Nature of the problem: Addiction as a chronic disorder (part 2)

In this Briefing, Professor David Clark focuses on a major problem: while addiction resembles other chronic disorders, society uses an acute model of care for treatment.

In my last Briefing, I considered the difference between acute and chronic medical disorders and emphasised that they have to be managed and treated in very different ways. I focused on a paper by William L. White and A. Thomas McLellan, which is due to be published shortly by the journal *Counselor*.

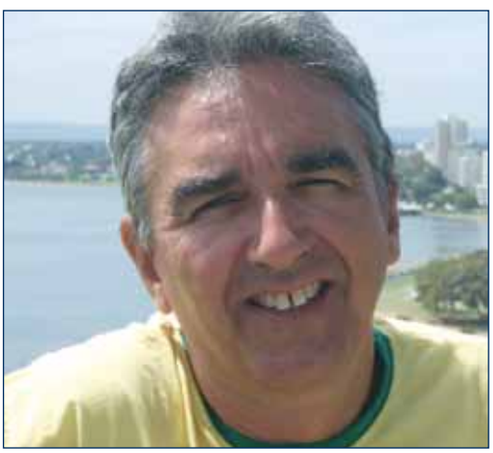
These American recovery experts point out that there are many similarities between severe drug and alcohol use problems (and addiction) and chronic disorders such as diabetes mellitus type 2, hypertension and asthma.

- 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.

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.

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.
- A practitioner directs and dominates the decision-making process during assessment, treatment planning and service delivery.
- Service delivery occurs over a relatively short period of time (*eg* 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.
- 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.



'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.'

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, some of which I describe here.

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 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.

The nature of accountability shifted from 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 late 1980s and early 1990s there was a massive slashing of federal funding to the treatment field, related in part to the system over-promising and under-delivering.

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.

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?

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?

We need to be seriously thinking about a chronic or continuing model of care.