Toward New Directions in Substance Use Treatment & Recovery

Interview with Scott Silverman, Community Advocate for Substance Use Recovery *by* Mary Mulvihill, Ph.D.

How did you begin your work with substance use disorders and their treatment?

For the past six years, I have been operating *Confidential Recovery*, an outpatient treatment center, but my community work began when I founded *Second Chance*, and ran it for 18 years. *Second Chance* is a program aimed at providing temporary residence for recently released prisoners, since it's not possible to go to a job interview without a home address. Ex-offenders are at high risk for substance use and re-offending, and this group-oriented, social model of recovery provides a safe place to live in a substance-free environment. Clients who need substance use treatment are referred to county-funded programs. An interesting feature of the program is the "relapse house," where a client can go if they relapse and get back on track quickly, rather than being kicked out and thus erasing all progress. Relapse is part of the disease of addiction, so the program plans for that, and does not push people out after one setback. *Second Chance* has 175 beds, including 30-50 on scholarship, where clients gradually earn more private accommodations in a staged housing model, using private homes the agency purchased. They are coached along the way into sobriety, job/finances training, economic self-sufficiency, and eventually, their own residence supported by full employment.

On a personal level, my own journey through recovery started 30 years ago. To recover, I had to quit working in my family business (which was killing me) and figure out another path. In my own experience, the social model is important as it helped me stay connected; I found the 12-Step Model to be very influential in this regard. I understood the process by which my own recovery worked, and from there, observed the many challenges and successes of people going through various forms of treatment, especially those who were just released from prison or homeless, and trying to stay "clean." I kept an open mind, and began to figure out gradually how I could play a role in facilitating change for people who needed it.

What are the three biggest substance use issues in the San Diego community right now?

As substance use is becoming more prevalent, so is its impact on workplaces, homes, schools and medical settings. Particularly hard hit is the large Native American community in San Diego.

The big three substance use issues impacting San Diego currently are:

1. Methamphetamine (meth) use: Local consumption of this highly destructive drug is at a 10-year high.
2. Fentanyl from China, often disguised as OxyContin, along with other new synthetic drugs which are extremely dangerous, as we have no idea what is really in them. If effective at inducing a "high," substance users tend to take more, hence putting themselves at high risk for dying from these drugs. Many of the substance-use fatalities are reported by medical examiners or morgues , rather than a medical facility, indicating sudden death. We may lose many more people to synthetic, possibly contaminated, drugs unless we get a grip on this quickly.
3. Easier access to cannabis or unused prescription opiates: 264 million prescriptions for opiates were written last year, and many of them cannot be tracked down. With legalization of cannabis, we are seeing more kids overdosing, particularly with edibles. And then, there is the new issue of driving while high, which is hard to measure and control.

From your long experience in the community, what do you see as some of the main challenges facing the substance use treatment industry overall?

First, we need improved access to treatment, and incentivize going to treatment so that more substance dependent clients seek it. Part of that involves reducing the stigma associated with being an "addict" and needing "addiction treatment."

Second, we need to hold treatment providers and insurers more accountable for the fact that substance use treatment has fairly poor results. Usually the client is blamed for treatment failure; clients are deemed "not ready" or "resistant," "not serious," "un-helpable" and so forth. This is a $40 billion industry, yet remains one of the few that persists in blaming the client for maladaptive behavior. I think this speaks to the stigma of substance use dependence: "*It is the client's fault*." This is so backward!

Third, there is currently no coordinated continuum of care, which is what most clients need to recover. Services are fragmented, and so poorly connected between the different levels of treatment that clients fall through the cracks. Critical information is lost from one phase to the next. The number of physicians well trained in Addiction Medicine is small, and general practice physicians have a completely different perspective to addiction and its treatment. Psychologists have a behavioral and psychological approach to

treatment, which is not well understood by physicians. Professionals who are trying to work together to help the clients do not understand each other's perspective, training, or value to the client trying to recovery. This is a mess!

Affluent clients seeking substance use recovery tend to seek out "destination" substance use recovery facilities. After completing those programs, they return to their old environment, cues, friends, and predictably, relapse. This treatment model does not work very well, yet is commonly employed, even widely accepted.

Of note, many professionals in the substance use field are themselves in recovery. Since there are no well accepted "best practices" or definitive standards for good substance use treatment, recovered professionals tend to treat their clients with the same approach they themselves used to "get clean." This may or may not work, since every client in recovery is a bit different. Some professionals have never looked beyond the model they benefitted from; their tool box may contain one or two tools, which limits its effectiveness.

Fourth, coverage and incentives by insurers or social welfare to access treatment need to be improved. Insurance coverage has declined dramatically in the last 3-5 years: In the past, a typical detox over 7-10 days within a 28-day inpatient program, followed by 4-6 weeks of outpatient therapy was the norm, whereas, today coverage is only provided for a typical 3-day detox, 14-day inpatient program, and just 2 weeks of outpatient therapy. The fog of withdrawal may not even clear by the time the client's insurance times out. We do not know how the consensus of a 30-day treatment period was established, but we do know that this schedule does not address the intensity or the chronicity of the client's medical problem; 95% of substance use clients in such programs will relapse. We would never treat diabetes this way.

What is your opinion of the new medically assisted therapy (MAT) as a new option for improving treatment outcome in substance use treatment? What are the barriers to implementing this approach more widely?

I think MAT is a much needed step forward, particularly, the use of long acting opioids to treat opiate addiction. Clients in withdrawal cannot cognitively or emotionally engage the way they need to in treatment to fully benefit or attain recovery. Cravings are too distracting.

There are a number of barriers. Most insurance plans only cover a few days of detox, and a recovery program that falls far short of what is needed. This is just a band aid to a deep wound of a problem. Traditionally, Medi-Cal programs have been abstinence-based, so accommodating clients on long acting opioids requires a big shift in their philosophy; despite advances in the research on neuroscience of addiction, programmatic changes can be a long and difficult process. MAT is essentially a harm reduction model, so that's in conflict with abstinence-based programs.

Long-acting opioids such as Methadone and Suboxone are controversial in that they can be abused or illicitly distributed, but recent advances in injectable buprenorphine (an ingredient in Suboxone) have made these drugs more acceptable. Also controversial is the use of Narcan, a "rescue medication" that some opiate users carry to use along with their drugs as needed. However, even people resuscitated with Narcan from a cardiac arrest, use within hours of their life being saved. Narcan can thus be enabling the maintenance of the drug use.

What do you wish therapists commonly knew about interacting in a helpful way with clients abusing substances?

First, one size does not fit all in treatment. People are different, substances are different, and circumstances are different. Evaluation and treatment planning has to be done on an individual basis.

Second, the client must be assessed throughout the continuum of care, which may take 3-5 years. It is helpful if the client can keep the same case manager throughout the recovery process: one who can advocate for them, be available across facilities, keep progress notes, and as shifts or dips occur, e.g., when an underlying trauma or mood disorder is uncovered. It is important to keep repeating assessments over time. Developing trust for honest communication may take months, and relapses may set back any progress. Keep at it, to really get to know the client and how best to help them.

Third, think beyond the treatment session as far as what structure and support the client in recovery from substance abuse needs. If a person who has been misusing substances 78 hours a week, 1 hour a week of treatment may not be sufficient to make a difference. What happens between sessions is important, and how that milieu is organized. Otherwise prior habits will return too easily. This brings up the potential benefit of easily accessible online communities for support and resources. This low-cost method might offer enough intensity over enough users to save lives. This is quite an exciting prospect I am working on now.

Remember that the person who comes in tomorrow for treatment, may be a terrific mentor to others in need six months from now. Virtual mutual self-help groups, followed by virtual therapy sessions can eliminate the excuse of not being able to get to an in-person meeting.

What do you wish family members commonly knew in order to help their loved one recover?

Concerned family members and friends play a key positive role in recovery. The main things for families to remember are:

- Ask for professional help!

- Realize that this is a family disease: Everyone in the family has been impacted by the substance use one way or another, and should consider seeking professional support as well. Treatment programs generally serve the substance user, not the family.

- There are gaps in treatment support for your loved one, sometimes huge ones, which must be anticipated and planned for. This makes the role of the family crucial both at the front end and "back end" of treatment participation. When a loved one returns from a treatment program, the family may need to rebuild trust and be familiar with recovery issues. The transition to recovery, for the former user, as well as the family takes time.

In summary, what is needed for successful long term recovery for an individual client seeking to move from substance use to sobriety?

Five things are most important for attainment of sobriety:

1. Reduce stigma for accessing substance use treatment.

2. Remember that "one size does not fit all"; The recovery program has to be tailored to fit each client and family, and their needs.

3. Create and use the full continuum of care, i.e., detox, residential treatment or sober living, intensive outpatient programs, regular outpatient treatment, mutual self-help groups, and family support.

4. The substance use treatment provider community needs to work more collaboratively to facilitate seamless transitions from one phase of treatment to another.

5. There is no quick fix. Recovery is a process of learning to be someone different, someone who runs their life completely differently, and this takes time.

What is the San Diego Society of Addiction Professionals (SD-SOAP)?

After working in the recovery field for so many years, I wanted to take my experience and expertise, and play a positive role in "cleaning up" the substance use recovery community (hence the acronym SOAP!). I observed that providers at different levels of treatment were not communicating with each other, and not cross referring even when appropriate to do so. My goal was to set up this idea of a continuum of care. Since there is no one profession which specializes in addiction treatment, it is by nature multi-disciplinary. The conversation needs to include stakeholders as varied as law enforcement officers, nurses,

physicians, therapists, families, and employers so that they learn to trust each other and collaborate in the client's treatment.

Recent statistics show we have approximately 50,000 substance users needing services in our community. We are all affected one way or another by the epidemic of substance use, even when we think we are not. For example, it may be a driver under the influence sharing the road with you. We need to do better!

Sam Quinones, author of *Dreamland: The True Tale of America's Opiate Epidemic* suggests that we, in the U.S., are experiencing a widespread loss of community ties because of the rise of technology, dispersal of the extended family, declining participation in community institutions like organized religion, and economic hardship or general isolation. He posits that this loss of community ties is a critical risk factor for substance use. Do you agree?

I do see the impact of increasing isolation in society. The outpatient treatment setting of *Confidential Recovery* addresses the needs of professionals with substance use problems who fear losing their jobs or reputation if they take the time off needed to attend residential treatment; this program gives them a new, healing community comprising peers that understand each other and working toward the same goals, and where recovery becomes the lifestyle.

Similarly, at *Second Chance*, there was a significant effort to create an atmosphere of family /community, and it worked! Interpersonal skills and meaningful relationships are built into "family models" of community living, and peers/staff serve as "substitute family." The typical stay here can be 9-12 months, which makes it easy to have a stable support system, and from which they could come and go to work. Family activities, like gardening in a community garden and ordinary chores also help facilitate the feeling of community. This is a rehabilitation model; the brain needs time to rewire, so this approach allows that. However, insurance does not cover the cost of necessary life skills training, and that remains a big challenge.

Despite the recent media attention on substance use and new legislation in support of treatment, providers continue to use outdated models that no longer apply to the current state of substance use. This is partly in response to mandates by insurance companies that are not necessarily based on what is best in terms of ensuring a good outcome for a substance using client. 72,000 people died directly from substance use last year; that translates to 10 deaths every hour or 140 a day. That is a staggering statistic.

We all have to start thinking outside the box to address this crisis, and become part of the solution! Please do your part, whatever it is.