



RESPONSE: NO MORE “28 DAYS AND YOU’RE CURED”

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Mel Taylor: The naïve question politicians and others ask is, “Why can’t they just quit?” The answer is that addiction is a chronic condition, and relapse is one of its behavioral consequences.

Claudette Wallace: To see that alcoholism and addiction are chronic diseases, you just need to look at the high rate of recidivism. Most of the people we work with make many attempts and have many failures before they get into ongoing recovery. And even then, the minute they relapse or slip, they’re immediately back where they started.

Allan Cohen: The view that drug dependence is a chronic disease has been implicit in the way opioid addiction has been treated for the past 40 or 50 years. Along with counseling and other psycho-support services, we give patients opioid agonist maintenance therapy to normalize the brain chemistry that opiates have disrupted.

I agree with this concept and approach. At the same time, I’m not convinced that everybody who starts abusing drugs immediately has a chronic condition. The scientific literature, especially current imaging work, confirms that repeated drug exposures produce organic, functional changes to the brain that support continued use and dependence, but this doesn’t happen all at once. It’s a developmental process that occurs over time. I think some of the patients we see are in acute rather than chronic stages of drug abuse, and we might prevent them from developing dependence if we can diagnose them soon enough and treat them effectively.

Wallace: Recovery, like addiction, is a process. People learn something each time they fail to stay sober. That doesn’t mean everyone

will succeed. Some people learn all they need to know to maintain a lengthy abstinence after one treatment episode; others take multiple episodes. Others may be neurologically damaged so that they cannot sustain recovery, even after many episodes.

Cohen: People get tired of the revolving door of going into treatment and then relapsing, and going back into treatment and relapsing again. At some point in time, something occurs, something changes. They come to a place where they’re more willing to transition into something other than what they’ve been going through.

Wallace: That’s true. After several relapses, people are tired and often feeling very hopeless.

Cohen: At the same time, just saying “Some people are more motivated” doesn’t come close to explaining why some people do well in treatment, and others don’t. We work hard to help our clients create their own relapse prevention plans and feel excited about them. We know, though, that as soon as they leave the program they will face challenges regarding housing, jobs, and families. Along with drug addictions, many have co-occurring psychiatric conditions, poor living conditions, or medical conditions. All these factors play important roles in the recurrence and chronicity of addiction.

Taylor: As the authors indicate (Dennis and Scott, 2007), comorbidity contributes to both the frequency and severity of relapse. Many people find it hardest to stay sober when they are depressed. If they can keep their mood up, sobriety tends to be more stable and relapse less likely. Genetic factors affect people’s drug histories too. I have read

that 20 to 25 percent of people who abuse substances at a high level have family members who do so as well.

Behavioral health responses

Taylor: When we frame addiction as a chronic disease, we begin to think in terms of a life-long effort to control certain vulnerabilities. “Managing” becomes the operative term—as it is with other chronic conditions. There’s no saying, “28 days, check out, and you’re cured.”

Wallace: We talk to our clients about relapse being part of the disease. I think that’s very important. I don’t think we do it enough.

Cohen: Most programs make patients aware that relapse is possible. Where I think we fall short is in not taking a closer look at what each individual patient’s relapses might look like, what might trigger them, and what to do if they come up. “Call your sponsor if you feel like taking a drink” might work for some people, but this article is talking about people with severe and persistent problems in their lives. Many are trying to stay sober and clean for the first time in many years. They need some sort of ongoing support structure.

Wallace: The first thing I would undertake, if my program, ChangePoint, were to receive a windfall, would be to implement a relapse prevention structure where clients would keep coming back to talk about whatever they’re struggling with. The program would provide support and help them remember and use the tools they learned in treatment. In the best of all worlds, people would not be simply invited to drop in—they would be expected to.

Cohen: Our predicament at present is that when it comes to incorporating chronic disease models into treatment programs, we don't yet know what interventions really work. The research results on long-term monitoring and early reintervention are mixed. To take one example, the Betty Ford Center makes telephone followup for several months part of its regular treatment. The clients love to hear from the center, and the center regards the calls as an indispensable tool. However, when NIDA's Clinical Trials Network put telephone monitoring to an empirical test, the data didn't show that it made much difference.

Wallace: As part of a methamphetamine research project at ChangePoint, we called clients periodically over 12 months to see how they were doing. I have the impression that the effect was very positive. Clients commented that they waited for the phone to ring and appreciated the fact that somebody was checking with them.

Cohen: In the 1960s, we had social workers or case workers, and they handled everything. We're very specialized now, and episodic in our approach. This article says, "Let's go back to being more comprehensive."

Public health and systems responses

Taylor: When we start talking about addiction as a chronic disease, I think we automatically imply that there's a need for a broad public health approach. Several years ago, some local doctors, working with us at the Council on Alcohol and Drugs Houston, reported that nearly 80 percent of admissions to the county hospitals involved substance abuse problems. The message was: It makes sense to provide more dollars for screening and assessment of these problems before people show up at the emergency room.

Cohen: I believe screening and brief intervention in primary care can help with a chronic disease model much better than complete reliance on isolated treatment programs that people have to find and access to get help. When primary care physicians can detect a chronic disease like substance abuse and intervene or refer the patient to a specialist, the impact is tremendous. We wouldn't see as many people needing to return for residential or inpatient treatment.

Taylor: Absolutely. We've been testing a protocol where a primary care physician identifies a possible substance abuse problem and refers the patient to someone who does a brief motivational interview. The interview consists of a discussion around, "If you keep drinking this way, you're going to end up with X, Y, or Z issue. Here's some information. I'd like to talk with you more about it next time. Take care of yourself." The study has been going on for 5 years, and the results are profound: More than 50 percent of the time, simply talking to the patient leads to a reduction in substance use. One factor that facilitates the program here in Harris County is that we are co-located with our physicians.

Cohen: We're starting to engage in some of that same kind of work now in California. I think it's the wave of the future.

Taylor: The approach is exactly parallel to the way we deal with other chronic diseases. For example, take patients at risk for heart attacks. The cardiologist knows that if the patient doesn't change his lifestyle, he's going to be back. So, the cardiologist works with nutritionists, dietitians, exercise coaches, and so on, who put the patients on a program of behavioral change, and the heart attack risk goes down.

Cohen: Implementing this approach won't be simple. For starters, do we put seasoned and educated substance abuse staff in primary medical settings, or train the staff in primary care settings?

Taylor: We were concerned initially that physicians might not be willing to add substance abuse counseling and brief motivational interviewing to what they do. As it turned out, they weren't. However, they are eager to have substance abuse counselors and others on board alongside them, carrying out that work. I guarantee you, if we said we're pulling out, the physicians would scream and holler. Pediatricians and obstetrician-gynecologists are also participating to prevent fetal exposure to drugs. What has been most exciting is these doctors' recognition that substance abuse professionals can, indeed, pull our fair share as part of a team that produces better outcomes for patients.

Cohen: I agree wholeheartedly with the authors' recommendations for research, particularly on cost-effectiveness. With accreditation and funding being tied to the use of evidence-based treatments, we need to show both clinical results and cost-effectiveness for whatever we implement.

Taylor: Investing in treating addiction as a chronic problem makes economic sense and public health sense. Demonstrating this fact is the only way we're going to see a fundamental change in policy. If you spend more for a longer term, more comprehensive program, you're going to get a better return—better recovery, less frequent relapse, and perhaps less intense relapse. The bottom line is that we can pay for it now, or we can pay for it later, and we can't afford to keep paying for it later.

REFERENCE

Dennis, M., and Scott, C.K. 2007. Managing addiction as a chronic condition. *Addiction Science & Clinical Practice* 4(1):45-55.