THE JOURNAL OF GLOBAL DRUG POLICY AND PRACTICE

Getting Serious about Substance Abuse Treatment Requires Adopting the Five-Year Recovery Standard

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It is estimated that 21.6 million individuals in the US aged 12 and older suffered from a substance use disorder in the past year, but less than 11% or 2.5 million people actually received specialty treatment.[1] It could be assumed that far more are in need of treatment, but the back story to what is called the "treatment gap" is that 95% of people with substance use disorders do not think they have a problem and do not want treatment.[1] Drug users spend about $100 billion of their own money each year on drugs[2] and virtually nothing on treatment. While many are screened for substance use problems and referred to treatment, it is difficult to ensure that they not only enter but complete treatment. For those who complete treatment, the danger of relapse remains for the rest of their lives. Substance use disorders are life-long diseases. While some individuals suffering from a substance use disorder have stopped using drugs; most have stopped numerous times. Stopping drug use is relatively easy; staying off drugs is very hard.

This conundrum is particularly worrisome in the context of a significant increase in drug overdose deaths in this country; the number of deaths has nearly quadrupled since 2002 to an all- time high. In 2014, the most recent year for which data are available, over 47,000 Americans died of drug overdoses. About half of these overdoses, 28,000, were opioid-related, due to prescription painkillers and heroin.[3] Fifty nine percent of heroin deaths include the concurrent use of other

drugs.[4] Opioid abusers are especially likely to simultaneously use many drugs, often including alcohol and benzodiazepines, such as Xanax.

The primary response to the current epidemic of opioid dependence has been a massive increase in medication-assisted treatment (MAT) using buprenorphine, methadone or naltrexone. It is regrettable but not surprising that the typical time a patient spends in MAT for heroin and other opioid addiction is commonly very brief (e.g., three to six months for buprenorphine and naltrexone and only slightly longer for methadone). Most patients who leave MAT return to opioid use, many shortly after leaving. Treatment programs that do not use medications for opioid and other substance use disorders typically retain patients for even shorter periods of time. No matter the type of treatment – or the primary drug of abuse – relapse frequently is the outcome of treatment for substance use disorders.

What can be done to reduce relapse? Though a life-long threat, addiction does not need to be a life sentence. A path to long-term recovery, not relapse, can be seen in the care management of addicted physicians. Because physicians with substance use disorders risk revocation of their medical licenses by their state licensing board, they voluntarily sign contracts for the management of their care with state physician health programs (PHPs) to avoid this penalty.

PHPs do not impose any sanctions but they do provide a safe haven for such physicians. Under PHP management, physicians are required to enter and complete treatment for substance use and any co-occurring disorders. Following discharge, PHP management continues with monitoring, typically for five years, with frequent random tests to detect any alcohol or other illegal drug use. During this prolonged period of monitoring, program graduates are required to engage with the

12-Step fellowships of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) or similar community-based recovery support.

A national study of PHPs showed that over the five-year period of monitoring, 78% of physicians never tested positive for drugs or alcohol, and of the 22% who had at least one positive test for alcohol or other drugs, two thirds (or 14% of the total) never had a second positive test.[5] Forthcoming data from a follow-up pilot study of physicians who successfully completed PHP monitoring contracts show that five or more years after mandatory monitoring stopped, 96% considered themselves to be in recovery, with the vast majority reported not using any alcohol or other drugs.[6] For decades the PHP model has set the standard for excellent long- term outcomes for the biological disease of addiction including addiction to opioids.[7]

How can other substance use disorder treatment programs achieve similar outstanding results? There are three elements that ensure success during PHP care management and in the years following discharge. Currently most other types of treatment do not include them:

1) There is an externally imposed mandate that funnels addicted patients into high quality treatment and helps them stay there from intake through completion.

2) After formal treatment concludes, patients are intensively monitored for up to five years. Any alcohol or other drug use leads to prompt, effective interventions to ensure a rapid return to abstinence.

3) Throughout the time of treatment and aftercare management all patients are actively and

continuously engaged in peer-based recovery support such as the 12-Step fellowships.

The PHP system of care management is part of the New Paradigm for the management of substance use disorders.[8,9] Is this prescription practical for most people with substance use disorders, including heroin addiction? Regrettably the answer is no, because it is not possible to put those three elements together for most patients. The source of an externally imposed mandate could be families, insurers, employers or agents of the criminal justice system but few of these entities understand that their roles could be crucial in ensuring that an individual enters treatment and remains in treatment through discharge, then providing meaningful consequences for any return to the use of alcohol or other drugs and support in order to ensure long-term recovery.

The US health care system is in the early stages of a transformation in the care provision for serious chronic disorders along a similar continuum, including prevention, early identification, effective treatment and long-term monitoring to prevent and intervene in relapses. There are few, if any, serious chronic disorders that are more prevalent or more costly to health care than substance use disorders. It is in health care that the most hopeful location for the New Paradigm of treatment can be found as it is here that the hard-won lessons from the PHPs are just beginning to be appreciated. The state PHPs provide a template for making recovery instead of relapse the most common outcome of treatment. Helping the public and the health care field understand what is possible and how to achieve long-term recovery is an essential public health priority.

Today substance use disorder treatment is a vital part of the solution to the national drug problem, with heroin and opioid addiction its greatest challenge. Some patients now complete

treatment, achieve sobriety and enter long-term recovery with the assistance of medications. Others do so without the assistance of medications. This is a worthy public health achievement to be celebrated. But most patients do not succeed with current care. The lessons and methods of the PHPs show the way to improve long-term treatment outcomes.

Using the measure of five years of recovery gives all treatment programs, those that use medication and those that do not, a standard against which to assess their rates of success based on a single easy-to-understand outcome.[10] It is important to recognize that continued use of medications (such as buprenorphine, methadone or naltrexone) is entirely compatible with being in recovery – provided the patient is not also using alcohol and other drugs of abuse.

Publication of five-year outcome results for all treatment programs will provide patients, families and payers, both private and public, with information that will allow them to assess the potential effectiveness of various treatment programs and to make smarter choices. Universal calculation of five-year recovery rates, however disappointing initially, will stimulate effective new strategies to achieve lasting recovery for more people suffering from substance use disorders, and result in the improvement in performance of all addiction treatment programs.

References

1. Substance Abuse and Mental Health Services Administration. (2014). Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Author. Available: http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf

2. Kilmer, B., Everingham, S., Caulkins, J., Midgette, G., Pacula, R., Reuter, P., … Lundberg, R.. (2014). What America's Users Spend on Illegal Drugs: 2000-2010. Washington, DC: Office of National Drug Control Policy, Office of Research and Data Analysis. Available: https://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/wausid_results_report.pdf

3. Center for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, Mortality File. (2015). Number and age-adjusted rates of drug-poisoning deaths involving opioid analgesics and heroin: United States, 2000-2014. Atlanta, GA: Center for Disease Control and Prevention. Available at: http://www.cdc.gov/nchs/data/health_policy/AADR_drug_poisoning_involving_OA_Heroin_US_2000-2014.pdf

4. Jones, C. M., Logan, J., Gladden, R. M., & Bohm, M. K. (2015, July 10). Vital signs: demographic and substance use trends among heroin users – United States, 2002-2013. *Morbidity and Mortality Weekly Report, 64*(26), 719- 725. Available: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6426a3.htm

5. DuPont R. L., McLellan A. T., White W. L., Merlo L., and Gold M. S. (2009). Setting the standard for recovery: Physicians Health Programs evaluation review. *Journal for Substance Abuse Treatment, 36*(2), 159-171.

6. Research study data submitted for publication by the Institute for Behavior and Health, Inc.

7. Merlo, L. J., Campbell, M. D., Skipper, G. E., Shea, C. L., & DuPont, R. L. (2016). Outcomes for physicians with opioid dependence treated without agonist pharmacotherapy in physician health programs. *Journal of Substance Abuse Treatment, 64*, 47-54.

8. DuPont, R. L. & Humphreys, K. (2011). A new paradigm for long-term recovery. *Substance Abuse, 32*(1), 1-6.

9. Institute for Behavior and Health, Inc. (2014). *The New Paradigm for Recovery: Making Recovery – and Not Relapse – the Expected Outcome of Addiction Treatment*. Rockville, MD: Author. Available: http://www.ibhinc.org/pdfs/NewParadigmforRecoveryReportMarch2014.pdf

10. DuPont, R. L., Compton, W. M. & McLellan, A. T. (2015). Five-year recovery: A

new standard for assessing effectiveness of substance use disorder treatment. *Journal of Substance Abuse Treatment, 58,* 1-5.

About the Author

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For more than 30 years, Robert L. DuPont, M.D. has been a leader in drug abuse prevention and treatment. Among his many contributions to the field is his leadership as the first Director of the National Institute on Drug Abuse (1973-1978) and as the second White House Drug Chief (1973-1978). From 1968 to 1970 he was Director of Community services for the District of Columbia Department of Corrections, heading parole and half-way house services. From 1970 to 1973, he served as administrator of the District of Columbia Narcotics Treatment Administration (NTA), the city-wide drug abuse treatment program that was the model for the federal government's massive commitment to drug abuse treatment in the early 1970s. Following this distinguished public career, in 1978 Dr. DuPont became the founding president of the Institute for Behavior and Health, Inc.

Dr. DuPont has written for publication more than three hundred professional articles and fifteen books and monographs on a variety of health-related subjects. His books include *Getting Tough on Gateway Drugs* A *Guide for the Family,* A *Bridge to Recovery: An Introduction to Twelve-Step Programs* and *The Selfish Brain: Learning from Addiction.* In 2005, Hazelden, the nation's leading publisher of books on addiction and recovery, published three books on drug testing by Dr. DuPont: *Drug Testing in Drug Abuse Treatment, Drug Testing in Schools,* and *Drug Testing in the Criminal Justice System.*

Throughout his decades of work in addiction prevention, Dr. DuPont has served in many capacities. His activities in the American Society of Addiction Medicine (ASAM) include chairing the forensic science committee and he is a Life Fellow. He is also a Life Fellow of the American Psychiatric Association (APA) and was chairman of the Drug Dependence Section of the World Psychiatric Association (WPA) from 1974 to 1979. In 1989 he became a founding member of the Medical Review Officer Committee of ASAM.

A graduate of Emory University, Dr. DuPont received an M.D. degree in 1963 from the Harvard Medical School. He completed his psychiatric training at Harvard and the National Institutes of Health in Bethesda, Maryland. Dr. DuPont maintains an active practice of psychiatry specializing in addiction and the anxiety disorders and has been Clinical Professor of Psychiatry at the Georgetown University School of Medicine since 1980. He is vice president of Bensinger, DuPont and Associates (BOA), a leading national consulting firm dealing with substance abuse, founded in 1982 by Dr. DuPont and Peter Bensinger, former Director of the Drug Enforcement Administration.

Dr. DuPont's signature role throughout his career has been to focus on the public health goal of reducing the use of illegal drugs.

Conflict of Interest

I declare that I have no proprietary, financial, professional or other personal interest of any nature or kind in any product, service and/or company that could be construed as influencing the position presented in, or the review of, the manuscript entitled *Getting Serious about Substance Abuse Treatment Requires Adopting the Five-Year Recovery Standard*.