Overview

The treatment of substance abuse disorders has taken an interesting and exciting turn in recent years resulting from a more comprehensive understanding of the nature of addiction along with an expanding array of effective treatments. Couple this with the increased spending in the next fiscal year budget, almost $1.5B proposed by ONDCP for treatment, and we see why an explanation of what “treatment” entails is very timely. As our understanding of addiction has grown we have been able to move away from the older, and less successful, acute care model to one that better addresses the nature of addiction as a chronic disease. The dated acute model of care charged providers with successfully treating a complex disease in a short period of time, often 30 days or less. This model views treatment only within the specialty sector of healthcare and therefore would attempt to “fix” the patient in a defined period of time and then discharge them back into the world with little thought given to continuing care.

Given the chronic and episodic nature of addiction, this approach clearly had its shortcomings. Imagine taking this approach with other chronic and potentially fatal diseases. Think diabetes, asthma or cardiovascular disease. Dr. A. Thomas McLellan, former Deputy Drug Czar and Professor at the University of Pennsylvania Center for Substance Abuse Solutions and the Treatment Research Institute, paints the picture well in his essay Addiction and Segregation. By accepting addiction as a chronic disease we opened up to the world of disease management, which in turn informs a newer view of treatment today. When managing and treating a long term, chronic illness the patient is often involved in varying levels of care for an extended period of time in order to give them the highest possibility of success, defined as an effective management of symptoms that recur and remit over the course of a person’s lifetime. Dr McLellan calls for a significantly expanded view of how the healthcare system should address the problem of substance use disorders. This view demands more effective strategies from Primary healthcare and extending throughout the healthcare system and more systematically and effectively incorporating the specialized sector of addiction and behavioral healthcare. An exhaustive review of this broader general healthcare integration is beyond the scope of this article but we will provide a brief overview then focus on the specialty sector and the different levels of treatment, often referred to as the continuum of care inside of the specialty treatment industry.

Effective interventions for substance misuse and addiction should often, but not often enough, begin with a primary care provider before transitioning to more specialized care providers. Because it can be easier for some people to discuss concerns about the issue of substance misuse with their primary care provider it is extremely important that the provider have a basis of knowledge on the topic in order to make an accurate recommendation to their patient. Studies indicate that most primary care physicians are reluctant to or feel ill equipped to discuss substance use problems with their patients. According to a 2008 report by the National Quality Forum, National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices, primary healthcare providers should screen new patients
and existing patients annually for “at risk drinking, alcohol use problems and illness” as well as try to identify patients who use drugs by “employing a systematic method that considers epidemiologic and community factors.” Patients should then receive further assessment, the goal being to “guide patient-centered treatment planning for substance use illness and any coexisting conditions.” This comprehensive report calls for a number of steps following the identification of a potential addict/alcoholic and ultimately recommends the patient “should be offered long-term, coordinated management of their care for substance use illness and any coexisting conditions.” Since this is often outside of the scope of primary care physicians the intent is for physicians to address these issues through a much better system of referral for specialized care. Unfortunately this is the exception rather than the norm in most primary care offices due to multiple factors including lack of time, inadequate education about effective interventions, discomfort, fear of patient reactions, and lack of knowledge of the specialty treatment sector.

Once inside of the specialty sector, patients should expect accurate placement based on multiple factors including their specific addictions, co-occurring psychiatric and medical conditions, resources of the patient and family, level of patient motivation, etc. It is at this point that individualized treatment planning can begin by trained professionals who will recommend and facilitate the transitions between levels of care based on the patient’s needs. The importance of introducing a patient into the continuum at the most appropriate level for that individual cannot be overstated. Both money and lives can be saved when a patient receives care that is appropriate for them from the beginning of their treatment experience. It is widely accepted that the longer one is engaged in some kind of treatment the better their odds will be of sustaining health and recovery gains. To give a patient the best chances of “engaging” in their treatment we must make every effort to introduce them to the continuum at the most appropriate level. Recovery is a developmental process and responds best to interventions matched to the specific stage of the progression of the addictive disease. For example, a patient who is physically sick from opiate withdraw isn’t very likely to engage in a sober living facility with little or no medical supervision where motivation towards sobriety is expected just as much as a highly motivated alcohol abuser who has remained abstinent through some means for several weeks isn’t likely to grow through a stay in a medically supervised detoxification facility.

With this in mind we rely on a thorough assessment completed by a professional in the field as the best starting point for those entering the treatment continuum. Beginning with this assessment we will highlight the options for those seeking help from the very beginning of their journey following the assessment and operating under the assumption that all of these options are necessary to serve the full range of needs by those with substance use disorders and that appropriate placement and navigation through the continuum is dependent on the assessed need of any individual patient.

The Specialty Treatment Continuum

Detoxification and Medical Stabilization

This critical first step for many is often overlooked or misused. The mindset that sees detox as a standalone service must be corrected. For some patients detoxification without medical supervision can result in injury or even death, for others it can be a process so riddled with physical pain and emotional distress that it runs the risk of setting a negative tone for the rest of their treatment. Treating a patient in a medical detox and then releasing them back into the community is a costly practice that rarely does long term good. While not everyone who enters a detox facility needs treatment, consider the person who goes overboard at a baseball game and ends up in a “drunk tank” to sober up following an incident. Many do. Now consider the person who can’t control their drinking which is highlighted by a binge-drinking episode at a baseball game that leads to an assault. For both the importance of an assessment at this point is critical and can impact significantly the patient’s experience of this “window of opportunity” for effective intervention. Ideally detoxification is a service that offers each patient close medical monitoring and stabilization. Their immediate medical needs can be addressed
while consideration is given to the appropriate next steps.

**Intensive Residential Treatment (Primary Residential Treatment)**

Traditionally done in a 30-day setting, this level of care is the most intensive form of specialty care after the medical stabilization provided in detoxification settings. As the name implies this treatment is done in a residential setting, patients live in the treatment facility for an extended period of time. The reprieve that this seclusion offers is both practical and therapeutic. For many patients daily life had become so unmanageable that the only hope we have of addressing their addiction is to first remove them from their surroundings and to assure safety and other basic needs. The communal setting helps to facilitate almost around the clock therapy in one form or another. Primary treatment provides patients with a basic understanding of what addiction is and helps them to understand what it is they need to do to engage in and sustain recovery. In addition to providing a fundamental understanding to patients this time is invaluable for providers. The opportunity to observe patients around the clock makes diagnosis much easier and more comprehensive. Often, patients enter primary with or without a diagnosis that can greatly aid in their long term treatment planning. For the provider this is a time to both educate and learn from the patient. While no program can hope to “cure” a patient in 30 days they can lay a solid foundation for recovery while carefully assessing what the best next steps are for the individual. We have found that the most successful primary programs take an interdisciplinary treatment team approach to assessment, treatment and continuing care planning for each patient.

**Intermediate Residential Treatment**

This level of care is most often considered a step down from Primary residential care but can sometimes serve as an appropriate level of care following medical stabilization for some. This level of care typically is provided for several months or more. It is a level of care in which a patient is given additional tools for their recovery while slowly experiencing less structure and medical monitoring. Patients often travel offsite to 12-step recovery support meetings and other community support events rather than rely on meetings that come into a primary setting. Ideally the therapeutic interventions will build on those milestones completed in Primary residential care and is appropriate to the level of recovery development underway. The needs and interventions are based on individualized ongoing assessment (trauma, life-skills, family, legal, etc.). Depending on the individual, Intermediate Residential Treatment often takes place over a 1-12 month period following Primary. In this time patients learn what it will really take for them to sustain their recovery gains once they return to the community and are given opportunity to practice those skills and principals.

**Intensive Outpatient Treatment (IOP)**

Consisting of between three and seven contacts with a therapist or therapist led group per week, IOP is used both as a step down from Residential care as well as an entry point (primary level of care) into the Continuum. We will consider both applications separately.

As a step-down from Residential, IOP can be very valuable especially when good communication exists between the treatment professionals in residential and IOP. In his paper, *The Role of Continuing Care in Outpatient Alcohol Treatment Programs*, Dr. James McKay (Department of Psychiatry, University of Pennsylvania) suggests that IOP “should have a unique set of therapeutic goals or tasks.” Obviously these unique goals and tasks are best identified when there is communication and coordination between the treatment providers who have been involved in the assessment of the patient prior to their involvement with the IOP. Given that there is considerably less structure for those in IOP than Residential we must assume that patients being recommended to IOP have a strong foundation in their early recovery and are able to engage community and housing supports to some degree. Often patients at this stage are reentering the workforce, reengaging with family and friends and have begun to take responsibility for their own recovery. They are engaged in activities more independently and are playing an active role in
their own treatment. IOP helps to make sure recovery is a priority while still providing important therapeutic input. Ideally this therapy builds on what was learned in Residential as well as introduces unique therapeutic goals around recovery advancement and relapse prevention.

As a primary rehabilitation level of care, IOP is often seen as a less restrictive treatment option than Residential. Sometimes IOP is used as a primary treatment model as a result of a court or insurance mandate. Many insurance companies insist that a patient attempt and “fail” at IOP prior to authorizing them for Residential treatment. This mentality seems to make little sense from a treatment perspective as well as financially when considered over the long term. It is encouraging that this practice of misaligning level of care to clinical need will end under the implementation of the Mental Health Parity and Addiction Equity Act of 2008. IOP as a first stop inside of the Continuum of Care makes sense for patients who are highly motivated, have a lower level of addiction severity and have access to adequate social support and housing.

**Standard Outpatient**

While most of this work is done with individual providers and based on the patient’s specific needs, Outpatient also takes place in group settings as a less intensive level of care than IOP. Working with a private provider is obviously very individualized and is necessary for patients on certain medications. While most often used as a step down from more intensive levels of treatment, standard outpatient is sometimes an effective and appropriate level of care as a primary intervention. Patients with low levels of severity or abuse patterns of substance use may benefit from individual or group therapy with a trained provider once per week for some period of time, typically 6-12 weeks. If a person is not able to sustain recovery of behavioral change goals then a referral to a higher level of care is identified and facilitated. As a step-down from a higher level of care, this therapeutic process is used to address relapse prevention needs.

**Sober Living**

When discussing Sober Living we must keep in mind that there are many different levels of sober, supportive housing ranging from a 100% peer run “Oxford House” model through programs with onsite paid, 24-hour supervision. Often, sober living residences are paired with outpatient programs as an effective alternative to more intensive, long-term residential programs and when based on individualized assessments can reduce the financial barriers many face.

- The Oxford House is a model of sober living that is wide spread; there are over 1,000 facilities across the United States. Oxford Houses are based on three primary rules: 1) Do not use drugs or alcohol and do not be disruptive 2) The House must be run democratically 3) Pay your equal share of expense. This relatively simple and straightforward model has established itself with a significant presence throughout the United States. While there is no centralized organization, it does give us a good example of Sober Living that is less organized placing primary responsibility on the individual.

- On the other end of the spectrum is a Sober Living facility that is closely monitored. Often locked at night with strict curfews and significant commitments built into the lease such as multiple 12 Step meetings in a week, minimum volunteering requirements, random and scheduled drug testing. Many of these facilities provide onsite therapy and groups, life skills classes and other required house activities and or require participation in offsite IOP groups. These programs are often referred to as half-way houses.

Given the diverse options within the construct of Sober Living, the decision where to go is critical and is best made with a treatment provider who has intimate knowledge of the patient and their specific needs. Sober Living should not be used as an entry into the Continuum; in fact the vast majority of Sober Living facilities will not accept someone who isn’t referred specifically by a program or provider that recommends it. Sober Living is often a part of the recommended continuum of treatment set forth by professional groups and licensing boards for their members.
who are working to regain good standing. The requirements for these patients, health care providers, attorneys, pilots, etc., frequently require involvement in structured treatment for a much longer amount of time and take place inside of a well vetted and trusted system.

**Recovery Support Services**

The importance of including community based and other nonprofessional groups into the Continuum cannot be overstated. If we are truly to move away from an acute care model of care into one that provides the best chances of sustaining long-term recovery, what we will refer to as Recovery Support Services are critical. In his groundbreaking publication *Recovery Management and Recovery-Oriented Systems of Care* William White, in calling for a chronic-care model of addiction treatment, tells us “This emerging recovery paradigm is evident in calls to reconnect addiction treatment to the larger and more enduring process of addiction treatment.” He goes on to caution that models of treatment that sustain their support for too long run the risk of becoming acute care themselves, they just last longer. At some point a patient must leave the professional Continuum and reenter their community. The hope is that they have been given sufficient tools to make this transition and are doing so as a part of their individualized treatment plan. What White points out to us is that there are dangers in keeping a patient in “the system” for too long just as there are in discharging them too soon. Ideally the professional and nonprofessional support for these patients works closely together respecting one another’s role inside of the broader Continuum. The options that fall into this category are growing every day and include services that are faith-based, community organized, population specific, self-help, 12 step, and “Alumni” extensions of formal treatment programs. All have in common one essential ingredient: the replacement of formal professional credentials with experiential/lived recovery credentials. For our current purposes we will look at 12-step, faith based and community based recovery supports.

• The 12-Step community is vast and diverse. At its core the 12 steps are a set of guiding principles and actions that guide one towards a life of recovery. These principals are central to the hundreds of thousands of independent groups built around them worldwide. While membership is impossible to quantify, it is safe to say that there are millions of people actively involved in the 12-step community today. These groups range from the traditional focus on recovery from substance dependence such as Alcoholics Anonymous (AA) to the secular Life Ring and include many more specific groups such as Cocaine Anonymous (CA), Marijuana Anonymous (MA), Crystal-Meth Anonymous (CMA), Narcotics Anonymous (NA), etc. Other 12 step groups also address non-substance process addictions, such as those addressing food, sex, gambling, and other behavioral addictions, including support for family members of addicts. These groups are organized around “meetings” that typically last 60 minutes and are equally as diverse in structure. The meetings are free and nonprofessional by design, they are truly peer driven and have a long standing and very well respected history of helping people maintain their recovery. Not only do 12-step facilitation and 12-step principals play a critical role inside of formal treatment, it is a critical component to most discharge plans put together for those leaving the professional Continuum.

• The faith-based community provides multiple options for individuals including the organized Celebrate Recovery groups that are based on 12 Step principals and emphasize spiritual growth and involvement in more traditional religious institutes.

• There are exciting developments taking place through other community based solutions that show a true cultural shift and acceptance of the recovering community. As this list grows daily we are unable to provide anything like a comprehensive description. These organizations tend to be very grass roots and peer driven ranging from recovery communities, schools, college programs, telephonic and Internet based support communities, sport based and even specific business communities made up of those in
recovery. The advent of these additional support services is obviously very exciting and will play a larger part in the Continuum in coming years as they develop.

The above cited work of William White as well as much of his groundbreaking research and writing outside of that specific paper focuses on this topic. For a better description of this emerging field and its potential see his work.

**An Interdisciplinary Approach:**

As we started this paper with a focus on the larger healthcare system and the needs for integration and an expanded view of addiction as a chronic disease, we should now look at what it means to approach chronic illness from an interdisciplinary perspective. In the case of care for substance use disorders there is extensive literature about treatment that is holistic and address a patient’s bio-psycho-social-spiritual needs. Depending on the extent to which the disease has advanced and the degree of impairment caused by active addiction, multiple providers with differing specializations should be included in the effective stabilization, rehabilitation and maintenance of a person in recovery. This is because the effects are truly manifested in all domains of a person’s life. The collaborative and integrated care between and within levels of care is essential to maximize the effectiveness of treatment while assuring the patient that care is coordinated and not fragmented. Gaps in care are significant contributors to relapse among those navigating the addiction treatment system.

Various professionals, often coordinated in the care of any one individual patient, deliver effective treatment. Physicians in all specialty areas and other general mental health and social service providers should have a basic knowledge of substance use problems and understated how to screen for and refer to specialized care when needed. Within the specialty field an integrated system should assure adequate access to addiction experts in all disciplines including primary medicine, psychiatry, psychology, social work, chaplaincy, professional counseling, nursing, nutrition and fitness and recovery support personnel. While the professional “addiction counselor” is a relatively new profession relative to the other disciplines in this list, they have become a key player in the care of those with addiction in all the levels of care. They offer effective care for the addicted patient and function often to assure the care of patients is indeed integrated and coordinated with all the other disciplines. In many programs they are the primary case managers assuring care is seamless and comprehensive. The professional Addiction Counselor is often someone who entered the field of recovery based on their own experience. They offer a unique perspective combining personal recovery and professional training.

The field of addiction treatment has evolved so much in the last 60 years and the once mandatory personal recovery experiential credentials are no longer mandatory. As is required in the birth and evolution of a profession; standards of care, knowledge and competency are professionalized and have crowded out the other experiential roots of the “addiction counselor”. This does not mean that experientially qualified members of the interdisciplinary team are not present.

Recovery Support Personnel available both within and outside of specific treatment programs serve to assure that the vital link between professional treatment providers/programs and the larger community of recovery is maintained. We believe this is essential in any future version of a system of care for people with the chronic disease of addiction. It should and has served as a model for the effective care of chronic illnesses and effective disease management processes. Robust holistic recovery, not simple symptom reduction, is the goal for rehabilitation programs and communities of recovery.
Editor's Note: Justice officials lack the necessary resources to implement and scale “ideal” programs to address every offender’s substance misuse issues and offenders often are unable (or unwilling) to pay for their treatment. Accordingly, some policy makers ignore the lessons learned in the private sector. That is a mistake. Effective private sector programs can serve as a model and teach us a great deal about offender needs and the best ways to address them. The Center for Dependency, Addiction and Rehabilitation (CeDAR) is a world-class residential addiction and co-occurring disorders treatment facility allied with the University of Colorado Hospital. It is part of the University of Colorado Health System. CeDAR provides comprehensive care for patients 18 and over including advanced medical and psychiatric services. Steven Millette is CeDAR’s Executive Director; Ben Court is CeDAR’s Director of Business Development and Community Relations.