

# Relapse Prevention: A Treatment Method Comes of Age

Terence T. Gorski explains how understanding and responding to relapse-prone patients can dramatically improve their chances of recovery.



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➤ People with substance use disorders are at high risk of relapse once they have stopped using alcohol and other drugs and started to recover. Many studies over the last 35 years have documented high rates of relapse among patients completing treatment for substance use disorders.

Studies of lifelong patterns of recovery and relapse indicate that patients who relapse are not hopeless. About a third achieve permanent abstinence from their first serious attempt at recovery; another third have a series of brief relapse episodes that eventually result in long-term abstinence. The remaining third have chronic relapses that result in eventual disability and death from chemical dependency. Around half of all people who are prone to relapse eventually find permanent abstinence; many others improve in spite of their periodic relapse episodes.

Of the patients entering treatment for the first time, at least 60 per cent are at high risk of becoming relapse prone. Relapse is a serious problem that increases the overall cost of treatment. Many alcohol and drug abusers are admitted to treatment a number of times before they are able to achieve long-term abstinence, and those admitted to substance abuse treatment more than once tend to generate significantly higher expenses.

As the number of repeat admissions increase, three things tend to happen: the severity of addiction and the number and severity of coexisting psychiatric and medical disorders tend to increase, driving up the cost of each subsequent treatment episode; the patient's social and economic stability tends to decrease; and the use of public funding for treatment and to meet basic survival needs tends to increase.

The 1990 National Drug and Alcohol Treatment Utilization Study (NDATUS) estimated that the United States spent a total of \$4.08 billion on treating people with substance use disorders. Since 40 per cent of these patients were relapsers, the nation spent \$1.63 billion treating relapsers in 1990. Unfortunately, most of this money was spent on recycling patients through treatment that had already failed.

In 2002 and 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA) completed

two important studies. The first was a snapshot of all patients in treatment on a typical treatment day. The second study compared patients in treatment for the first time with relapse-prone patients who had multiple admissions. These studies clearly demonstrate both the high cost of relapse and the need for the systematic application of effective relapse prevention methods within existing treatment programs.

To contain the costs of treatment, a new emphasis on implementing specialty relapse prevention (RP) approaches is needed that will lower relapse rates and rapidly intervene with patients who relapse. Such RP approaches exist, and there is a growing body of evidence of their effectiveness. When appropriately matched to individual patient needs, RP methods tend to reduce the duration, severity, and consequences of relapse episodes. As a result, the cost of treatment can be significantly reduced by effectively integrating relapse prevention methods into the treatment process. Let's briefly explore the developmental history of these RP methods.

Since the mid-1970s an increasing emphasis has been placed upon developing and using RP methods. The work of Marlatt, Gorski, and Daley was influential in motivating clinicians to use, research, and continue to develop and apply relapse prevention methods in a wide variety of settings with many different specialty populations. After nearly 30 years of progressive development, RP has become a recognised and effective treatment method, with a wide array of proven programme models.

The evolution of RP methods has set the stage for the development and use of manualised treatment methods that can be quickly, inexpensively, and effectively deployed to clinicians.

RP is a systematic method for teaching recovering addicts to prevent relapse by recognising and managing early relapse warning signs. It also teaches patients to stop relapse quickly by using early intervention methods, and becomes the primary focus for patients who are unable to maintain abstinence from alcohol or drugs after receiving primary treatment.

Twelve key themes distinguish RP from other treatment methods:

- Clients learn to identify high-risk

situations that can cause relapse and develop strategies for dealing with them.

- They are educated to understand relapse as both a process and an event.
- They begin to deal with alcohol and drug cues and cravings.
- They understand and deal with social pressure to use substances.
- They build a social support network.
- They develop methods for coping with negative emotional states.
- They identify and receive treatment for coexisting psychiatric disorders related to past relapse.
- They make the transition from residential and inpatient treatment to normal living, with follow-up outpatient treatment and aftercare.
- They cope with cognitive distortions

effectiveness of RP with smokers, alcohol abusers, marijuana abusers, cocaine abusers, opiate addicts, and other substance abusers showed that there is good evidence for the effectiveness of RP approaches, compared with 'no treatment' controls. RP was also shown as most likely to be effective when used with patient treatment matching procedures. The most notable positive outcomes across studies of RP included maintaining abstinence and positive changes from treatment, and reducing the severity of relapse when they occur.

All addiction treatment facilities are providing treatment to patients who are either relapse prone or in treatment for the first time with a high risk of becoming relapse prone. The problem is that many treatment programs lack specialised science-

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that can increase the risk of relapse.

- They work towards achieving a balanced lifestyle that promotes effective stress management, sober and responsible living, and physical and mental wellbeing.
- They evaluate their need for and appropriate use of medication.
- They develop effective plans for stopping a lapse or relapse should it occur.

There is evidence that RP does help improve recovery and reduce relapse rates. A review of 26 published and unpublished studies of RP programs, representing a sample of 9,504 participants, found that RP was generally effective, particularly for alcohol problems.

Randomised controlled trials on the

based treatment for relapse-prone patients, leaving them less likely to recover. This is unfortunate because it is no more expensive to treat patients using relapse prevention therapy than it is to use traditional recovery methods – and the difference in improved outcomes with relapse-prone patients can radically increase recovery rates, while lowering the long-term costs of treatment.

*Relapse Prevention Counselling (RPC) is available as a two-day workshop and is being offered by Lifeworks Community on 2-3 October 2006 at Regents College, London. For more information on this workshop please contact Lifeworks Community Ltd. Tel: +44 (0) 1483 757 572, email: elinzell@lifeworkscommunity.com or log onto www.lifeworkscommunity.com*

## Post-its from Practice

### Sun, Surf and Schengen

**Experiencing the hassles of checking in for her flight amid heightened scrutiny and security, Dr Janet Gillespie considered how much more stressful it must be to travel with the fear of your methadone being seized.**

**In the middle of August** I travelled through Stansted, passport and purse to hand in their regulation clear plastic bag. Surrounded by tired infants, brittle nerves and raised voices, I pondered how much more anxious I might be if I had prescribed methadone in my hold baggage and a UK export licence in my clear plastic bag.

The current UK export licence scheme is long established: we apply to the Home Office on behalf of the patient, giving information about their prescription, and the Home Office sends a personal export licence direct to the patient. (The Home Office contact details have changed recently – see [1] below.) The export licence only applies to leaving the UK but, it is argued, its existence supports the arriving traveller's claim of legitimate possession. Unfortunately, we have found that some countries (in particular, Italy) do not subscribe to this opinion and several of our patients have had their medication seized by immigration. This is a pity – because it doesn't need to happen...

Surfing the net is so often a process led by intention but guided by chance. So it was that I discovered a German website for substance misusers that reminded its readers to obtain their Schengen certificate in good time for their forthcoming summer holidays. In Norway, the certificate is available through the dispensing pharmacist, although the Netherlands have decided that the matter should be controlled from a central government office. Here in the UK, the House of Lords Select Committee on the European Union, nominated the Home Office as 'the competent authority to issue Schengen Certificates'. (15 February 2000)

A Schengen Certificate authorises the holder to carry up to 30 days supply of prescribed controlled medication for personal use AND to travel freely across national borders within the 'Schengen states' [2]. In 1999, the UK chose to implement 'those measures of the Schengen acquis, now integrated into the EU Treaties, that relate to law-enforcement and criminal judicial co-operation, including the SIS.' This includes Article 75: Schengen Certificates, whose primary aim is to keep those carrying prescribed medication out of the criminal justice system. However, the certificates inadvertently also help us in our strategy of harm reduction.

When emailed recently about Schengen certificates, the Home Office stated that, as the present system works, there was no immediate intention of changing their current practice. In a further reply to our experience with the Italian authorities, the Home Office pleaded ignorance but are happy to receive information on any future incidents.

As I took off my shoes before being frisked by airport security, I decided that, on balance, I would prefer to have a Schengen certificate, rather than an export licence, in my plastic bag. If providing evidence to the Home Office is 'what it takes' to get them for our patients, then please email the helpful Mr Evans on MichaelAnthony.Evans@homeoffice.gsi.gov.uk with any travel problems that have come to your notice and enclose my best wishes.

*Dr Janet Gillespie is a GP at Lonsdale Medical Centre*

#### References:

[1] Home Office, Drugs Branch 6th Floor Peel Building, 2 Marsham Street, London SW1P 4DF Telephone 020 7035 0484 Fax 020 7035 6161

[2] The following countries fully implement the provisions of the Schengen acquis: Austria, Belgium, Denmark, France, Finland, Germany, Greece, Iceland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Spain and Sweden. The newly acceded EU countries (Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia, Slovenia) are not expected to fully implement the Schengen acquis until the end of 2007.