Understanding the nature of addiction, and shaping the delivery of treatment

If we are to help people overcome serious substance use problems, then it is essential that we understand the nature of addiction and recovery, and the processes required to help someone move from addiction to recovery.

One key issue centres around whether addiction is an acute or chronic condition. This and related issues can lead to considerable controversy.

The terminology used to describe addiction can be influential in a variety of ways. It can shape people’s attitudes towards whether they can overcome addiction, shape the way we deliver treatment and the way we help people along the path to recovery, and influence society’s attitudes towards people with substance use problems. The idea that addiction may be a “disease” has caused considerable controversy over many years.

My concern in this article is not whether addiction is a disease – or whether it is a habit, illness, disorder, or whatever. My concern is the temporal course of addiction and how this influences the treatment system that we should be offering to people affected by substance use problems, and all other forms of support that help them along the path to recovery.

These issues have been considered in depth in a recent seminal article by two of America’s leading addiction recovery experts, William L. White and A. Thomas McLellan. The article entitled ‘Addiction as a Chronic Disorder: Key Messages for Clients, Families and Referral Sources’, should be required reading for people working in the treatment field. I am grateful to Bill White for allowing me to quote freely from this work.

In considering the nature of addiction, in relation to its time course, I will look at a number of different issues in this article.

Firstly, I will consider the nature of acute and chronic disorders in the medical world. This is essential because we need to understand that chronic disorders cannot be treated and managed like acute disorders.

Secondly, I will outline the idea that addiction shares many characteristics with chronic disorders such as diabetes mellitus type 2, hypertension and asthma.

Given these similarities, one might think that the same treatment model (chronic care) would be used to help people overcome addiction to drugs and alcohol as is
used to help people overcome other chronic disorders. This is not the case – essentially, an acute care model is used - as we will show in the third part of this article.

I will then pose the question, why an acute care model has been developed to help people overcome addictions to drugs and alcohol? I will also consider in this fourth section some of the negative implications of using the wrong care model.

In a fifth section, I emphasise how important it is to be careful about how we communicate the chronic nature of addiction, particularly as it can arouse strong feelings and generate unintended, harmful consequences.

1. Acute and chronic disorders

In the medical world, acute disorders, such as broken bones, bacterial infections or short-lived emotional trauma, can be typically attributed to a clearly defined source (e.g. infectious agent, physical trauma) and ‘cured’ by treatment and recovery processes that span a relatively short period of time.

Whilst acute disorders may have been serious and have disrupted the person’s life, they do not typically leave a lasting mark. In general, the person is no more likely to have a reoccurrence of the disorder than a person who has not experienced the same problem. The person may get another infection or break another bone, but this is considered a new occurrence of the problem, rather than a relapse.

Chronic disorders such as heart disease, asthma and diabetes are caused, and complicated, by a variety of biological, psychological and social factors. Mostly, it is not possible to identify the precise determinants of the condition – chronic disorders are caused by an interaction between multiple factors.

Choices of “life-style” and other behavioural choices often play a role in the development and maintenance of these conditions.

Not surprisingly, the treatment of chronic disorders is more protracted and complex than that required for acute disorders. Moreover, it does not produce as good outcomes as acute treatments.

White and McClellan (2008) point out that all chronic treatments, regardless of the disorder, share three important features.

1. Whilst they generally remove or reduce the symptoms of the disorder, they do not affect the root causes of the disease. For example, beta-blocking drugs reduce blood pressure and insulin improves the body’s ability to digest sugar and starches, as long as the person continues the treatment. However, the person is not restored to normal after these treatments.

2. All chronic treatments require the person to significantly change their lifestyle and behaviour for the benefits of the treatment to be maximised. For
example, even if diabetics take their insulin as prescribed, they will not stop their disorder progressing unless they also reduce sugar and starch intake, increase exercise and reduce stress levels.

3. Because of the complex and multiple factors underlying chronic disorders and the need for ongoing medical care and lifestyle change, it is not surprising that relapses (or a reoccurrence of symptoms) regularly occur in all chronic disorders.

Clearly, treatment strategies for chronic disorders need far more than periodic visits to the doctor. They need regular in-person and/or telephone/internet monitoring of medication adherence, coupled with encouragement and support for changes in diet, exercise and stress that benefit health.

2. **Similarities between addiction and chronic disorders**

White and McClellan point out that there are many similarities between severe drug and alcohol use problems (and addiction) and chronic disorders such as diabetes mellitus type 2, hypertension and asthma.

- They have a prolonged course, that varies across individuals in terms of intensity and pattern, and there is the risk of pathophysiology, disability and premature death.
- They are influenced by behaviours that begin as voluntary choices, but evolve into deeply ingrained patterns of behaviour. The pattern of onset of the disorder can be gradual or sudden.
- They are influenced by genetic heritability, and other personal, family and environmental risk factors. They can be identified and diagnosed using validated screening and diagnostic tools.
- They have effective treatments, self-management protocols, peer support frameworks and similar remission rates, but no known cure.
- They often lead to psychological problems that include hopelessness, low self-esteem, depression and anxiety
- They generate excessive demands for adaptation by families and intimate social networks.

The striking similarities between severe substance use problems and chronic medical disorders do not imply that similar disease processes underlie these disorders. However, it does strongly suggest that we should be using chronic or continuing care strategies for substance addiction that resemble those used for other chronic medical disorders.

3. **Addiction and the acute care model**

Despite the fact that addiction is a chronic disorder, it has been treated in an essentially acute care model of treatment. White and McLellan outlined the central elements of an acute treatment model as such:
• Services are delivered in a programme of activities - screening, admission, a single point-in-time assessment, treatment procedures, discharge, and brief ‘aftercare’ followed by termination of the service relationship.
• The intervention is focused on the elimination of symptoms for a single primary problem.
• Practitioners direct and dominate the decision-making process during assessment, treatment planning and service delivery.
• Service delivery occurs over a relatively short period of time (e.g. 12 weeks).
• The individual/family/community is given the impression at discharge that “cure has occurred”. It is implied that long-term recovery is now self-sustainable without ongoing professional assistance.
• If evaluation does occur, it does so at a short-term, single-point-in time follow-up that compares pre-treatment status with discharge status and post-treatment status generally months (sometimes years) following the treatment intervention.
• Post-treatment relapse and re-admissions are viewed as the failure (non-compliance) of the individual, rather than potential flaws in the design or execution of the treatment protocol.

It doesn’t take much to see that current treatment for addiction follows this model – it is time-limited, and has no long-term professional monitoring, support or strategic re-intervention. Treatment has a beginning, middle and end.

It is therefore not surprising that many people with severe substance use problems oscillate in and out of treatment. As White and McClellan point out, there are two main findings from outcome studies that are consistent across treatment modalities:

• treatment effects decay over time
• long addiction and treatment careers often precede the achievement of sustainable recovery.

4. Development of the acute care model for severe substance use problems

In his fascinating book “Slaying the Dragon: The History of Addiction Treatment and Recovery in America”, William L White points to a number of key factors that contributed to the acute care model seen in the US in the 1970s and 1980s. Such an analysis has not been conducted for the UK, although we also use an acute care model - in part based on the American system.

In the US, the desire to legitimise addiction treatment led to the field trying to emulate primary care medicine. Treatment programmes were adapted from standards for acute care hospitals with little focus on service support for long-term recovery. Ironically, this occurred at the precise time that critics were documenting the ineffectiveness of this acute model for chronic primary health disorders.

The movements that led to the professionalisation of addiction counselling (certification and licensing) modelled themselves on the short-term psychotherapy
roles within the fields of psychology and social work. Whilst this raised the professional legitimacy of the counsellor and elevated his or her role in recovery initiation, it had a negative impact on the client’s efforts to receive post-treatment recovery maintenance.

The shift to an institution-focused business orientation in the 1980s diminished client advocacy and contributed to the development of an aggressive programme of managed care that shortened lengths of stay and eliminated continuing care. During this time, many treatment programmes were merged into larger organisational networks. Larger national organisations are likely to be more divorced from the needs and realities of local communities.

The nature of accountability shifted from the individuals and families they served, and long-term recovery outcomes, to procedural efficiency and cost containment. There was an erosion in the impact of factors known to contribute to long-term recovery. Grassroots treatment programmes closely connected to local communities of recovery became professionalised, bureaucratised and disconnected from these communities over time.

In the wake of the professionalisation and commercialisation of addiction treatment in the US, the relationships between treatment agencies and indigenous communities of recovery were weakened or lost altogether.

In this regard, it is essential to emphasise the difference between the factors that sustain recovery (‘maintenance factors’) and those that serve to initiate recovery (‘triggering mechanisms’). Whereas treatment can play a critical role in recovery initiation, factors outside the treatment experience play a more important role in long-term recovery maintenance.

In the late 1980s and early 1990s, there was a massive slashing of federal funding to the treatment field in the US, related in part to the system over-promising and under-delivering. The factors described above clearly paid an important contributory role to the system failing to deliver.

By the late 1990s, the assumptions of the acute care model began to be questioned. This criticism was accompanied by widespread calls to change the design of addiction treatment from an acute care model to a model of sustained recovery management.

American addiction experts have not minced words in describing the need to shift philosophy to an appropriate chronic care model, calling for a ‘fundamental shift in thinking’, a ‘seismic shift rather than a mere tinkering’, and a ‘sea change in the culture of addiction service delivery’.

Importantly, the acute care model sets the field (and individuals) up to fail. This erodes long-term societal confidence in addiction treatment as a social institution:
'One of the problems with the expectation of long-term change following a single episode of care is that it holds substance abuse treatment to a very high standard - one that is not imposed on treatments for most medical or behavioral disorders’ (O’Brien & McLellan, 1996)

You may think what has this got to do with the situation in the UK? However...

We have an acute model of care. We have copied many (certainly not all) aspects of addiction treatment from the United States. We are focused on performance measures, cost effectiveness, improving the business “efficiency” of treatment agencies, and we have larger organisations taking over programmes around the country. We do not understand recovery or recovery management.

Some people argue we are 15-20 years behind the US. Are we now facing the slashing of treatment funds in the near future?

5. Taking care in delivering the message about the chronic nature of addiction

I emphasised earlier that the terminology we use to describe addiction can be influential in a variety of ways. It can:

• shape the attitudes of people towards whether they can overcome addiction,
• shape the way that a community delivers treatment and the way that it helps people along the path to recovery,
• and influence society’s attitudes towards people with substance use problems.

We need to be very careful, therefore, how we communicate the message about the chronic nature of addiction, to avoid potential harmful consequences, many of which may be unintended.

On the one hand, we need people to realise that society must develop a treatment and support system that allows for the fact that some people need considerable help to overcome their addiction, with some types of that support occurring over a prolonged period of time due to the chronic nature of the condition. On the other hand, we must be flexible enough to recognise that some people may overcome their addiction very much easier than others.

Knowing that they are suffering from a chronic disorder may help some people understand and relate to their problem much better, and this in turn may facilitate their recovery.

On the other hand, some people may feel disempowered by being told they are suffering from a chronic condition. Others who have gained and maintained recovery may even resent the idea that they have a chronic disorder.
Some individuals in society may feel more positive towards people who are trying to overcome an addiction to substances if they are made aware of the chronic nature of the condition, whilst others may feel no sympathy at all and say that this is an abrogation of personal responsibility. In fact, the latter group may show more prejudicial attitudes, thinking that the person will never overcome their problem and will always be a burden to society.

There are no simple answers here - what we must ensure is careful communication. In trying to facilitate better communication, White and McLellan looked at what the concept of addiction as a chronic disorder does NOT imply.

The following points need particular attention:

• Not all substance use problems are chronic and most do NOT have a prolonged time course. There is a continuum of severity of substance use problem. It is very difficult to predict which early substance use problems will develop into a chronic problem. However, in general, it is more likely that a therapeutic intervention will be successful if used with less severe than with more severe problems.

• Not all people with substance use problems need specialised, professional treatment, and long-term monitoring and support. Some people overcome their problems on their own, whilst others may do so with the help of family and friends.

• We do not know enough about identifying who is most likely to need professional care. However, we can make a generalised statement that people who need treatment tend to have more severe substance use problems and possess less recovery capital (internal and external resources to support the recovery process) than those who do not need treatment.

• Amongst those people who enter treatment, relapse is NOT inevitable and all people who are addicted to (a) substance(s) do NOT require multiple treatments before they achieve a successful, long-term recovery.

• The possibility of recovery exists for all sorts of people, even those who have relapsed on multiple occasions. In fact, most people make a number of attempts to change their behaviour before they are able to achieve permanent change.

• Having the chronic disorder of substance addiction DOES NOT reduce a person’s responsibility for making continued efforts to manage that disorder. They must manage their addiction.

• White and McLellan emphasise that, ‘Appropriate treatment for chronic addiction is NOT simply a succession of short-term detoxifications or treatment stays. Appropriate continuing care requires personal commitment
to long-term change, dedication to self-management, community and family support and monitoring.’

• They also point out that current addiction treatment outcomes are NOT acceptable simply because they are comparable to those achieved with other chronic disorders.

I know that some people do not like the use of the word ‘chronic’ when we talk about addiction. However, if we do not accept the chronic nature of the condition, how is society going to accept that it must develop the resources required for that described by White and McLellan?

‘Chronic disorders require strategic, sustained stewardship of personal, family and community resources. Core strategies for achieving long-term recovery from chronic disorders include stabilization of active episodes, global assessment, enhancement of global health, sustained professional monitoring and early re-intervention, continuity of contact in a primary recovery support relationship, and development of a peer-based recovery support network.’