IF ADDICTION IS A DISEASE
HOW COME I’M NOT IN A DOCTOR’S OFFICE?

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Southeast ATTC is one of 10 Regional and 4 National Focus resource centers for addiction-related information funded through by the Substance Abuse and Mental Health Services Administration (SAMHSA). Southeast ATTC, located at the National Center for Primary Care at the Morehouse School of Medicine in Atlanta, serves the states of Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee.
ATTC PURPOSE

- Raise awareness of evidence-based and promising treatment and recovery service practices,
- Build skills to prepare the workforce to deliver state-of-the-art addictions treatment and recovery services, and
- Change practice by incorporating these new skills into everyday use for the purpose of improving addictions treatment and recovery outcomes.
LEARNING OBJECTIVES

- What criteria must be met for a medical condition to be a “Disease”
- Explore the “Acute Care” and “Chronic Care” models and how they relate to AOD Treatment
- What is the “Public Health Model” and how it relates to AOD Prevention.
- Discuss how our language reflects our concepts of AOD Treatment and Prevention.
Expand

Your Mind
MEDICAL CONDITION

- Affects specific organs or parts of the body
- Has identifiable causes
- Has identifiable signs and symptoms
- Is either acute or chronic
WHAT IS “ADDICTION”? 

Addiction is a primary chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behavior. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

American Society of Addiction Medicine, 2011
**ACUTE VS. CHRONIC**

- **An “Acute” Condition has:**
  - Rapid onset
  - Short course
  - May be severe

- **A “Chronic” Condition has:**
  - Gradual onset
  - Lifetime course
  - May have “acute” episodes
  - Multi-modal Treatments
  - Variable response rates depending on patient, treatment and outside factors
TYPES OF ACUTE CONDITIONS
TYPES OF CHRONIC DISEASES

- Hypertension
- Diabetes
- Asthma
- Addiction
<table>
<thead>
<tr>
<th><strong>DIABETES</strong></th>
<th><strong>ADDICTION</strong></th>
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<tbody>
<tr>
<td>- Genetic predisposition</td>
<td>- Genetic predisposition</td>
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<tr>
<td>- Lifestyle choices are a factor in development of the disease</td>
<td>- Lifestyle choices are a factor in development of the disease</td>
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<tr>
<td>- Severity is variable</td>
<td>- Severity is variable</td>
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<td>- There are diagnostic criteria</td>
<td>- There are diagnostic criteria</td>
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<td>- Once diagnosed, you’ve got it</td>
<td>- Once diagnosed, you’ve got it</td>
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<td>CHRONIC DISEASE COMPARISON</td>
<td>DIABETES</td>
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<tr>
<td>Primary treatment is</td>
<td>Primary treatment is lifestyle modification</td>
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<tr>
<td>lifestyle modification</td>
<td>Small percentage of patients comply with same</td>
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<td>Medications can help</td>
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<td>Patients often don’t comply with medical regimen</td>
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CHRONIC DISEASE COMPARISON

DIABETES

- Patients who are partially compliant are the rule, and outcomes are better than those who do not get treatment
- Support systems improve outcomes

ADDICTION

- Patients who are partially compliant are the rule, and outcomes are better than those who do not get treatment
- Support systems improve outcomes
CHRONIC DISEASE COMPARISON

**DIABETES**
- Even in highly motivated patients, only a small percentage will succeed without medication. “Abstinence” from medication is lowest priority

**ADDICTION**
- Abstinence is still often the underlying goal, without which treatment (and the patient) is judged a failure???
DISEASE COMPARISON: CONCLUSION

- Chronic disease may be controllable, but not usually curable
- Medications, if available, are useful to promote this “disease control”
- Results will be suboptimal
- There is a “disconnect” between treatment of addiction vs. other chronic diseases
Reoccurrence Rates Are Similar for Addiction and Other Chronic Illnesses

Number of abstinent periods one month or longer followed by return to drug use prior to current abstinence*

- One: 17%
- Two: 22%
- Three: 11%
- Four to five: 16%
- Six to nine: 7%
- Ten to 19: 17%
- 20 & over: 10%

50% reported 4 or more abstinent periods followed by a return to active addiction

*Outside of controlled environment, among those who report one or more such periods: 71%  N=248  Laudet & White 2004
DEALING WITH A MEDICAL CONDITION

- What kind of words and phrases are used to refer to people with medical conditions?
- How does society deal with people who have medical conditions?
What happens when………

- A person with hypertension does not take their medication and has a stroke?
- A person with asthma continues to smoke cigarettes?
- A person with diabetes is stable on medication but will not make the lifestyle changes that would allow them to discontinue taking medication?
MORAL ISSUE

Good

Bad
A client stops attending mutual support group meetings and resumes drinking?

A client who has been in multiple levels of care, leaves treatment and continues drinking?

A person who is opioid dependent is stable on medication but chooses not to make the lifestyle changes that would allow them to discontinue taking medication?
WORDS AND PHRASES TO THINK ABOUT

- Relapse
- Denial
- Clean / Sober
- Drug of Choice
- Relapse is part of Recovery
- Abstinence
- A Drug is a Drug is a Drug
- Self Help Groups
- Consumer / Patient / Client
- Substance Abuse
- Not Ready Yet, Doesn’t Want it Bad Enough
- Retreads / Frequent Flyers / Chronic Relapser
- The Medical Model
- Treatment Team Talk
- Addressing Folks
SHAME & STIGMA
Watch your thoughts, they become words
Watch your words, they become actions,
Watch your actions, they become habits
Watch your habits, they become character
Watch your character, it becomes your destiny
Anon.
If addiction is a chronic medical condition:

- Is our “treatment” appropriate?
- Do we treat our “patients” like patients with other chronic diseases are treated?

If not, why not?
TYPES OF CARE
THE ACUTE CARE MODEL

- Encapsulated set of service activities (assess, admit, treat, discharge, termination of service relationship).
- Professional expert drives the process.
- Services transpire over a short (and ever-shorter) period of time.
- Individual/family/community is given impression at discharge (“graduation”) that recovery is now self-sustainable without ongoing professional assistance.
THE CHRONIC CARE MODEL

- Initial triage and stabilization, support services are varied and open ended most concentrated early on.
- Professionals serve as consultants. Goal is for course of treatment to be patient driven to achieve highest level of adherence.
- Services are open ended, routine follow-up the norm.
- Individual/family/community educated on the “process” nature of “treatment”. Goal is to facilitate improved quality of life and wellness for the patient in whatever way works best for the patient.
8 KEY PERFORMANCE ARENAS LINKED TO LONG-TERM RECOVERY OUTCOMES

1. Attraction, access & early engagement
2. Screening, assessment & placement
3. Composition of the service team
4. Service relationship
5. Service dose, scope & quality
6. Locus of Service Delivery
7. Assertive linkage to communities of recovery
8. Post-treatment monitoring, support and early re-intervention
1. ATTRACTION, ACCESS & EARLY ENGAGEMENT

**Acute Care Limitations**

- 10% & 25% data; late stage and under coercion; waiting list drop-out data; attrition data (more than 50% will not complete)

**Recovery Management Directions**

- Assertive community education & outreach
- Assertive waiting list management
- Lowered threshold of engagement; rethinking motivation; institutional outreach
- Changes in administrative discharge policies
2. SCREENING, ASSESSMENT & PLACEMENT

**Acute Care** assessment is categorical, pathology-focused, professionally-driven, an intake function & focused on individual; placement based on problem severity.

**Recovery Management** assessment is global, strengths-based, client focused (rapid transition to recovery plans), continual and encompasses the individual, family and recovery environment; recovery capital factored into placement decisions.
3. COMPOSITION OF THE SERVICE TEAM

**Acute Care model** uses disease rhetoric but few medical personnel; recovery rhetoric but decreasing involvement of recovering people.

**Recovery Management** expands role of medical (including primary care physicians) and other allied professionals, recovering people (P-BRSS) and culturally indigenous healers. Also emphasizes reinvestment in volunteer and alumni programs.
4. SERVICE RELATIONSHIP

**Acute Care:** Dominator model; emphasis on professional authority; great power discrepancy; role of client is one of compliance.

**Recovery Management:** Sustained recovery partnership (long-term consultation) model; emphasis on prolonged continuity of contact; client as co-leader; philosophy of choice; greater use of personal/professional self; contrasting ethical guidelines.
5. **SERVICEx DOSE, SCOPE & QUALITY**

**Acute Care** model has become ever briefer, narrower via reimbursable services & continues to incorporate methods lacking scientific support.

**Recovery Management** model emphasis on importance of dose (NIDA principles—90 days), role of ancillary services and weeding out practices that are not linked to recovery outcomes or that may produce inadvertent injury.
6. LOCUS OF SERVICE DELIVERY

**Acute Care** model locus is the institution: How do we get the individual into treatment—get them from their world to our world?

* Problem of transfer of learning

**Recovery Management** model emphasizes the ecology of long-term recovery: “How do we nest recovery in the natural environment of this individual or create an alternative recovery-conducive environment?”

* Healing forest metaphor (Coyhis)
* Concept of “community recovery”
7. ASSERTIVE LINKAGE TO COMMUNITIES OF RECOVERY

**Acute Care Model:** Passive linkage, low affiliation and high early attrition, single pathway model of recovery

**Recovery Management Model:** Assertive linkage, multiple pathway model of recovery, linkage beyond recovery mutual aid groups; active relationship with local service committees, involved in recovery community resource development
8. POST-TREATMENT MONITORING, SUPPORT AND, IF NEEDED, EARLY RE-INTERVENTION

- 25-35% of clients who complete addiction treatment will be re-admitted to treatment within one year, 50% within 2-5 years (Hubbard, et al, 1989; Simpson, et al, 2002).
- An Acute Revolving Door: Of those admitted to the U.S. public treatment system in 2003, 64% were re-entering treatment--23% accessing treatment the 2nd time, 22% for the 3rd or 4th, and 19% for 5 or more times (OAS/SAMHSA, 2005).
• 50-80-90 rule: More than 50% of clients discharged from Tx will return to some use in the next year—80% of those will do so in first 90 days after discharge.

• 15-25 rule: The stability point of recovery (risk of future lifetime relapse drops below 15%) isn’t reached until 4-5 years for alcohol dependence; 25% of opioid dependent persons who achieve five years of abstinence will later resume narcotic addiction.

But only 1 in 5 (McKay, 2001) to 1 in 10 (OAS, SAMHSA, 2005) adult clients receive such care (McKay, 2001) and only 36% of adolescents receive any continuing care (Godley, et al, 2001).
8. RECOVERY MANAGEMENT MODEL: ASSERTIVE APPROACHES TO CONTINUING CARE

- Post-treatment monitoring & support (recovery checkups)
- Stage-appropriate recovery education & coaching
- Assertive/continued linkage to recovery resources
- Early re-intervention & re-linkage to Treatment and recovery support resources
- Recovery community building
SO WHAT ABOUT PREVENTION?
TWO “MODELS”

- Crime Control Model
  + Punishment and Moralizing with the “offender”

- Public Health / Disease Control / Harm Reduction Model
"Public Health" – Is the art and science of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private communities and individuals.
THE “MODEL”

- Define the Problem
- Identify Risk and Protective Factors
- Develop and Test Prevention Strategies
- Assure Widespread Adoption
DEFINING THE “PROBLEM”

- The “Big Three”
  + Agent
  + Host
  + Environment

- The Goal
  + Reduce harm and negative impact on the individual and the community
The best protection is early detection.
THE “MODEL” WITH BREAST CANCER

- Define the Problem
- Identify Risk and Protective Factors
- Develop and Test Prevention Strategies
- Assure Widespread Adoption
"Mind if I smoke?"

"Care if I die?"

Smoking damages the tissues in your penis.

There are over 4,000 chemicals in cigarette smoke. Some of them damage your arteries, including the parts that keep you hard. If they go floppy, so do you.
THE “MODEL” WITH TOBACCO

- Define the Problem
- Identify Risk and Protective Factors
- Develop and Test Prevention Strategies
- Assure Widespread Adoption
DRUGS

No drugz

LAW ENFORCEMENT

HELP
SO WHAT WOULD THE “MODEL” LOOK LIKE WITH ADDICTION?

- Define the Problem
- Identify Risk and Protective Factors
- Develop and Test Prevention Strategies
- Assure Widespread Adoption
THE "BIG THREE" WITH ADDICTION

- The "Big Three"
  - Agent – The individual
  - Host – The Psychoactive Substance
  - Environment – The availability and accessibility of the substance; community attitudes

- The Goal
  - Reduce harm and negative impact on the individual and the community
questions anyone?
thank you sooooooooooo much
The End