Retooling Substance Use Care to Support Long Term Recovery

Addiction is our most pressing public health crisis. The science is showing us that five years of sustained substance use recovery is the benchmark for 85% of people with a Substance Use Disorders (SUD) to remain in recovery for life. So why are we not designing our care systems around this reality?

The National Institute on Drug Abuse (NIDA) identifies that the minimum dose of effective treatment is 90 days, yet too few people get even that. Negative public perception about people with SUDs underpins much of our system problems – we ration care as they are not seen as deserving. As a result, fewer achieve lasting recovery. As SUDs impact one in three families, we must recognize these are "our" people and not "those" people and they deserve our help. It makes sense and it saves resources.

The White House recently noted that opioid crisis alone caused a 2.8% reduction in our Gross Domestic Product. For perspective, alcohol use disorders still surpass opioid use disorders in annual fatalities. Many resources are spent shoveling up after SUDs. Despite these facts, we have set arbitrary limits on service, long wait time to access care, insurance denials as a norm and a byzantine process for persons needing help to navigate. People are often served at lower levels of care and for shorter durations. As a result, they often feel like they failed, rather than the system failing them. This is not acceptable.

In contrast, when a person gets a diagnosis of cancer, our medical system orients care to support multiple interventions, procedures, and checkups over the long term. If one thing does not work, we move to another. It is a chronic care model that is flexible, properly resourced and offers multiple pathways to health. It coordinates care through the disease process to get them to the day they can celebrate five years in remission. This is the model we need to orient to for SUDs.

When a person achieves five years in full remission, the likelihood of remaining in recovery for the rest of their lives is around 85%. Achieving this standard of care across our service system would mean expanding peer services and reorienting care to a long-term service model. It would involve treatment assisted by medication, peer support services, family support and case management to help people get back into care quickly in the event of a lapse. People could obtain multiple services based on individual need. In the event of relapse, they could access care in real time free of delays or barriers.

We envision a service system that supports long-term recovery, establishing and funding SUD treatment and long-term recovery support services that address the needs of the person, including co-occurring conditions over a minimum of five years. A system that meets the needs of our young people by developing Recovery High Schools, Collegiate Recovery Programs, and Alternative Peer Groups (APGs). This provides local family education, professional referral, and support programs to assist each young person with a SUD to sustain and support recovery for a minimum of 5 years.

We need to build the 21st Century workforce to serve the next generation by developing stable funding streams, reasonable compensation, administrative protocols, and peer recruitment and retention efforts. Employment, education and self-sufficiency are fundamental to healthy recovery and functional communities. We envision a network of employers that provide opportunities for persons in recovery. We must expand college and trade educational opportunities while reducing and eliminating barriers to employment for persons in recovery. And, there must be simple processes for persons to clear their records from past criminal charges as they reach stable recovery.

Finally, we must develop a system of quality recovery housing. People in recovery need stable, supportive and affordable transitional and long-term housing opportunities. This system needs to include adolescent and special population housing, infrastructure development, and training for house operators to support recovery from a SUD. And, it must work collaboratively to support long-term treatment and recovery as part of a system of care with a five-year recovery goal.

Reorienting treatment systems in this way will be difficult and expensive. But SUDs already drive medical costs, criminal justice costs, human service costs while pulling apart our families and communities. We can address it by focusing on the destination and treating SUD as health care issue and not a moral failing.

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