

Acute Versus Long-Term Care Strategies for Individuals in Treatment for Substance Use Disorders

Bahram Edward K Shahrokh*

Department of Psychology, Antioch University Santa Barbara, USA

Submission: April 07, 2017; **Published:** April 24, 2017

***Corresponding author:** Bahram Edward K Shahrokh, Department of Psychology, Antioch University Santa Barbara, USA,

Email: e.shahrokh@gmail.com

Abstract

In the United States, addiction or substance dependency is a problem that has received a lot of attention through media and research. For individuals who are addicted, the disorder wreaks havoc in social, psychological, medical and economic domains. The majority of research regarding addiction appears to be concerned with psychological and pharmacological interventions that address the issue in individual's first coming to treatment or for those who have been struggling with treatment. Some studies [1] and articles [2] have been concerned with a necessary paradigm shift in the conceptualization of treatment from an acute care model to one of long-term recovery management. The basis for this shift is in the consideration that addiction is a chronic disease that remains in remission but is never fully cured [2].

Introduction

Additionally, recovering persons who have been able to maintain abstinence for a long-period of time, such as 15 to 20 years and then relapse are given less attention by researchers, clinicians and social support [3-5]. It would seem if an individual has been able to achieve the behavioral, cognitive, attitudinal and mood changes [6] required to get sober and maintain their sobriety for this many years they would have surpassed the threshold for relapse. However, limited research indicates this is a growing phenomenon [3]. The problem is compounded by the focus of other recovering persons in self-help 12-step fellowships on the "newcomer" who is starting out their journey rather than the "old-timer" who had a slip. "Old-timer" is a term used within the 12-step community referring to a recovering person who has remained abstinent from drug and alcohol use for 15 years or more.

There is a lack of literature regarding the experience of individuals who were in recovery and were able to maintain abstinence from alcohol and drug use for a substantial period of time and then relapsed. Although the literature concerning this population is very scarce, there is substantial literature regarding a conceptual shift in approaching alcohol and substance use disorder treatments, types of evidence based treatment, models of addiction and recovery, factors for relapse and factors for recovery. Historically, drug addiction treatment protocols have

overwhelmingly focused on treating patients and clients with interventions that conceptualize addiction as an acute disorder as opposed to a chronic disease. As the research base regarding effective evidence based treatment models grow, data points to the need for recovering persons to continue engaging with health care and social support. In addition, literature regarding substance abuse treatment focuses on personality traits, cognitive deficits and social influences that increase the risk of relapse for individuals who are in early and ongoing recovery while other researchers focus on factors that increase treatment retention, ability to cope with difficult affect, and protective factors. The following literature review will explore current studies, reviews, and meta-analyses regarding the above as well as some recent qualitative studies that have also begun looking at older adults in recovery.

Prevalence

According to the 2014 National Survey on Drug Use and Health, approximately 21.6 million individuals aged 12 or older met the criteria for a substance use disorder in 2013. This translates into 8.2% of the population aged 12 or older. Additionally, an estimated 22.7 million individuals aged 12 or older needed treatment for an illicit drug or alcohol use problem in 2013 while only 2.5 million received treatment at a specialty facility for an illicit drug or alcohol problem [7].

Prevalence in Older Population

As of 2014, it is estimated 2.8 million older adults (aged 50 and older) meet the criteria for a substance use disorder [8]. Han, Gfroerer, Collier and Penne [9] estimate this number will increase to 5.7 million older adults meeting the criteria for a substance use disorder by 2020. Therefore treatment and intervention is relevant issue among older adults with a substance use disorder regardless of the status of the individual as relapsed or currently using. Older adults who have a substance use disorder have an enhanced risk of mortality [10].

Acute vs Long Term

White and Kelly [2] provided historical reasoning for the use of treatment measures which address addiction as an acute disorder and provide a case for the treatment of addiction as a chronic disease. The authors additionally compared the two approaches and provided a detailed framework for a possible long-term treatment protocol that is aimed at providing sustainable recovery assets and tools to individuals who suffer from substance use disorder. The differences are important to examine for the following reasons: if a recovering person relapsed after a considerable amount of time abstinent from drug and alcohol use, it would be pertinent to examine and explore whether the relapse occurred due to deficits from having been treated with the acute framework. It would also be pertinent to get feedback on whether treatment from a chronic disease framework could have either prevented the relapse or served to moderate the relapse to minimize harm done. White and Kelly [2] described eight changes in service practices regarding “(1) attraction/access to treatment, (2) assessment and level of care placement, (3) composition of the service team, (4) service relationship/roles, (5) service dose, scope and duration, (6) locus of service delivery, (7) linkage to communities of recovery, and (8) post-treatment monitoring, support and early re-intervention.”

McLellan et al. [11] conducted a literature review of chronic medical illness and drug dependency. The authors presented an argument by analogy whereby drug dependency is compared to well-studied chronic medical illnesses such as type 2 diabetes mellitus, hypertension, and asthma. Although drug dependence does not require the presence of physical symptoms, it does affect the neurocognitive structure and functioning of the brain (i.e. ventral tagmental area connecting the limbic cortex through the midbrain to the nucleus accumbens) and produces enduring and possibly permanent pathophysiological changes in reward circuitry, levels of specific neurochemicals, and the stress response system. Twin studies show there is a genetic heritability for the disposition toward drug dependence to a similar degree of type 1 diabetes and adult onset asthma. Although personal responsibility plays a role in the onset of drug dependence, personal responsibility also plays a role in the onset of hypertension. In addition to behavioral, cognitive,

and emotional intervention, individuals in treatment for drug dependency may also benefit from various medications that have shown to accentuate long-term admission similar to other chronic medical illnesses. Treatment and medication adherence rates are similar for drug dependency and other chronic illnesses [11]. Despite these similarities, drug dependency is still treated as an acute disorder. Long-timers treated with an acute care model may suffer long-term consequences of relapse due to a lack of contact with healthcare professionals.

Scott et al. [10] reviewed data from stratified sample of 1,326 patients from 222 addiction treatment programs on the West Side of Chicago to determine the effect of number of treatment episodes, abstinence and time spent using on mortality. Scott et al. determined baseline factors of older age, preexisting chronic illness, and engagement in illegal activity enhanced mortality whereas abstinence was associated with lower risk of mortality. The duration of sustained abstinence achieved had direct and indirect effects on the relationship of long-term treatment and mortality. The authors found participating in more treatment episodes in early years of use decreased risk of mortality while participating in treatment later in life and spending a greater percentage of one's lifetime in treatment did not. According to Scott et al. [10] the findings do not support acute care and augment the chronic disease model.

Chi, Parthasarathy, Mertens, and Weisner [1] reviewed results from a meta-analysis of two longitudinal studies conducted by Kaiser Permanente Northern California. The results from these studies provided quantitative support for some of the proposed service changes by White and Kelly [2]. Chi et al. [1] followed remission or readmission of a sample of 1,953 participants at one, five, seven, and nine years. Among other factors, Chi et al. [1] studied the likelihood of participants who were at risk of returning to active use when attending yearly follow-ups with primary care physicians versed in substance abuse treatment. According to Chi et al. [1], “This study found that having yearly primary care and specialty care (substance use treatment and psychiatric services) when needed was associated with remission over nine years for substance use patients in a private, nonprofit, integrated managed care health plan”. This provides evidence for the expansion of the treatment team suggested by White and Kelly [2] as well as the need for post-treatment monitoring, support and early intervention. The current study may provide additional evidence if participants felt this was a factor in leading to relapse or may have been a protective factor.

An additional study by DuPont and Humpreys [12] reviewed three new highly effective treatment models that support long-term recovery for drug and alcohol dependence as opposed to treatment as usual which is typically a few weeks of outpatient counseling with no biological testing, no use of contingency management and no medication. Physician Health Programs, Hope Probation and South Dakota's 24/7 Sobriety Project were reviewed.

Physician Health Programs are intensive treatment approaches that require physicians who have substance use disorders to complete a rigorous five-year treatment in order to maintain their medical licenses and ability to practice. Initially, physicians will attend a 30-90 day residential inpatient or 90 day outpatient program depending on the case and are randomly screened for drug and alcohol use one to two times per week. After a period of abstinence, these physicians are tested approximately one to two times per month. Physicians are also required to attend 12-step meetings [12]. One study showed that 64% completed their contract, 16% extended their contracts or signed new contracts, and 28% had not completed their completed or were no longer monitored indicating a high success rate [12] over the national average of outpatient treatment success of 40% [13]. Of the physicians who completed their contracts, 81% had no relapse and 45% had one or two positive tests [12]. Critics of the program contend the higher SES and education of physicians indicate a higher prognosis. Therefore DuPont & Humpreys [12] reviewed two programs that involved participants involved in the criminal justice system in order to provide additional evidence for their argument for the benefits of long-term care models.

Hawaii's Opportunity Probation with Enforcement (HOPE) and South Dakota's 24/7 Sobriety Project are similar programs requiring treatment of individuals in the criminal justice system. HOPE participants are convicted felons who are likely to violate the terms of the parole. South Dakota's 24/7 Sobriety Project participants are individuals convicted of multiple Driving While Intoxicated charges [12]. Both treatment protocols involve heavy random testing and mandatory short-term incarceration for violations and substance abuse. Twelve-step meetings are encouraged but not required [12]. Studies have shown that 85% of HOPE participants and 66% of Sobriety Project participants complete the program. The main limitation of these studies is the mandatory nature of treatment. These participants may have had a higher motivation to complete and succeed with treatment. However due to the bottom-up processing and impulsivity characteristics of individuals in recovering from a substance use disorder, consequences are not viewed as the primary factor in rehabilitation [14-16].

Conclusion

The above studies and literature reviews indicate there is a need for a shift of treatment of substance use disorder from an acute treatment model to a long-term treatment model. Substance use disorders or drug dependency demonstrate similar characteristics as other chronic medical illness in which current treatment approaches are based on a long-term model.

Additionally, it has been demonstrated that success rates as demonstrated by abstinence and remission are enhanced by treatment models that embrace the spirit of a long-term recovery approach.

References

1. Chi FW, Parthasarathy S, Mertens JR, Weisner CM (2011) Continuing care and long-term substance use outcomes in managed care: Early evidence for a primary care-based model. *Psychiatr Serv* 62(10): 1194-1200.
2. White WL, Kelly JF (2011) Recovery management: What if we really believed that addiction was a chronic disorder? *Addiction recovery management*, pp. 67-84.
3. Milani AJ (2013) The experience of elder alcoholics anonymous group members of a relapse after a long period of sobriety: A descriptive phenomenological exploration. *ProQuest Dissertations & Theses*.
4. Milliard S (2006) The lived experiences of alcoholism in older women. *ProQuest Dissertations & Theses*.
5. Strawbridge JM (2007) The experience of long-term sobriety for men ages 55 through 65 who are currently members of alcoholics anonymous. *ProQuest Dissertations & Theses*.
6. Daley DC (1987) Relapse prevention with substance abusers: Clinical issues and myths. *Social Work* 32(2): 138-142.
7. Substance Abuse and Mental Health Administration. (2014) National Survey on Drug Use and Health Short Report [data file].
8. Ellin A (2014) More older adults are struggling with substance abuse. *The New York Times*.
9. Han B, Gfroerer JC, Colliver JD, Penne MA (2009) Substance use disorder among older adults in the United States in 2020. *Addiction* 104(1): 88-96.
10. Scott CK, Dennis ML, Laudet A, Funk R, Simeone RS (2011) Surviving drug addiction: the effect of treatment and abstinence on mortality. *Am J Public Health* 101(4): 737-744.
11. McLellan AT, Lewis DC, O'Brien CP, Kleber HD (2000) Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcome evaluations. *JAMA* 284(13): 1689-1695.
12. DuPont RL, Humpreys K (2011) A New Paradigm for Long-Term Recovery. *Subst Abus* 32(1): 1-6.
13. National Institute on Drug Abuse (2012) Principles of drug addiction treatment: a research-based guide (3rd edn).
14. Davis C, Patte K, Tweed S, Curtis C (2007) Personality traits associated with decision-making deficits. *Personality and Individual Differences* 42(2): 279-290.
15. Evans E, Li L, Hser Y (2009) Client and program factors associated with dropout from court mandated drug treatment. *Eval Program Plann* 32(3): 204-212.
16. Staiger PK, Dawe S, Richardson B, Hall K, Kambouropoulos N (2014) Modifying the risk associated with an impulsive temperament: A prospective study of drug dependence treatment. *Addict Behav* 39(11): 1676-1681.



This work is licensed under Creative Commons Attribution 4.0 License
DOI: [10.19080/PBSIJ.2017.3.555611](https://doi.org/10.19080/PBSIJ.2017.3.555611)

**Your next submission with JuniperPublishers
will reach you the below assets**

- Quality Editorial service
- Swift Peer Review
- Reprints availability
- E-prints Service
- Manuscript Podcast for convenient understanding
- Global attainment for your research
- Manuscript accessibility in different formats
- (Pdf, E-pub, Full Text, Audio)**
- Unceasing customer service

Track the below URL for one-step submission
<https://juniperpublishers.com/online-submission.php>