Dr. Willenbring founded his outpatient center, Alltyr, in St. Paul in 2012. Instead of spiritual confession, he relies on a range of behavioral therapies to help patients identify the triggers that lead to risky behaviors. They include motivational interviewing, in which therapists ask a series of questions intended to help clients understand why they drink or use drugs, and cognitive behavioral therapy, short-term counseling that helps patients recognize and avoid high-risk situations.

Dr. Willenbring also treats patients for depression, anxiety and post-traumatic stress disorder, which can make recovery from addiction difficult. He prescribes medications to reduce alcohol cravings, along with Suboxone to eliminate opioid
cravings and block their highs. And he trains relatives to support their loved ones with kindness and compassion, not ultimatums.

The first year of treatment costs roughly $2,600; it decreases afterward.

A gentle man with a trim beard, graying buzz cut and green-framed glasses, Dr. Willenbring was raised in the rugged Iron Range of northern Minnesota. An avid skier and cyclist, he has been married to Kate Meyers, an artist and his business partner, for 37 years, and they have two sons. He has an eclectic style: He pairs John Varvatos suits with cowboy boots, and his office speakers pipe in blues and hip-hop.

Most of Alltyr’s 500 patients have mild to moderate alcohol-use disorder and want to try to curb their habits before they are out of control. But some have been on a long, tangled journey to multiple treatment programs.

“I don’t want anybody to have to go through the crap I had to,” said Joe Karkoska, 32, an elder care worker. Mr. Karkoska said he had tried 10 rehab clinics before he found Alltyr. Dr. Willenbring prescribed Suboxone, the drug Mr. Karkoska credits for his not having taken opioids for three years.

Dr. Willenbring’s embrace of medications for those who struggle with addictions is anathema to many involved in traditional recovery programs. Only about 2 percent of Americans with alcohol-use disorder are ever prescribed anti-craving medications, according to John Bowersox, a National Institute for Alcohol Abuse and Alcoholism spokesman.

The majority of those addicted to heroin or prescription painkillers do not receive methadone or Suboxone, Dr. Willenbring and other experts said, despite evidence of their effectiveness.

Dr. Willenbring is adamant that for many, such drugs are crucial for a safe recovery. Long-term use of opioids can halt the brain’s mechanism for producing its own painkilling chemicals, he said; without replacement drugs, many users remain in continuous discomfort.
In abstinence-based rehab, users are detoxed and lose their tolerance for drugs, he said — but they do not lose the cravings. “So what do they do when they get out?” he said. “They use the same amount as they did before and die of an overdose.”

Dr. Willenbring supports open-ended, long-term drug-replacement therapy for his patients with opioid-use disorder. That raises eyebrows among those who favor abstinence. John Johnston, a counselor at Serenity Lane, a treatment center in Eugene, Ore., said that although the drugs could help prevent overdoses, they did not address the core cause of addiction.

“Substituting one drug for another is an external solution for an internal problem,” Mr. Johnston said. Dr. Willenbring’s approach deprives “his patients of the opportunity to have a full range of emotional experiences, a change of spiritual perspective and a return to an improved quality of life.”

But for many of Dr. Willenbring’s patients, Suboxone has been instrumental in helping to find just that. Most, like Kyle Larsen, a 23-year-old nursing student from Albert Lea, Minn., began misusing opioids after they were prescribed for sporting injuries or operations.

He found Alltyr after a stint at Hazelden Betty Ford and another in a so-called sober-living facility. “It was one-size-fits all, except that it didn’t fit,” Mr. Larsen said.

Suboxone, he said, has eliminated his cravings, allowed him to regain the equilibrium he needed to return to school and to restore his family’s trust. Like many of Dr. Willenbring’s patients, Mr. Larsen attends a regular Suboxone group, which costs $100 a session and is offered to those who have been on a sustained, stable dose for many months. (They must submit urine samples to check for recreational drug use.)

The meeting offers a forum for patients to discuss struggles and successful coping strategies, as well as the camaraderie some studies have found to be supportive in drug- and alcohol-use recovery.

Despite being in addiction programs for years, many patients have never been treated effectively for depression, anxiety or other emotional disorders.
Mr. Karkoska, for example, began having severe social anxiety when he was in elementary school. He discovered opiates as a young adult, and they helped blunt his fears. Yet the repeated instructions he received in rehab — to “do the steps” and call his sponsor when he had cravings — did little to ease the panic that returned whenever he stopped shooting heroin.

Some years ago, one doctor prescribed high doses of the anti-anxiety medication clonazepam, which helped a little. “But I really didn’t have any idea how to calm myself down otherwise,” Mr. Karkoska said.

Since he began taking Suboxone, he has worked with Ian McLoone, an Alltyr therapist, to learn breathing exercises and cognitive behavioral techniques that help identify and change unhelpful, irrational beliefs. They have helped him cut down on clonazepam, overcome his fear of groups and work.

“I’ve got people depending on me now,” he said. “I’m a part of my community.”

The group’s conversation does not steer away from somber topics: friends who have overdosed; sad breakups, suicidal thoughts and job disappointments. But members encourage one another, and there are moments of levity, too.

Dan Bolmgren, an aspiring Minneapolis filmmaker who tried 12 rehab programs from Antigua to Utah, mentioned that he had smoked a lot of marijuana the past week. Dr. Willenbring made a theatrical gasp: “Oh no, not weed!”

This is a critical, and controversial, aspect of Dr. Willenbring’s approach to opiate addiction: He tolerates the casual use of drugs such as marijuana and alcohol. Overdoses, he argues, are the biggest threat.

“In here, we focus on the drugs that can kill you,” he told Mr. Bolmgren, 30. “The only way weed is going to do that is if a bale of it falls on your head.”

Some specialists questioned Dr. Willenbring’s tolerance for marijuana and alcohol use among patients who have misused opioids. Dr. Willenbring describes the notion of “cross-addiction” — the chance that a person with alcohol-use disorder will develop, say, an opioid problem — as overblown, and points to a large 2014 JAMA study that found it unlikely.
But Dr. David Sack, an addictions psychiatrist who is the president and chief executive of Elements, a California-based chain of treatment centers, disagrees, cautioning that cannabis or alcohol use could undermine the efficacy of Suboxone treatment.

“Alcohol and marijuana are real drugs,” he said. “People enjoy their lives most fully when they use the fewest amount of substances. Why wouldn’t we want to maximize that potential?”

Dr. Sack said that he supports the use of Suboxone and methadone, but added that their success rates, which are difficult to track, are oversold.

Still, their use is becoming more mainstream. The Hazelden Betty Ford Foundation, long a bastion of 12-step care, has been offering patients Suboxone and extended-release naltrexone, another drug that blocks the high of opioids, since 2013.

Deciding to Fill a Void

Dr. Willenbring did not set out to be an addictions psychiatrist. During his residency at the University of California, Davis, in the late 1970s, fellow residents were clamoring for grant money to study psychotherapy. His mentor directed him to an even larger set of National Institutes of Health funds to study effective treatments for complex patients, including medically ill veterans who were also alcohol dependent.

Quickly, he became an expert in a field that had attracted relatively few researchers and was neglected by general practitioners, who often have biases against patients with alcohol- and substance-use disorders.

Indeed, few medical school students ever learn about addiction, and only a small percentage of physicians are specifically trained to treat them, said Kathryn Cates-Wessel, the executive director of the American Academy of Addiction Psychiatry.
By the early 1980s, Dr. Willenbring was treating patients with severe drinking problems at the Department of Veterans Affairs hospital in Minneapolis. Most had dire living circumstances but aspired to conventional lives: a wife, children, two cars in the driveway.

“They were in the deep, deep hole of addiction,” Dr. Willenbring said. “And the traditional approach to treatment — just work this program and you’ll dig yourself out — wasn’t working.”

One night while walking his dog in a snowstorm, Dr. Willenbring wondered why so few of his patients were able to abstain from drugs and alcohol. Most people with alcohol and substance use disorders need months or years to achieve stable recovery.

But they were seldom treated as if they had a chronic illness. “If you went to a doctor during your first bout with asthma, would you expect to be cured after just one inhaler?” he said. “Of course not. Why not approach addiction the same way?”

These days, Alltyr is expanding, recently adding a second psychiatrist to its staff of three therapists and a nurse. Dr. Willenbring said he saw treatment of addictions moving toward the mainstream of evidence-based medicine.

“Before Prozac,” he said, “nobody thought a depressed person could get well outside a mental hospital. But that’s not true anymore, either.”

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