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Chronic Addiction and Recovery Management: Implications for Clinical Practice

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In 2001, Dr. Lonnie Shavelson published *Hooked*, a provocative study of the lives of five individuals whose addictions propelled them through multiple episodes of addiction treatment and encounters with a host of other community institutions. Shavelson's ethnography of addiction was in part an exposé of a treatment system that failed to comprehend and respond to the chronic and complex nature of addiction and recovery. This article summarizes the empirical evidence that addiction is for many a chronic condition, identifies risk factors for such chronicity, highlights the consequences of treating chronic addiction in the context of an acute care model, and notes the emergence of sustained recovery management models as well as the clinical implications of such models.

Addiction: Acute or Chronic Condition?

Community surveys reveal high lifetime consumption of alcohol and other drugs in the general population and the existence of substantial numbers of people with transient AOD-related problems who resolve these problems without the aid of professional treatment or recovery support groups. Clinical studies, however, reveal people with more severe and chronic conditions who are unlikely to recover without such assistance and support. There is growing evidence that many individuals in this latter group experience prolonged cycles of addiction, recovery, relapse, and repeated treatments before achieving stable recovery or experiencing permanent disability or death (Anglin et al., 1997; Dennis, Scott et al., 2005; Scott, Foss et al., 2005b). The evidence of chronicity among the population admitted to publicly funded addiction treatment is striking.

Most people entering publicly funded addiction treatment in the United States have prolonged histories (measured in years and decades) of AOD problems prior to their first admission to treatment (Dennis et al., 2005).

- While the majority of people with lifetime substance dependence eventually enter sustained recovery (i.e., no symptoms for the past

- Of the people admitted to the U.S. public treatment system in 2003, 64% were re-entering treatment (including 23% for the second time, 22% 3-4 times, and 19% 5 or more times) (OAS, 2005).
- The majority of individuals discharged from addiction treatment will relapse within 3 to 12 months after discharge, most within 30-90 days (Wilbourne & Miller, 2003; Hubbard, Flynn, Craddock, & Fletcher, 2001; Scott et al., 2005b). Instability of recovery continues throughout the early years of recovery (Scott et al., 2005a).
- Post-treatment recovery outcomes are compromised by the low rate of participation in continuing care activities following discharge and the substantial drop-out rate of recovery support group participation in the year following treatment (McKay, 2001).

Findings such as these have prompted leading researchers to speak of addiction and treatment “careers” (Anglin et al., 1997), call for the reconceptualization of addiction as a chronic disorder on par with cancer, diabetes, asthma, and hypertension (McLellan et al., 2000; Scott & Dennis, 2006; Dennis & Scott, in press), and advocate a shift to models of sustained recovery management similar to those used in the treatment of other chronic diseases (White et al., 2002).

Factors Contributing to the Chronicity

Prolonged complex service histories are especially prevalent when addiction is accompanied by medical, psychiatric, and other problems—a significant finding given the high rate of co-occurring disorders among those entering addiction treatment. Relative to people with lower severity, those who have more chronic substance use disorders are characterized by:

- Greater personal vulnerability (e.g., family history of AOD problems, early age of onset of AOD use/problems, developmental trauma),
- Greater problem severity (e.g., amount of use, number of abuse/ dependence symptoms),
- Greater problem complexity (e.g., co-occurring medical/psychiatric illness, personal and environmental

- Lower recovery capital (e.g., fewer internal and external assets that can be used to initiate and sustain recovery) (White et al., 2002).

Chronic Conditions and Acute Models of Care

Historically, most health care systems, including substance abuse treatment, have been organized around an episodic relationship in which a person seeks help, is diagnosed and treated, and is discharged and presumed to be cured—all in a relatively short period of time. In the addictions field, policy makers, funders, clinicians, patients and their families, and the public often have the unrealistic expectation that all patients entering addiction treatment should achieve and maintain lifelong abstinence following a single, ever-briefer episode of specialized treatment. The earlier noted post-treatment relapse rates invalidate this assumption and challenge the adequacy of an acute care model of treatment for individuals suffering from chronic substance use disorders. Unlike conditions or illnesses that are time-limited and treatable in single episodes of acute care, chronic conditions ebb and flow over long periods of time, and their course is not fundamentally altered by acute episodes of stabilization.

Treating chronic conditions in the context of an acute care model can harm service consumers, service professionals, and service organizations. Clients become demoralized, give up on themselves, and may give up on professional treatment. Family members, friends, employers, judges, probation officers, child welfare workers, professional licensing boards, and others become frustrated by frequent relapse and attribute relapses to willful recalcitrance. Unrealistic expectations of treatment often result in clients being punished for their inability to establish instant and permanent sobriety. Facing repeated relapse, clinical staff can also become demoralized and avoid confronting the client's or their own self-perceived "failures" by refusing to re-admit the client or shaming the client at re-admission. If addiction treatment is evaluated based on the short-term expectations of the acute care model, then everyone, including the public and policy makers, risks disillusionment regarding the effectiveness of addiction treatment.

It is our contention that treatment "works" but not in the way many have presumed it should (i.e., that a single episode of care is a self-contained fix for severe AOD problems) and that it could "work" better if the treatment model better matched the growing understanding of the condition. In the

next section, we briefly review some of the more recent attempts to shift treatment toward a model of long-term recovery management.

From Acute Care to Sustained Recovery Management

The shift from acute models of addiction treatment to models of long term recovery management requires changes in service philosophies, significant shifts in service practices, and a transformation in the way addiction treatment and recovery support services are planned, funded, monitored, and evaluated. In states (e.g., Connecticut), cities (e.g., Philadelphia), and research studies (e.g., the Early Re-intervention experiments) where such transformations are underway, it is clear that the shift to a recovery management model entails changes in client engagement strategies, the assessment and service planning process, the service menu, the timing and duration of service delivery, the location of service delivery, the service relationships, and the relationship between treatment institutions and the local communities they serve (White et al., 2002; Dennis & Scott, in press).

One of the most profound changes in this model is its movement beyond brief stabilization to ongoing monitoring and intervention via telephone contact, recovery check-ups and early re-intervention, recovery coaching, and assertive linkage to communities of recovery. Research findings such as the following suggest that more assertive and long-term approaches to managing addiction hold great promise.

- The shorter the time span from first use to first treatment, the shorter the total years of use (Dennis et al., 2005).
- The more severe the substance use disorder, the less likely people are to seek help, but the amount of treatment in any year predicts who moves from addiction to recovery, and the amount of support group participation in any year predicts who stays in recovery (Scott et al., 2005a & b).
- Providing assertive continuing care increases the percentage of clients participating in post-treatment continuing care activities and improves recovery outcomes (Godley et al., 2002, in press).
- Providing recovery management checkups reduces the time from relapse to treatment readmission, increases treatment participation, increases rates of abstinence, and reduces future needs for treatment (Dennis et al., 2003).

Recovery management approaches also hinge on the recognition of multiple pathways and styles of long-term recovery. Such varieties of recovery

experience are confirmed in our interviews with thousands of clients conducted months and years following an index episode of treatment. Yesterday's addiction counselor often worked within a particular pathway of recovery; tomorrow's addiction counselors will work across these pathways of recovery emphasizing a philosophy of choice with each client.

Implications for Clinical Practice

Educate Stakeholders about the Implications of the Chronic and Cyclical Nature of Addiction. Given that many individuals seeking publicly funded treatment have a substance use disorder that will likely span several years and multiple episodes of treatment, educating stakeholders and successfully shifting expectations and attitudes about relapse are primary challenges. Educating clients and their families about the chronic and cyclical nature of addiction may help families sustain their support during times of relapse. Education of treatment staff will help them appropriately attribute relapses to the condition being treated rather than the person and result in less shame for clients and families. In addition, educating policy makers and funders will be crucial to both creating new financing models and changing regulatory standards to accommodate models of sustained recovery management.

Develop new models for treating individuals who need multiple episodes of care. Our current approach to treating chronic substance use disorders often leaves both clients and staff frustrated with burdensome readmission processes and repeated cycles of "treatment as usual" for individuals who return for multiple episodes of care. In fact, one clinical supervisor asked one of our study participants why she returned again and again for treatment when she had already been exposed to their treatment. The supervisor said "there's nothing more for you here." If the same array of services has not worked several times, is it sensible to provide the same services and expect a different outcome or ethical to abandon such clients by refusing further services?

It is important when running any business to understand why the services we provide do not adequately meet our customers' needs. In the addictions field, we need to understand why so many clients drop out of treatment early and/or continue to relapse. The problems may be logistical (e.g., a lack of transportation, childcare), social (e.g., a partner, social peers), or due to a lack of linkage to a community that supports recovery. In our follow-up interviews, we have been struck by the number of relapsed clients who experienced their requests for further help as a shaming ritual and who were often refused re-admission on the grounds that they would be taking a

bed from someone who was more deserving or told that the program had nothing new to offer them. Disrespect (e.g., castigation as “retreads” or “frequent flyers”) and abandonment seem to be the norm for clients with chronic addiction problems. It is ironic that the treatment system is least welcoming to those who need its services the most. We need a new approach for clients whose problems are marked by high severity and chronicity.

Utilize ongoing monitoring and early re-intervention to prevent and/or shorten the length of major episodes of relapse. Ongoing management of other chronic health conditions successfully controls the severity and progression of these conditions when such conditions cannot be cured. A core assumption underlying this approach is that long-term monitoring through regular checkups and early re-intervention facilitate early detection of relapse, reduce the time to treatment reentry and consequently improve long-term participant outcomes. This approach also does not rely on participants to self-identify their symptoms and return to treatment. Recovery checkups are pro-active and include quarterly assessments and personalized feedback for each participant on the status of their condition. The clients we have interviewed for years often describe the value of these checkups in terms of empathy and acceptance, kindness and courtesy, belief in the client’s capacity to change, respect for the client’s right to learn from good and bad choices, linkage to crucial resources, and simply hanging in through the client’s setbacks and successes.

Provide multiple avenues in addition to traditional treatment. There is growing evidence that the processes of recovery maintenance are different than the processes of recovery initiation (White & Kurtz, in press). While treatment as currently designed can be a boon to recovery initiation, it offers little support for long-term recovery maintenance for those with the most severe problems. Many returning clients need only the briefest of treatments to re-achieve biopsychosocial stabilization, but they often need a broad range of non-clinical recovery support services to sustain recovery over time. As models of recovery management emerge, treatment agencies will develop larger service menus and will collaborate with a much larger spectrum of community agencies in helping people both get sober and stay sober. Such resources will include the growing diversity of recovery mutual aid societies, the rapidly expanding network of recovery homes, new recovery support organizations (e.g., recovery support centers, faith-based recovery ministries, recovery schools, recovery work co-ops) and roles (e.g., recovery coaches).

One of the contributions of longitudinal studies is a clearer picture of the course of addiction and the affirmation of the potential for recovery even

among those clients whose addictions are characterized by great severity, chronicity, and the need for multiple episodes of treatment. We have been humbled and inspired by the stories we have collected and hope you will benefit from the understandings we have tried to extract from these stories. The traditional concepts of “discharge” followed by brief “aftercare” have less meaning in the shift from acute care to recovery management models. To quote Dr. J. H. Kain (1828, p. 295), “Chronic diseases require chronic cures.” His adage suggests the need to remain involved with clients to help them manage the prolonged course of both addiction and recovery.

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