Why the hard work starts on the day you finish rehab

Imagine a scenario in which patients with diabetes are told, “We aren’t going to treat you until you’re in a coma or lose a foot.” Unreal? Not for people with substance abuse disorders.

The current approach to addiction treatment creates the identical effect: After residential treatment, addicts are sent off to fend for themselves, returning when they relapse and hit rock-bottom again.

Acute care for addiction without long-term recovery management is doomed to fail, according to Tonmoy Sharma, founder and CEO of Sovereign Health, a group of addiction and mental and behavioral health treatment centers headquartered in San Clemente, with nine facilities in five states. “Addiction is a chronic, relapsing, remitting illness, but it’s treated with episodic care,” he said. Treating addiction “like an infection that can be cured” keeps people from recovery, he said, creating false expectations that treatment can be finished. Sharma advocates providing long-term, continuous care and monitoring for addicts, much as chronic conditions like asthma, high blood pressure and diabetes are managed.

Change the language, change the paradigm

Changing the care model for addicts begins with changing the way we talk about addiction, according to Sharma. “Do we say that a diabetic who has unstable blood sugar has relapsed? No. And if a diabetic has a piece of cake and his blood sugar gets out of control, he is not shamed.” He added, “We need to get rid of the language of guilt and shame that makes people feel like they have failed. They haven’t failed; their treatment has failed.”

Sharma dismissed the notion that addicts can “graduate” or become “alumni” of addiction treatment programs. “Addicts need lifelong treatment,” he said. “Terms like ‘alumni’ imply that it is over. [Recovery] is hard work, and it does not complete.” He compared the end of a residential addiction treatment program to moving from the intensive care unit in a hospital to another floor. “It’s only the beginning of a lifetime of recovery,” he said.

No more relapse

Rather than use the term “relapse,” Sharma prefers to say that addicts are either stable or unstable, the expression used to describe blood sugar levels in diabetic patients. “Forty to 60 percent of addicts become unstable in the first year after treatment. That’s not much different from people with other chronic illnesses, like asthma or diabetes,” he said. Higher recovery rates are achieved when addicts receive long-term management of the condition.

Recovery management yields better outcomes

Studies that have targeted two types of professionals, physicians and pilots, shed light on treatment for all alcoholics and addicts: When care is managed and monitored after initial treatment, addicts stay sober longer. A 2009 study in the Journal of Substance Abuse Management showed that a sample of 904 physicians admitted to health programs for addiction

had a 78 percent sobriety rate in the five-year period following their treatment. With their medical licenses at stake, these physicians were consistently managed and monitored with frequent and random testing for alcohol and drug use.

According to the Human Intervention Motivation Study, an industry-specific addiction treatment program for pilots, structured care and monitoring after treatment for substance abuse produced a remarkable 85 to 90 percent sobriety rate two years after intensive treatment. Recovery management for pilots — mandated by the FAA in order to fly again — typically requires the pilot to participate in weekly group meetings, have periodic one-on-one meetings with an addiction counselor, and undergo routine drug and alcohol testing.

Nothing unique about doctors or pilots leads to these better outcomes, said Thomas McClellan, co-founder of the Treatment Research Institute in Philadelphia. McClellan served as senior scientific editor of "Facing Addiction in America," the 2016 Surgeon General's report on alcohol, drugs and health. "The biological changes in the way your brain works and your gene expression happen in the same way for doctors and for unemployed, addicted felons," he said. "There is no distinction." Higher sobriety rates for physicians and pilots are a direct result of recovery management.

Recovery folklore

Recovery management needs to be tailored to the individual, taking their job, home, family and sources of support into account, Sharma said. No hard-and-fast rule governs the ideal length of inpatient treatment or the best type of follow-up meetings. "It's folklore that you have to have 28 days of inpatient treatment," he said. Some people may need more, others less — the length of treatment required depends on the person.

Sharma said that 12-step programs help many addicts recovering from substance abuse disorders, but other types of community-based peer support can also be effective. "The important thing is that there is an accountable system of care management and that the patient can say, 'I am a participant in this,'" Sharma said.

Costly, outmoded and dangerous

The economic benefit of providing adequate follow-up care is understood in physical medicine, but not in treating addiction, according to Sharma. He recounted receiving a follow-up phone call from his healthcare provider after he had a hand injury. "They asked me, 'Are you OK? Do you need physical therapy?' They understood that if my hand deteriorated, I would have to go for surgery, and it would cost them more," he said.

This principle is ignored in treating addiction, Sharma said, a shortsightedness that disregards the economic consequences of substance abuse, which costs more than $400 billion annually in crime, health and lost productivity, according to the Surgeon General's report.

The acute care approach to treating addiction developed in the 1950s requires a 21st century upgrade based on science, said Michael Flaherty, clinical psychologist and co-founder of the

Institute for Research, Education and Training in the Addictions in Pittsburgh. Modernized policies, regulations and practice should include a broadened and updated workforce to address addiction as a public health problem, Flaherty said.

“A public health focus uses more peer and family supports and transparently reports health outcomes,” he said. Funding for addiction treatment should be concentrated on continuing care rather than short-term care. “We can’t just keep financing the pathology,” he said.

Failure to monitor addicts after treatment is not only ineffective and expensive but also dangerous, McClellan said, spiking the risk of death from overdose.

“If you go into detoxification, jail or residential care for two weeks, 30 days or whatever, you get rid of your withdrawal, and your tolerance goes down,” he said. “When you come out and go back to the same level of use, you have a markedly higher chance of overdose death. There is a higher — not lower — risk of overdose than people who have maintained their addiction.”

Improve discharge planning

According to McClellan, addicts are typically “given a handshake and sent off to a church basement” after residential treatment — in other words, without any monitoring or follow-up. Sharma said the most important aspect of improving outcomes for addicts is to “pay attention to discharge planning.”

The cavalier “so long and good luck” approach to discharge planning needs to be replaced by systematic and careful preparation for the next phases in the addict’s life, experts say. This includes assessment of what has been done in treatment, identification of the physicians and counselors who will provide the next level of care and oversight, and direction on outpatient community-based support. With a specific and detailed discharge plan, recovery management physicians and counselors “will know what they need to do” to help the addict remain stable, Sharma said.

Come in for a tune-up

Sharma described certain components of effective recovery management. “There should be a signed mutual agreement between the person in treatment and the family, the employer or a legal authority,” he said. The agreement is important to set out the expectations toward recovery, rather than toward relapse. Then, the addict sees a physician regularly for checkups, said Sharma.

Recovery management also includes active monitoring by objective means, like urine tests, just as people with hypertension have their blood pressure tested regularly and people with diabetes have A1C blood tests. There need to be “swift and certain consequences” when a patient either fails a random test or doesn’t show up for one, according to Sharma. “We need to find out why they didn’t come, what’s happening, and then intervene quickly by bringing them in for a tune-up instead of waiting for them to hit rock bottom,” he said.

More is not more

A focused effort to provide lifelong recovery management to addicts represents a transformation of the healthcare system, said Ijeoma Achara, psychologist and president of Achara Consulting in Chicago. Achara consults with healthcare providers and policymakers on developing recovery management models and intervening early to “prevent the slide into devastation.”

Better outcomes for addicts won’t happen by “adding more detox beds,” cautioned Achara. “Simply adding more services to an acute care model based on disjointed, fragmented, very short-term treatment won’t work,” she said. “Without changing the nature and approaches to [addiction treatment], we are not going to get the outcomes that we so badly need.”

Importance and respect

Sharma supports building on the work that has been done with pilots and physicians so that every patient with a substance abuse disorder has access to extended support systems for life. “When people with addiction are monitored, they can lead productive, stable lives, Sharma said.

“Addiction is a brain illness,” he said. “Let’s give it the importance and the respect that it deserves.”

—Treacy Colbert for Sovereign Health Group