

Long Term Recovery: What We Know and What We Need to Know

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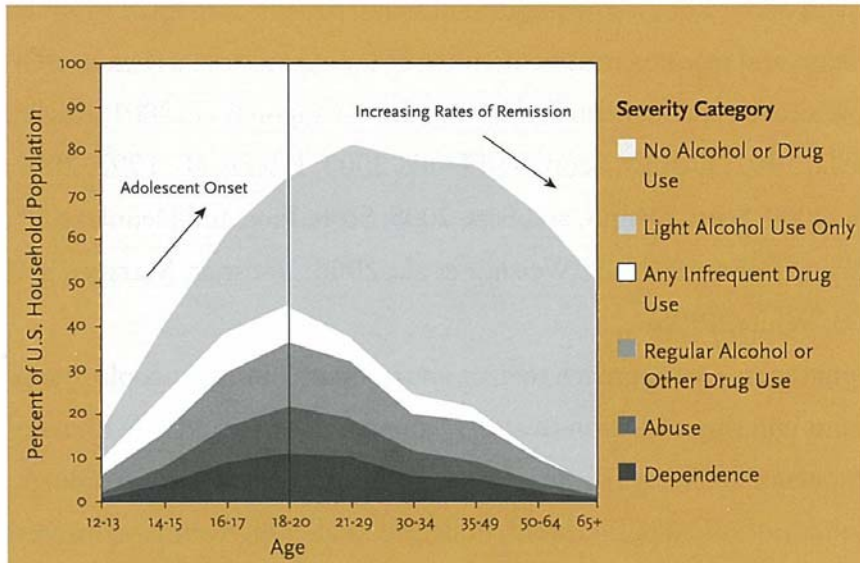


What We Know About Addiction

- Alcohol and drug use over the life cycle exists on a continuum demarcated by patterns of non-use, minimal use, regular use, risky use (dosages, combinations, and contexts that threaten self or others), and regular heavy use (Saha et al., 2007; Willenbring, 2008)
- The DSM-IV-R (American Psychiatric Association, 2000) classifications capture only a narrow range of alcohol and other drug use behaviors.
- Substance dependence is not nor does not become a chronic illness for all individuals (McLellan, 2002; Willenbring 2008).
- While substance dependence is most often documented in research studies as a progressive disorder, community studies reveal that it is not in a majority of cases. (e.g., Schuckit, et al., 2002; Harford et al., 2006)

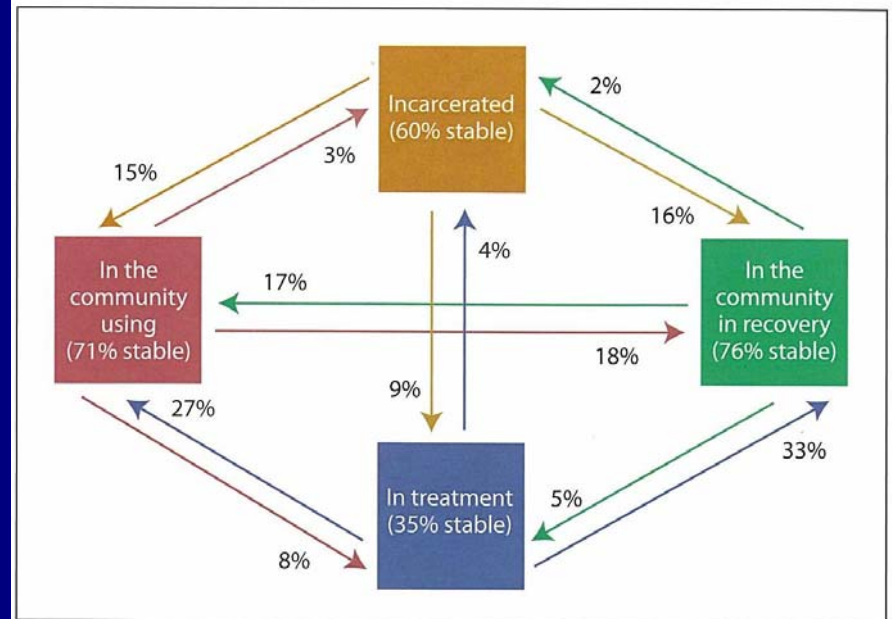
What We Know About Addiction

FIGURE 1. Substance Use Disorders Begin in Adolescence and Last for Decades



In the U.S. household population in 2001, the percentage of people who reported substance dependence or abuse rose through the adolescent age groups to peak among the 18- to 20-year-olds, and declined through subsequent age groups (OAS, 2002).

FIGURE 2. The Pathway to Recovery Is Cyclical



Over a 2-year period, 82 percent of drug users transitioned one or more times between use, incarceration, treatment, and recovery. An average of 32 percent changed every 90 days, with movement in every direction and treatment increasing the likelihood of getting to recovery (Scott, Foss, and Dennis, 2005).

Both Figures from Dennis & Scott (2007)

What We Know About Addiction

- Many individuals who meet clinical criteria for addiction resolve the problems on their own – without formal or peer-assisted recovery (“natural recovery”). (White, in press; Moos & Moos, 2005; McIntosh & McKeganey, 2002; Tucker, 2003; Finfgeld, 1997; Sobell et al., 1991)
- Only a small portion of individuals with alcohol or other drug problems seek to resolve these problems through formal treatment (Dawson et al., 2005)
- Current scientific knowledge is based on understanding one subgroup that struggles with addiction (those who enter formal treatment; Dennis & Scott, 2007).

Treatment and Recovery: The Long View – Early work

George Vaillant (1988)

- Followed 100 hospital-treated heroin addicts for 20 years and 100 hospital-treated alcoholics for 12 years.
- Concluded that the goal of treatment should be the prevention of relapse (as opposed to detoxification).
- Treatment of D/A addiction is like the treatment of diabetes and hypertension.
- If treatment is no more effective than the natural healing processes, we need to better understand those natural healing processes.

Yih-Ing Hser, et al. (2001)

- Conducted a 33 year follow-up of narcotic addicts who received compulsory treatment for criminal offenders.
- Found death rate in group steadily increased, but heroin use stabilized over lifetime.
- Those who continued to use heroin experienced far more problems in health and other areas of their lives than those who achieved abstinence.
- Information supported earlier assertion that reaching long-term abstinence from heroin use is a very long process.

Treatment and Recovery: The Long View-Early Work

George Vaillant (2003)

- Conducted a 60-year follow-up of alcoholic men
- Found that by age 70 chronic alcohol dependence was rare (only 12% were still alcohol dependent).
- Of the rest in the study - 54% had died; 32% were abstinent; and 9% were controlled drinkers.
- The two best predictors of sustained abstinence were prior alcohol dependence and AA attendance.
- No single factor was observed for prediction of safe return to social drinking.
- the factors predicting recovery are different than those predicting the onset of alcoholism.
- Long-term follow-up appears to be a viable and needed course for treatment.

What We Know Now About Treatment and Recovery

Moos & Moos (2007)

- Documented the positive impact on long-term outcomes after treatment through developing or enhancing “protective resources” such as financial resources, better health, and participation in AA.
- Family and social resources were strong predictors of positive outcomes. (supports the use of family-oriented approaches)
- “Maintaining and enhancing individuals’ personal and social resources may contribute more to long-term remission than does treatment oriented toward reducing or eliminating substance use per se.”

Schutte et al. (2001)

- Older individuals classified as problem drinkers only achieved a 10-year stable remission rate of 30% (only 12% of the sample ever received treatment).
- 71% of older problem drinkers who were remitted at the 4-year follow-up were also remitted at the 10-year follow-up.

What We Know About Treatment and Recovery

- The majority of those discharged from treatment do not receive the NIDA (1999) recommended 90 days of continuous care (White, in press).
- 80% of individuals who relapse after treatment do so in the first 90 days (Hubbard et al., 2001).
- The majority of substance dependent individuals only achieve stable recovery after 3-4 treatment episodes over multiple years (Anglin et al., 1997; Dennis et al., 2005).
- Only 17% of individuals who complete one level of care successfully access the next recommended level of care (OAS, 2005).
- Only 1 in 5 adults and 36% of adolescents receive any professionally-directed post-discharge continuing care even though research has shown that such care enhances recovery outcomes (Godley et al., 2001; McKay, 2001)
- Linking treatment to recovery supports improves outcomes 20-22% (White/2006; Dennis, 2008)

What We Know About Recovery: A Working Definition

“Recovery is the process through which severe alcohol and other drug problems (here defined as those problems meeting DSM-IV criteria for substance abuse or substance dependence) are associated in tandem with the development of physical, emotional, ontological (spiritual, life meaning), relational, and occupational health”
(White & Kurtz, 2006).

What We Know About Recovery

Recovery can be:

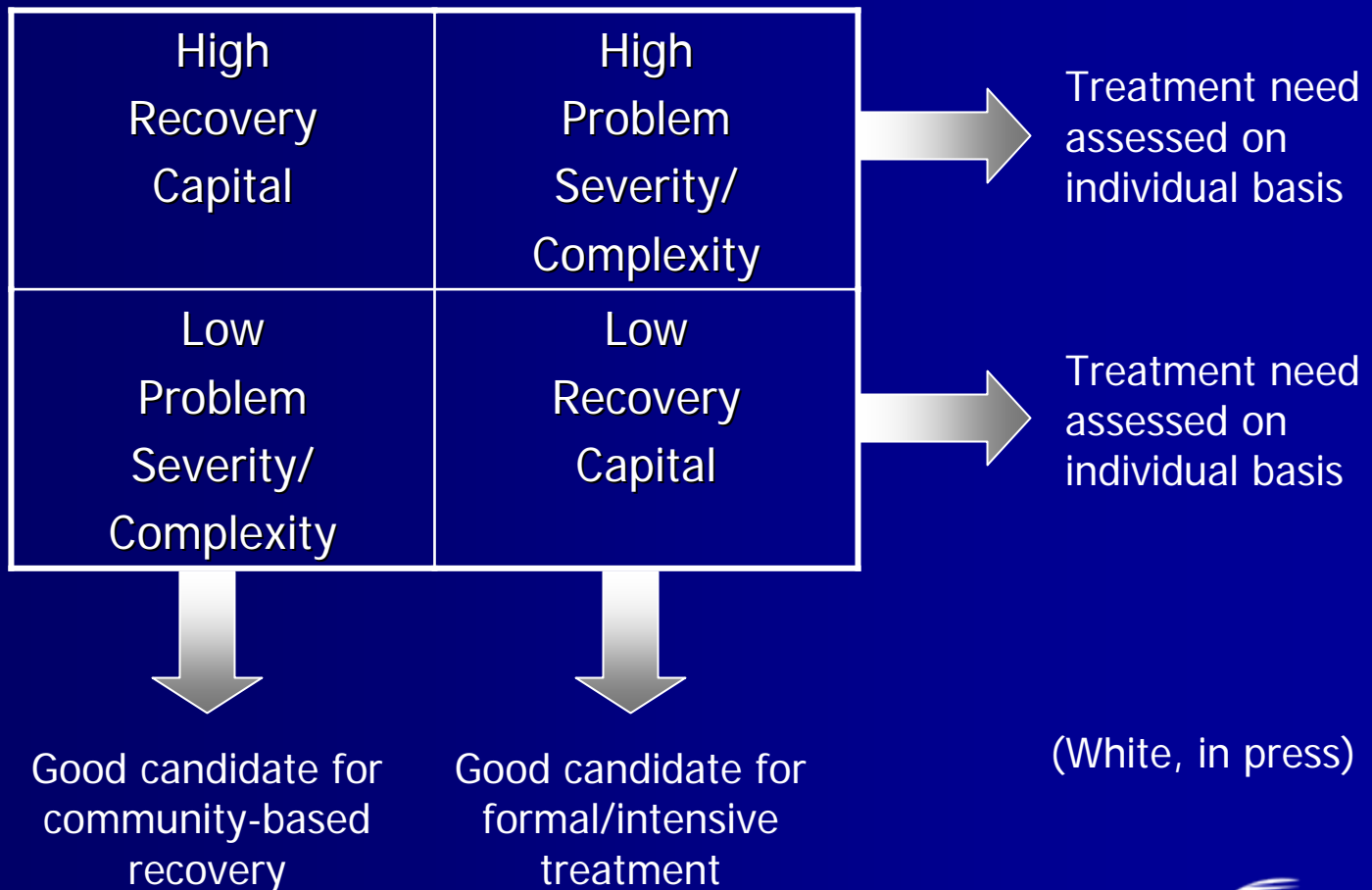
- Solo (Natural)
- Treatment-assisted (including medication-assisted recovery)
- Peer-assisted
- Partial or full

Recovery can be initiated in different frameworks:

- Religious (faith-based)
- Spiritual
- Secular

- Family/community support plays a key role in all recovery.
- Recovery capital is “the total intrapersonal, interpersonal, and community resources that can be brought to bear on the initiation and maintenance of recovery ” (White, in press).
- Recovery capital should be assessed during screening and factored into any level of care decisions (White, in press).

What We Know About Recovery: Problem Severity/Recovery Capital Matrix



Recovery – What we now do know

- The need for post-treatment check-ups and recovery support services intensifies as problem severity increases and recovery capital decreases (White, 2006)
- Addiction treatment outcomes are compromised by the lack of sustained recovery support services (White, 2006)

Recovery – What we now do know

- Participating in peer-based recovery support following treatment enhances long-term recovery but needs ancillary support from professionals. (Whitae, 2006)
- At present, the resolution of severe substance use disorders can span years (even decades) with multiple treatment episodes before recovery is sustained. (all)

Recovery – what we now do know

- For most in recovery, sustained recovery was not achieved in the short time span a traditional treatment.
- There appears to be cumulative and synergistic effects resulting from multiple treatment episodes.

What We Know About Recovery: The Brain

- Neuro-imaging studies support the chronicity of addiction and recovery (Fowler et al, 2007; Condon, 2008).
- Chronic substance use is associated with physical changes in the brain:
 - Cravings, cue activity, tolerance, withdrawal, and “normality” can be seen in the brain;
 - Substances interact with brain development (particularly among adolescents); and
 - Changes in the brain respond to medications as well as changes in the social and physical environment;

Chang et al, 2005; Volkow, Fowler and Wang, 2003; 2004;
Paulus, Tapont, and Shuckit, 2005; et al.

What we know about Recovery – the brain

- There are four Major Neurobiological Processes identified as triggers for relapse:
 - - Conditional cuing
 - - Drug Priming
 - - Stress-Induced Increase in Drug Intake
 - - Eroded Frontal Lobe Inhibitory Systems

(Condon ,2008 – see
www.neattc.org)

What We Know About Recovery

- Co-Occurring problems, if unaddressed, will undermine long-term recovery (Moos, et al., 1994; Chi, et al., 2006).
 - Persons with PTSD and substance use disorders are less likely to participate in post-treatment continuing care activities and will relapse faster and use more subsequent inpatient resources compared to persons with only a substance use disorder" (White, in press)
- Nicotine dependence is associated with poorer outcomes in treatment and higher post-treatment relapse (Patkar et al., 2003; Hillemacher et al., 2006; Sobell et al., 1995).
- "Socioenvironmental factors are known to contribute to increased prevalence of comorbidities, and attention to them can be expected to improve preventive interventions, treatments, functional outcomes, and service system organization" (Mueser & Drake, 2007).

Emerging Strategies to Support Long-Term Recovery

- Improve the continuity of care
 - Individuals discharged from intensive levels of addiction treatment should be transferred to outpatient treatment before leaving the treatment system (APA, 1995; ASAM, 2001)
 - Use a recovery plan (as opposed to a treatment plan) (White & Kurtz, 2006; Scott, Dennis & Foss, 2005)
 - Use assertive (not passive) strategies to link treatment and recovery support services (White & Kurtz, 2006)
 - Used performance measures (e.g., Garnick et al., 2002; McCorry et al., 2000; McLellan et al., 2005)
 - The increased costs of a full continuum of care (inpatient and outpatient vs. outpatient only) are offset by the significant reductions in societal costs in the 9 months following Tx (French et al., 2000)

Emerging Strategies to Support Long-Term Recovery (cont'd)

- Use recovery monitoring and early re-intervention
 - Telephone-based continuing care (McKay et al., 2004)
 - Recovery Management Checkups (Dennis et al., 2003; Scott et al., 2005)
 - Assertive Continuing Care (Godley et al., 2004)
- Link individuals to other recovery support services
 - Provide a choice of peer-support groups
 - Use technology – telephone-based self-monitoring or internet-based groups

Results: Recovery Management Checkups

Individuals:

- Returned to treatment in greater numbers (60% vs. 51%)
- Returned to treatment sooner (median 376 vs. 600 days)
- Attended treatment more days (63 vs. 40)
- Were less likely to be in need of treatment after 2 years (34% vs. 44%)

Dennis & Scott, 2007

What Now?

Recovery Oriented Systems of Care

- Fundamentally change the way the system provides options for individuals to achieve recovery.
- Even if the presentation of the illness is not chronic, the system needs to approach addiction as a chronic illness.
- There needs to be a common definition of recovery and clearly defined paths to achieve it.

Examples of ROSC Approaches

Connecticut (T. Kirk, Ph.D.)

Philadelphia Module (A. Evans, Ph.D.)

New York State (Karen Carpenter-Palumbo)

Veterans Administration (Clinical Practitioner)

Central City Concern (Oregon- Ed Blackburn)

RWJF Advancing Recovery Initiative

SAMHSA/CSAT ATR Initiative

What We Need to Know to Transform Addiction Care

Why we Need a Science of Recovery:

- Decades of research has resulted in a vast knowledge about the nature (etiology, “causes”), patterns, consequences and treatment of addiction. But we don’t know:
 - How many people in the U.S. are in recovery?
 - How did they get there?
- Since less than 1/3 of people who need it ever seek treatment, we need to know how to “sell” treatment better.
- Long-term recovery is very poorly understood. Therefore, how can we effectively promote it without examining it?

What We Need to Know to Transform Addiction Care

- What is recovery?
 - What are the required ingredients?
 - In what domains does there have to be improvement for there to be recovery?
- What constitutes a satisfying quality of life in recovery and how does that change over time?
- What needs to happen to motivate an individual to initiate recovery?
- What is long-term recovery?
- How do people recover?
 - What works and for whom?
 - What are the common themes in recovery?

What We Need to Know to Transform Addiction Care

- What are the effectiveness and cost-effectiveness of recovery-oriented systems of care in terms of lives and dollars saved, communities restored, families reunited, employment rates increased, and demonstration of good “citizenship”?
- What is the most effective role for peers in recovery services?
- How is recovery from addiction similar to and different from recovery from other chronic conditions?
- How do we disseminate the message of hope and increase the attractiveness of recovery services?

We are in the midst of a profound paradigm shift. Yet, our ultimate goal has not shifted – to offer individuals the best options to achieve freedom from addiction and maintenance of long-term recovery. Together we have a renewed chance to contribute new knowledge, learn from each other, and advance science to better support long-term, stable recovery.

Thank you!!

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