DEMYSTIFYING RELAPSE: *Rethinking Return to Treatment*

NATIONAL COUNCIL *for* Mental Wellbeing

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INTRODUCTION

The path to overcoming substance use disorder (SUD) is rarely brief or straightforward and typically cycles between improvements and setbacks. Despite this reality, our prevailing approaches, societal attitudes and treatment methods frequently overlook these inherent complexities.

Emerging from the evolution of SUD treatments outside traditional medicine and the unique stigma associated with the condition, our current systems of care predominantly employ an acute care model. This approach, overly focused on immediate crisis management instead of long-term, continuous intervention, results in a fragmented system. Such a system, which often neglects to provide sustained, cohesive care or to reevaluate treatment approaches effectively, tends to alienate individuals during symptom recurrence.

Unlike many other chronic conditions, a recurrence in SUD symptoms is frequently seen as a total regression or interpreted by insurers as a failure by both the patient and the provider. A return to treatment after a recurrence is often inaccurately seen as a repetitive cycle, a "revolving door." These misperceptions overlook the progress of the patient and the reductions made in the overall severity and frequency of symptoms resulting from treatment.

This second brief in our "Demystifying Relapse" series addresses the challenges and opportunities that emerge from returning to treatment after recurrence, highlighting underlying factors contributing to relapse rates and the significant opportunity that reengagement in treatment provides.

The return to treatment is a crucial juncture for reassessing recovery plans, identifying exacerbating factors, reigniting recovery motivation and customizing care to individual needs. Addressing impediments and capitalizing on the chance to reevaluate and improve treatment strategies at the point of symptom recurrence has the potential to significantly transform the landscape of SUD treatment in America.

CONTRIBUTORS

Alexandra Plante, MA,
National Council for Mental Wellbeing

Annie Peters, PhD, LP,
National Association of Addiction Treatment Providers

Michael Johnson, MA,
CARF International

Joseph Parks, MD,
National Council for Mental Wellbeing

Marvin Ventrell, JD,
National Association of Addiction Treatment Providers

Chuck Ingoglia, MSW,
National Council for Mental Wellbeing

Philip Rutherford,
National Council for Mental Wellbeing

THE CHALLENGES

Rigid timelines

Rigid timelines and insurance stipulations for reimbursement present significant obstacles for individuals returning to treatment after a recurrence of SUD symptoms. A prominent example is the widely accepted 28-day inpatient treatment model, even though there is scant clinical evidence to support the 28-day model as universally optimal.

Insurance companies sometimes require a "readmission waiting period," often around 30 days, after a patient completes a treatment program — which may have been insufficient in length to begin with —before allowing them to return for additional treatment. This means that patients who never entered remission, which occurs at 90 days, will be denied ongoing care for symptoms that reflect the same episode of the disorder. These time-stipulated treatment denials create a substantial gap in care, advance disease progression and ultimately leave patients at increased risk for overdose and death. This arbitrarily determined service gap would be considered unconscionable for other chronic conditions and should be for SUD as well.

Reforming reimbursement protocols to center on actual clinical requirements would better allow the SUD treatment system to strike while the iron is hot, ensuring patients can return to treatment when they need it.

Medical necessity

Insurance providers frequently employ a narrow definition of medical necessity that centers on immediate danger to oneself or others. **Payers typically don't consider the inability to maintain abstinence outside of an inpatient setting to be an immediate danger, leading to non-reimbursement for continued treatment.** This limited perspective and global approach to care can result in denials of extended treatment or the premature discharge of patients experiencing sub-acute mental health symptoms, trauma or high relapse risk. Such rigid insurance requirements pose significant hurdles for those seeking comprehensive, sustained treatment for SUD.

Additionally, the requirement by many payers for a "failed treatment at outpatient level" to establish medical necessity, before approving residential treatment creates additional risks for SUD patients. This approach often delays access to more intensive care that could be crucial for a patient's recovery, potentially increasing the likelihood for relapse. Such policies highlight a critical gap in aligning insurance protocols with the urgent and individualized needs of patients, where timely and appropriate treatment level decisions are essential for effective recovery.

Cookie-cutter care

The narrow programmatic focus of some SUD treatment programs may inadequately address the complexities of recurrence. Inflexible treatment frameworks can sideline vital aspects of a patient's recovery, leading to impersonal treatment strategies that fail to evolve with the individual or address the unique factors that lead to their return to use.

To help guide service planning and treatment, the American Society of Addiction Medicine's (ASAM) six-dimensional patient assessment framework includes criteria around relapse, continued use or continued problem potential. A relapse-specific dimension asks providers to consider each patient's unique circumstances, including psychological and anthropological factors, to pinpoint what may heighten the risk for recurrence. It also crucially advises that each return to treatment include a thorough reevaluation and understanding of why previous interventions didn't produce the desired outcome.

Repetitive reassessment

Each return to treatment should serve as an opportunity for a refreshed, individualized strategy, specifically attuned to the patient's current state and needs, rather than a repetitive backtracking to the outset of an established treatment. Repeatedly administering the same treatment resembles mandating a student to repeat a grade in school, a methodology ill-suited for the complex and chronic nature of SUD.

Moreover, current reassessment protocols are laden with repetitive and redundant queries, often compelling patients to tediously rehash their entire histories upon intake. Single State Agencies, for example, often require repetitive intake questions and processes due to overlapping services for similar populations and standardized procedures aimed at ensuring consistency and legal compliance. Limitations in data sharing and coordination between programs within the same agency add to this redundancy, requiring patients to provide the same information multiple times.

Recognizing that a return to use is rarely an arbitrary event, refined reassessment techniques can pave the way for well-informed, effective recovery planning that meets the patient where they are. Specialized re-assessments for patients returning to treatment could better align with the patient's present circumstances and goals, putting the focus on identifying the specific events and complex reasons that precipitated the patient's current recurrence in symptoms.

Addressing patient motivation

A return to use can be a vulnerable period where an individual's motivation for recovery wavers. This emphasizes the importance of treatment providers fully ascertaining what might deter a patient from using substances and what would bolster their resilience and commitment to recovery.

While formalizing structures centered on an individual's motivation for change is not always a priority, a recurrence of symptoms presents a chance to establish and reinforce such structures. This approach equips professionals with tools to provide tailored encouragement, effectively reengaging patients with treatment and services. By broadening the use of established frameworks such as motivational interviewing, providers can further improve patients' commitment to recovery.

Absence of primary care monitoring

While SUD shares characteristics of conditions like diabetes or asthma, its management differs significantly. Unlike these other chronic conditions, primary care is not the central point for managing, monitoring or tracking SUD. This absence often leads to missed or delayed early detection and interventions that are vital to managing chronic disease. Such a gap results in a fragmented care scenario where patients lack a centralized monitoring system. Integrating SUD management into primary care could create a more cohesive continuum of care, enhancing the identification of symptom recurrences and enabling prompt intervention.

This gap in primary care monitoring also makes the path back to treatment ambiguous. After departing from residential treatment and reintegrating into their community, a person facing a recurrence in symptoms often lacks access to a caseworker, recovery coach, sponsor or therapist. Combined with the absence of primary care monitoring, there is a disconnect between residential treatment and ongoing services and support within the patient's home community. That makes it extremely challenging for a patient to know how to find and reengage with services when needed. Greater investments in behavioral health care coordination embedded within primary care would allow for better tracking of service utilization over time, avoiding service gaps, ensuring smooth transitions to changing levels of care and assisting in timely responses to recurrence.

With the rise of artificial intelligence (AI), biometrics and digital applications, it is worth noting that emerging technologies may increasingly play a role in monitoring patients post-treatment. For example, geospatial technologies can identify when an app user enters a high-risk area, such as a liquor store or drug dealer's house, alerting a pre-identified support network of family members and peer support specialists to engage the at-risk individual.

Limited referral systems

It is crucial to develop and enhance the referral networks linking patients with SUD to community services and noncrisis support. Often, patients leave treatment facilities armed only with a list of contact numbers for further care and lacking a solid bridge to the next stage of their recovery. Existing referral systems do not always adequately provide a detailed understanding of treatment options or capacities. Communication breakdowns between providers and patients, often present when there is misalignment in health motivation and recovery goals, further inhibit individuals from receiving subsequent care.

There is untold benefit in enhanced post-treatment care coordination — particularly for patients who are in the first 90 days of recovery and have not achieved remission. Strategies that focus on ensuring continuous, comprehensive care and implementing personalized "warm handoff" referral processes following initial intervention have shown higher success rates in helping patients stay engaged in treatment, avoiding relapse.

Medications for addiction

SUD medications prevent relapse by addressing the biological aspects of addiction — like helping to reduce cravings and withdrawal discomfort — providing a more stable foundation for the individual to engage in recovery efforts such as counseling and lifestyle changes. Unfortunately, medications such as naltrexone, buprenorphine and methadone continue to be underused as tools to prevent a recurrence in symptoms.

While the X-waiver requirement for buprenorphine to treat opioid use disorder (OUD) was lifted and the significance of medications for SUDs more broadly is widely acknowledged, there have been only minimal increases in prescription rates among health care providers; it is estimated that only 11% of patients with OUD receive medication for their condition. Certain populations are even less likely to receive OUD medications, such as adolescents, African Americans and criminal justice-involved individuals.

THE OPPORTUNITIES

Navigating the path back to treatment after SUD symptoms recur is a complex and daunting task, fraught with obstacles that can hinder patients from obtaining necessary care. Each stage of this journey, from initial reassessment to post-treatment referrals, holds the potential for significant improvements. This perspective reframes the recurrence of symptoms not as an outright failure, but as a pivotal moment demanding deeper assessment, engagement, and if necessary, a reconfiguration of treatment approaches.

Improving the pathway back to treatment requires a collaborative effort involving key players including residential treatment facilities, outpatient care providers, primary care providers, insurance payers, digital health developers and recovery community organizations among others. Each of these entities plays a role in the evolution of extensive continuums of care and networks of comprehensive support mechanisms to aid in relapse prevention. This collaborative approach aims to shift SUD treatment from a short-term, crisis-driven model to a sustained, comprehensive care approach.

Further research is needed to comprehensively understand the myriad factors leading to and predicting a recurrence in substance use. That means increasing the allocation of resources toward both implementing the strategies outlined in this issue brief and developing evidence-based, individualized approaches. Working toward standardizing treatment, ensuring timely data sharing among providers, and implementing relapse prevention protocols across various care environments are essential steps.

These efforts aim to provide consistent and effective support throughout an individual's recovery journey, ultimately improving the overall success of SUD treatment.

A recurrence of symptoms is not a failure! Rather, it is a crucial opportunity for SUD treatment and recovery systems — a call to lean in, reassess, reengage and rethink strategies, transforming every return to treatment into a gateway for sustainable long-term recovery. Enhancing the efficacy of SUD treatments to better address recurrence of symptoms will ultimately reduce overall healthcare costs, improve wellbeing and save countless lives.

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