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Matching Treatment to Rhetoric – A Challenge to Policy and Programming

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Consensus is difficult to achieve in any field of service delivery or scientific inquiry. That makes all the more remarkable the consensus that exists within the service and research communities regarding a core deficiency in addiction treatment, namely that even the most dedicated and best informed efforts of providers are routinely unequal to the risk of relapse post-treatment. Indeed, many characterize substance use as a “chronic relapsing disorder/disease” suggesting that relapse is not simply a risk but an inevitability.

This is not to suggest that the field has been unresponsive to the danger of relapse and all it portends for the life of the client, and the well-being of his/her family and community. The American Society of Addiction Medicine (American Society of Addiction Medicine, 2014) has promoted treatment standards designed to provide assurances of continuity of addiction treatment. In its most recent survey of treatment services, the Substance Abuse and Mental Health Services Administration (Substance Abuse and Mental Health Services Administration, 2014) found that 84% of programs report offering aftercare or continuing care services. The Addiction Technology Transfer Centers, through the invaluable contributions of William White, have made available important supports to continuing care initiatives (White, Kurtz, & Sanders, 2006; White, 2008, 2009). And some have sought to describe what has long been regarded as “treatment” to be only the “intensive” phase of a process, suggesting that treatment is properly seen as a fuller experience than has been credited, involving a venue or venues beyond the clinic. Indeed, within the framework of medication assisted treatments, programs of methadone medical maintenance (MMM) have been in existence since 1983, most notably in New York (Novick & Joseph, 1991; Salsitz et al., 2000) and Baltimore (King et al., 2006; Schwartz, Brooner, Montaya, Currans, & Hayes, 1999). MMM protocols provide for multi-year administration of methadone to well-functioning patients, making use of clinic visits as infrequently as once a month for brief counseling, monitoring and receipt of take-home medication. However, in spite of positive

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reports of MMM effectiveness in the studies cited above, that intervention has only minimally penetrated the treatment field (King et al., 2008).

The latter report raises larger question about programs' capacity to deliver continuing care consistent with the long-term risk of relapse believed to be integral to a diagnosis of substance use disorders. More particularly, while 84% of programs report providing continuing care, one must ask what percentage of clients are, in fact, receiving continuing care, for how long, and employing what continuing care regimen given that respondents are free to define continuing care however they choose. Our concerns are not unique. McKay and colleagues reported that most substance use treatment clients were not engaged in continuing care even where that service was reportedly available (McKay, Lynch, Shepard, & Pettinati, 2005). Moreover, in a review of continuing care studies, McKay (2009) found that those interventions conducted for 12 or more months were the most likely to achieve success, and that more aggressive efforts to involve clients, including community outreach and involvement of significant others, were more successful than those relying solely on the client's initiative to appear at the intervention.

Herein, we believe, lies a dilemma for treatment. With often large caseloads of clients, nearly all of whom manifest multiple problems and needs, is it realistic to expect hard pressed counselors to provide long-term continuing care, employing aggressive community-based outreach activities? The answer appears obvious. Thus, while we speak of substance use disorder as a "chronic condition" not unlike recurring physical diseases, the services we provide are more akin to those made available in acute treatment. Why then do we routinely place limits on the course of treatment in spite of our beliefs about the nature of substance use and the challenges that exiting clients can expect to face in their communities over time?

It is important to note we do not lack for continuing care models which have been evaluated and found effective (McKay, 2009). Several can be found on SAMHSA's National Registry of Evidence Based Programs and Practices (NREPP). To make even these interventions appropriate to a client population seen as at long-term risk of relapse, they would presumably need to be extended through time well into a post-discharge period, and that need highlights the difficulty with their implementation. Scarce resources must be expended on emergent need, i.e., on new and substance involved clients. Moreover, treatment providers are reimbursed in association with services rendered to "active patients", i.e., to patients enrolled in treatment. Whatever our beliefs about relapse risk or the need for an extended period of support and monitoring post-treatment, the capacity to make those services available is, at best, limited. Yet, even the physical conditions to which substance use disorders are commonly compared (e.g., arthritis, high blood pressure) are seen as requiring at least long-term periodic monitoring after acute care has been provided. While treatment staff are well aware of the contradiction, they are limited by resources of time and money, as well as a tradition of care emphasizing disease abatement, from taking any additional action, i.e., from maintaining ongoing contact with exited patients.

There is, we believe, a need to revisit policy and program to allow for the development of strategies appropriate to our conceptualization of substance use and the user, particularly with the potential provided with full implementation of the Affordable Care Act (ACA). The

ACA provides opportunity to eliminate the limits placed on lengths and types of services, and extend the delivery of services beyond the episode of acute care (McGovern, 2015). Under ACA, most annual and lifetime dollar limits for benefits have been eliminated, making it easier to conceive of continuing care as fiscally sound and conceptually appropriate (Tai & Volkow, 2013). The ACA can then provide important impetus to continuing care efforts. Regardless, it can be argued we have a responsibility now to take steps to bring services provided more in line with our conceptualization of the substance use client. To employ an old parlance, if we talk the talk, we should walk the walk.

We believe therefore it would be important to convene a panel to consider the issue of treatment programming and policy in relation to our conceptualization of substance use disorder. A panel, the nature of the Institute of Medicine (IOM), would be charged with considering programming and research direction in light of the need, implied in our conceptualization of the client as subject to relapse over an extended period, for strategies of support/monitoring delivered through long-term continuing care. As we conceive of it, the panel would also be empowered to make recommendations for the policy and financing changes required to undergird the expected changes to the course and duration of client contact. We have no illusions about the difficulty in effecting change to treatment programming, or the speed with which such change is likely to occur. However, only by taking the first steps to explore the nature of the change required can we hope to move nearer to matching the rhetoric we routinely employ to describe substance users to the services we provide to affect their recovery.

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