RETOOLING TREATMENT PRACTICES FOR LONG TERM WELLNESS

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GOALS

• Understand the varieties of the recovery experience and the research behind “solo” recovery;
• Analyze the role of specialized treatment within the recovery experience; and
• Articulate how the clinical process can support self-change.
Starting the discussion

• What is a typical client profile?
• What is your notion of recovery?
• What is your role as a professional in the recovery process?
• What is the goal/purpose of treatment?
• How do you know if you’re successful?
The present substance use disorder system of care is strained.
Triage

The SUD care system does not effectively or efficiently use its resources for wellness.

• It says, "Everyone needs treatment."

• Programs expect recoverees to fit the program rather than the program fitting the recoveree.
Past Year Perceived Need for and Effort Made to Receive Treatment among Persons Aged 12+ Needing But Not Receiving Specialty Treatment for Illicit Drug or Alcohol Use: 2006

- 95.5% Did Not Feel They Needed Treatment (20,114,000)
- 3.0% Felt They Needed Treatment and Did Not Make an Effort (625,000)
- 1.5% Felt They Needed Treatment and Did Make an Effort (314,000)

21.1 Million Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use
RESOURCES

The SUD care system does not identify, develop and use all the resources at the recoveree’s disposal.

• Assessments focus on pathology.
• Recovery/social capital is not assessed.
The SUD care system ignores the evidence of self correction.

- Many studies including broad Federal epidemiologic studies demonstrate that the most common pathway to recovery is self correction.
MEASURING SUCCESS

The SUD care system does not demonstrate achievable, broadly-acknowledged, meaningful metrics for personal recovery or population health.

• An effective system of care must be able to demonstrate (to the patient, payer and community) that improvement has been gained and maintained in the patient’s ability to function.

• Although it has become more evident that abstinence alone is no longer a viable marker of success, additional metrics of change are not widely identified and used.
A System View:
Institute of Medicine Protractor 1992
A new paradigm
Terminology: Primary Health Care

- Prevention (Primary)
- Early identification (Selective and indicated prevention)
- Treatment

- Recognize different problem sets
  - Present dangers
  - Future dangers
Terminology: Substance Use Disorders

- Substance abuse
- Substance misuse
- Substance use disorder

John Kelly, PhD
What’s the difference?

ADDICTION

DEPENDENCE
ADDICTION

• is characterized by
  o inability to consistently abstain,
  o impairment in behavioral control,
  o craving,
  o diminished recognition of significant problems with one’s behaviors and
  o interpersonal relationships, and a dysfunctional emotional response.

• IS NOT A CLINICAL DIAGNOSIS
DEPENDENCE (PHYSICAL)

• Physical dependence develops when the neurons adapt to the repeated drug exposure and only function normally in the presence of the drug.

• When the drug is withdrawn, several physiologic reactions occur. These can be mild (e.g., for caffeine) or even life threatening (e.g., for alcohol). This is known as the withdrawal syndrome.

• PHYSICAL DEPENDENCE AS A NEUROBIOLOGICAL CONDITION IS NOT THE SAME AS “SUBSTANCE DEPENDENCE”
Our beliefs and policies about these problems: morality v. science
Systemically: Drug classifications

• Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse.

• Schedule I drugs are the most dangerous drugs of all the drug schedules with potentially severe psychological or physical dependence.

• Heroin, LSD, peyote, cannabis
Clinically: Treatment approaches

• Our view of substance use disorders [and how to treat them] has been distorted by focusing on people attending treatment programs. (Willenbring)

• Much of present elements of treatment practices are based on traditional 12-Step beliefs.
Previously

Substance abuse
Substance dependence
Now

Substance use disorders:

mild

moderate

severe
The spectrum of alcohol use

Continuum of care for excessive drinking and alcohol use disorders. (Percentages represent the approximate proportion of the U.S. population age 18 and older in each category in any given year.) [Mark Willenbring, MD]
AOD problems vary in their course!

NO BROAD BRUSH!
There is no sharp delineation of severities of problems
SUD Incidence and Prevalence

**PREVALENCE:**
Current rate is about 8.2% of the US adult population

**INCIDENCE** (new cases)
Substance Dependence or Abuse in the Past Year among Persons Aged 12 or Older: 2002-2013 (SAMHSA)
Incidence and Prevalence

Incidence = 20,500/year input*

*[US population growth approximately 250,000/yr X 8.2% = 20,500]
WHERE DO THEY GO?
Current Status PPY Alcohol Dependence

PPY = Prior-to-past-year
25.5% ever received treatment

Dawson et al (2005)
Problems Vary by Age

NSDUH Age Groups

Adolescent Onset
Remission
Increasing rate of non-users

Severity Category
- No Alcohol or Drug Use
- Light Alcohol Use Only
- Any Infrequent Drug Use
- Regular AOD Use
- Abuse
- Dependence

Source: 2002 NSDUH and Dennis et al forthcoming
SUD status is fluid
A “Typical” Course of Recovery

[A] typical course of recovery might consist of continued drinking, accompanied by symptoms of alcohol use disorders, that would persist for 5–10 years before resolving into asymptomatic risk drinking and, ultimately, into either low-risk drinking or abstinence.

Dawson
Most persons who develop alcohol dependence have mild to moderate disorder. They primarily experience impaired control.

National Epidemologic Survey on Alcohol and Related Conditions 2001-2002
Many heavy drinkers **do not** have alcohol dependence.

National Epidemiologic Survey on Alcohol and Related Conditions 2001-2002
About 70% of affected persons have a single episode of less than 4 years.

National Epidemiologic Survey on Alcohol and Related Conditions 2001-2002
“High-functioning alcoholic”
High-Functioning Alcoholics

19.5%

Nearly 1/5th of all American alcoholics belong to the high-functioning subtype

Chronic Severe Alcoholics

9%

NIAAA 2007 study
Typology of Alcoholics

- Jellinek’s “species” of alcoholism
- Cloninger: Type I and Type II
- Lesch: Four types
- Babor: Type A and Type B
Sticks and Stones
CHRONIC

(Once an addict, always an addict!)
SUDs are similar to other chronic disorders such as arthritis, hypertension, asthma, and diabetes that are generally accepted as requiring life-long treatment.
Comparison to Other Chronic Disorders

• Like substance-use disorders, the onset of these chronic diseases is determined by multiple factors, and the contributions of each factor are not yet fully specified.

• Behavioral choices seem to be implicated in the initiation of each of them.

• Behavioral control continues to be a factor in determining their course and severity.
Outcomes with chronic diseases

• 40%-60% of discharged AOD patients continuously abstinent at 1 year

• <60% adult patients with type 1 diabetes fully adhere to medication schedule

• <40% of patients with hypertension or asthma fully adhere to their medication regimens

• <30% of patients with adult-onset asthma, hypertension or diabetes adhere to prescribed diet and/or behavioral change

McLellan et al. (2000)
PROGRESSIVE
(Inevitably!!)
COMPROMISED DATA
BELIEF IN THE INEVITABILITY OF PROGRESSION

• Leads us to design recovery strategies based on potential severity
• Inhibits our ability to respond to the recoveree’s current severity and resources
Progression is not inevitable

“Aging out” contradicts the concept of inevitability.
RELAPSING

(Of course.)
## Success rates for the treatment of various SUDs

<table>
<thead>
<tr>
<th>Disorder (DSM-IV)</th>
<th>Success rate (%)*</th>
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<tbody>
<tr>
<td>Alcoholism</td>
<td>50 (40-70)</td>
</tr>
<tr>
<td>Opioid dependence</td>
<td>60 (50-80)</td>
</tr>
<tr>
<td>Cocaine dependence</td>
<td>55 (50-60)</td>
</tr>
<tr>
<td>Nicotine dependence</td>
<td>30 (20-40)</td>
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*Follow-up 6 mo. Data are median (range).

McLellan
COMPARISON OF RELAPSE RATES BETWEEN DRUG ADDICTION AND OTHER CHRONIC ILLNESSES

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percent of Patients Who Relapse</th>
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<tbody>
<tr>
<td>Drug Addiction</td>
<td>40 to 60%</td>
</tr>
<tr>
<td>Type 1 Diabetes</td>
<td>30 to 50%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>50 to 70%</td>
</tr>
<tr>
<td>Asthma</td>
<td>50 to 70%</td>
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www.drugabuse.gov/publications/science-addiction/treatment-recovery
Treatment adherence for chronic disorders

• As with the treatment of SUDs, treatments for hypertension, diabetes, and asthma heavily depend on behavioral change and medication regimen to achieve their potential effectiveness.

• Lack of adherence with treatment regimen is a major contributor to reoccurrence and to the development of more serious and more expensive "disease-related" conditions, e.g., limb amputations and blindness are all too common consequences of treatment non-response among diabetic patients. Stroke and cardiac disease are often associated with exacerbation of hypertension.
Adherance and recurrence in selected medical disorders

**Insulin Dependent Diabetes Mellitus**
- Medication regimen: <50%
- Diet and foot care: <30%
- Relapse [a]: 30-50%

**Hypertension [b]**
- Medication regimen: <30%
- Diet: <30%
- Relapse [a]: 50-60%

**Asthma**
- Medication regimen: <30%
- Relapse [a]: 60-80%

[a] Retreatment within 12 mo by physician emergency room or hospital.
[b] Requiring medication
William Miller on relapse: refocus
“I only lost one pound before I quit my diet. But if I can do that 50 times, I’ll lose 50 pounds!”
Defining and responding to “relapse”

A reasonable definition must distinguish a temporary recurrence that involves a few occasions of use from a return to persistent drug use.
POTENTIALLY FATAL
“My problem isn’t that bad”
“I can handle it myself.”
Denial or Choice?

Among the 17.0 million people aged 12 or older who met the criteria for an alcohol use disorder

- 698,000 (4.1 percent) felt they needed treatment for their alcohol use problem.

95.9% DID NOT
Denial or Choice?

Of the 6.4 million people aged 12 or older who met the criteria for a substance use disorder

• 392,000 (6.1 percent) reported that they perceived a need for treatment for their illicit drug use problem.

93.9% DID NOT
Conclusions

• **CLINICALLY:**
  – We treat SUDs as a monolithic disorder with little regard to the individual degree of severity, amount of resources and level of functioning
  – We use a moral rather than science base to describe and interact with and treat persons with SUDs
  – We don’t identify and develop indigenous client resources to support recovery

• **SYSTEMICALLY:**
  – We do not use available science about severity and typologies to help design effective responses
  – We identify all persons with SUDs as *needing* treatment, creating an enormous, unrealistic and unnecessary service burden
WHAT DO WE MEAN BY “recovery?”
Recovery from substance use disorders is a person’s efforts to stop, control and repair that damage.
The Betty Ford Institute Consensus Panel

- Sobriety
- Personal health
- Citizenship
White’s Definition of Recovery

“Actively managing one’s vulnerabilities”
THE RECOVERY DYNAMIC

Risks
Vulnerabilities

RECOVERY

Resilience
Recovery Capital
Recovery is a process, not an event.
DEVELOPMENTAL STAGES OF RECOVERY

- PRIMING
- INITIATION
- MAINTENANCE
- TERMINATION
Recovery is not sainthood

Or even being a Boy Scout
The experience of recovery:
not always the same
for everyone
Looking at the varieties in the experiences of recovery

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<thead>
<tr>
<th>SCOPE</th>
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<tbody>
<tr>
<td>• Primary chemical health</td>
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<td>• Secondary chemical health</td>
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<td>• Global health</td>
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<tr>
<th>DEPTH</th>
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<tr>
<td>• Partial</td>
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<tr>
<td>• Full</td>
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<tr>
<td>• Enriched</td>
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<table>
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<tr>
<th>TYPES</th>
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<tbody>
<tr>
<td>• Abstinence-based</td>
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<tr>
<td>• Moderation-based</td>
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<tr>
<td>• Medication Assisted</td>
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<tr>
<th>CONTEXT OF INITIATION</th>
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<tbody>
<tr>
<td>• Solo</td>
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<tr>
<td>• Peer assisted</td>
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<tr>
<td>• Treatment assisted</td>
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<table>
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<tr>
<th>FRAMEWORKS OF INITIATION</th>
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<tbody>
<tr>
<td>• Religious</td>
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<tr>
<td>• Spiritual</td>
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<tr>
<td>• Secular</td>
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The **SCOPE** and **DEPTH** of recovery
Scope of recovery

What do I want to recover from?
Depth Of Recovery
How much recovery do I want?

Partial Recovery

Enriched Recovery

Full Recovery
Depth of Recovery: Partial Recovery

- Moderate use
- Problematic use
- Abstinence
Partial recovery can convey two different conditions

A reduced frequency, duration, and intensity of AOD use and reduction of related personal and social problems

The achievement of complete abstinence or stable moderation but not achieving parallel gains in physical, emotional, ontological, relational or occupational health.
Moderation

...[A]lcohol dependence—at least when defined in terms of the DSM-IV criteria—may not preclude a return to low-risk drinking for some individuals.

Typically, these might consist of people with less severe disorders who mature out of their drinking problems without treatment.

Dawson et al
Addiction, 100, 281–292
Self Correction:
The Most Common Pathway
Synonyms

- Solo recovery
- Maturing out
- Auto remission
- Self-initiated change
- Unassisted change
- Spontaneous remission
- De-addiction
- Self-change
- Self-managed change
- Natural recovery
SELF CORRECTION

NO TREATMENT
NO MUTUAL AID

75%

National Epidemologic Survey on Alcohol and Related Concerns 2001-2002