Comparing Conventional Addiction Rehab Approaches to Ultra-Rapid Detox

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Introductory Note

The following white paper has been written based not only on extensive secondary research (see footnotes and other references), but also based on my own extensive professional experience with treatment facilities and advocacy groups involved in drug and alcohol addiction prevention and treatment. While specific references are shown for most specific assertions about the relative merits of various types of rehab and recovery treatments, my own substantial personal and professional experience is also reflected in these conclusions.

Regarding that personal and professional experience, for a period of more than fifteen years, I worked as advisor, advocate, consultant or executive with most of the major for-profit alcohol and drug rehab hospital corporations, as well as many free-standing hospital-based and outpatient rehab programs. These hospitals and hospital corporations included – but are not limited to – HCA’s Psych Division, Charter Medical, Glenbeigh, Raleigh Hills, Republic Health and AMI, as well as a number of individual hospitals, including Monte Vista Hospital, Hurley Medical Center, Desert Springs Hospital and St. Mary’s Medical Center.

I have also represented a variety of not-for-profit drug-fighting organizations. These have included the American Foundation for Drug Prevention, the National Drug Prevention League, American Families in Action and 34 other drug and alcohol addiction-fighting non-profit organizations. More recently, I have worked with the Moapa Valley branch of the Paiute Nation on issues which included preventing addiction among the next generation of Native American children.

In addition, for two years, I served as a consultant to General Barry McCaffrey, President Clinton’s Drug Czar, on issues relating to drug abuse and addiction among teen-agers. I have also testified before Congress on
two separate occasions regarding national healthcare policy. Once, my testimony was given after leading a group of medical experts to Canada, where we were guests of the Quebec Minister of Health and McGill University. We went there to explore the best aspects of Canadian healthcare, and to report back to Congress and the public on ways that Canadian healthcare service models could best be adapted to use in America.

I have written ten published books on hospital-based healthcare, and in 1984, I was named a Fellow by the American Hospital Association for my contribution to hospitals across America in their efforts to better serve the American people.

The following White Paper is based both on that depth of personal and professional experience, as well as research conducted specifically for this White Paper.

Author’s Note: For purposes of this White Paper, nothing here is meant to be seen as a negative judgment against AA or any other 12 Step program. My decades of experience in the drug-treatment field has shown to my satisfaction that people who have either gone through a conventional rehab program, or who have made a personal commitment to go “cold turkey,” often seem to do better with the support provided by active and sustained participation a committed 12-step group. However, for the purposes of demonstrating that willpower is not an effective rehab-program substitute for a sound medical solution to addiction – which is the purpose of this White Paper – many sources cite AA as the archetype of those willpower-based rehab programs.

Background – Addiction Recovery in America

The addiction recovery movement in America was an outgrowth of the widespread effort, from the 1840s all the way through to the end of prohibition, to fight alcohol abuse and to help addicts to recover. Initially, this effort was linked to the temperance movement, and while medical doctors were often involved, addiction was largely seen as a moral failing requiring personal willpower and God’s help.
Addiction to opiates was relatively late-arriving on the American scene; initially, opium was used to fight pain. Once it’s addictive qualities were realized, other opiates were synthesized to – incredibly – fight the opium addiction, without quite realizing that morphine – and later heroin (both created to fight opium addiction) were, in fact, more addictive than opium.

Opium, and these two synthesized derivative of opium – morphine and heroin – were also used in the 19th and early 20th centuries as “cures” for alcohol addiction, with unfortunate and predictable results.

Another addictive drug, cocaine – was also advocated for use in breaking addictions by pioneering psychiatrist Dr. Sigmund Freud.

When opiate addiction was finally recognized as a public health problem in its own right, this addiction was treated separately from alcohol addiction, in separate treatment facilities and with separate treatment modalities. It was not until the 1960s and 1970s that the treatment of alcohol and opiate addictions became acknowledged as illnesses. In this same time-frame, treatment for these two addictions were united under the single banner of hospital-based rehab.

For economic reasons, in the late 1980s, much of the rehab industry began transitioning from inpatient to outpatient – this was driven by the insurance industry’s growing unwillingness to fund inpatient programs that seemed to have a fairly high failure rate – though just how high was not immediately apparent. Inpatient rehab became largely an option limited to the wealthy, as “elective” self-pay recovery centers – as well as centers that accepted insurance but also added a hefty self-pay fee to the treatment program – began to proliferate.

More recently, insurance appears to have resumed paying for at least some traditional inpatient addiction rehab programs, though coverage is often limited by “lifetime caps” on mental health coverage.

**Willpower As A Failed Solution For Addiction**

For the past fifty years, the addiction-rehabilitation community’s “answer” to overcoming an addiction to alcohol – or to prescription opiate painkillers – has focused almost exclusively on willpower. Successful rehab under this
“old-school” conventional approach ultimately depends entirely on an addict’s ability to “gut it out” in terms of both facing down the intense suffering that is triggered by withdrawal, as well as by repeatedly facing down the temptations created by physiological cravings.

Specifically, under this long-established treatment modality, victims of addiction have to endure weeks of seemingly-endless suffering that occur during the body’s detoxing itself from the addictive substance, an experience called withdrawal. This, then, is followed by a lifetime spent resisting the craving-fueled temptation to have “just one drink” or “just one pill.”

AA sums this life-long ordeal quite neatly, with their philosophy, “One day at a time.”

This dependence upon willpower and the addict’s ability to overcome personal physical and psychological suffering may explain why even the best of the old-school addiction rehab programs typically fail in stopping an addiction more than 75 percent of the time. They fail because they lack the willpower to “gut it out.”

On August 8, 2010, an article in the Washington Post, penned by Bankole A. Johnson, Chairman of the Department of Psychiatry and Neurobehavioral Sciences at the University of Virginia – and author of the book: “The Rehab Myth: New Medications That Conquer Alcoholism” – explained why willpower is the core of conventional treatment, and goes further to explain why that approach is the core of its ultimate failure:

As outlined in "Alcoholics Anonymous" (also known within AA as "The Big Book"): "Those who do not recover are those who cannot or will not give themselves completely to this simple program, usually men and women who are constitutionally incapable of being honest with themselves. There are such unfortunates . . . they seem to have been born that way."

That Washington Post article offered a fuller explanation for this:

For decades, Americans have clung to a near-religious conviction that rehab – and the 12-step model pioneered by Alcoholics Anonymous that almost all facilities rely upon -- offers effective treatment for alcoholism and other addictions.
Here's the problem: We have little indication that this treatment is effective. When an alcoholic goes to rehab but does not recover, it is he who is said to have failed. But it is rehab that is failing alcoholics. The therapies offered in most U.S. alcohol treatment centers are so divorced from state-of-the-art of medical knowledge that we might dismiss them as merely quaint – if it weren't for the fact that alcoholism is a deadly and devastating disease.

A recent review by the Cochrane Library, a health-care research group, of studies on alcohol treatment conducted between 1966 and 2005 states its results plainly: "No experimental studies unequivocally demonstrated the effectiveness of AA or TSF [12-step facilitation] approaches for reducing alcohol dependence or problems."

In a 1990 summary of five membership surveys from 1977 through 1989, AA reported that 81 percent of alcoholics who began attending meetings stopped within one month. At any one time, only 5 percent of those still attending had been doing so for a year.10

Others view this failure rate even more pessimistically. For instance, The Baldwin Research Institute claims that “95 percent of existing treatment centers in America adhere to the (willpower-based) 12 Step philosophies. Not surprising, the success rate of treatment is no different from the success fate of AA: 3%.”9

AA itself offers a different perspective. Every three years, the organization conducts random surveys of members, and the study for 2007 reported that “33 percent of the 8,000 North American members it surveyed had remained sober for over 10 years. Twelve percent were sober for 5 to 10 years; 24 percent were sober 1 to 5 years; and 31 percent were sober for less than a year.”11

However, an independent review of five membership surveys from 1977 to 1989 reported that 81 percent stopped attending within a year, and only 5 percent had been attending for more than a year. Evaluating this finding, Dr. David Sack, an addiction psychiatrist, observed that “when you look at people just taking themselves to a meeting, long-term abstinence is pretty low – but the fact is, it works well for people who work it.”

Again, willpower seems to be the decisive factor.
The most optimistic assessment of conventional rehab programs’ treatment success claims “just” a 40-60 percent failure rate. However, that number, offered by the National Institute on Drug Addiction of the National Institutes of Health, relates to people who have been in treatment programs that last significantly longer than 90 days – “participation for less than 90 days is of limited effectiveness,” the report claims – and their optimistic claim of only a 40-60 percent failure rate is based around individuals relapsing and re-entering treatment four to six or more times before rehab “takes.”

The New York Times handily summed up the success rate for conventional willpower-based alcohol and drug rehab programs in an article entitled “Drug Rehabilitation or Revolving Door.”

“Very few rehabilitation programs have the evidence to show that they are effective. The resort-and-spa private clinics generally do not allow outside researchers to verify their published success rates. The publicly supported programs spend their scarce resources on patient care, not costly studies.”

Addiction as a Medical Condition

Although the conventional addiction-rehab community has long paid lip-service to the idea that addiction was a disease, they continue to treat addiction like a moral failing. A recent survey found that Americans as a whole – and not just counselors in conventional rehab programs – see addiction as a moral failing. A study conducted by John Hopkins Bloomberg School of Public Health found:

The American public is more likely to think of addiction as a moral failing than a medical condition. The addict is seen as a bad or weak person, especially because much drug use is illegal.

Only 22 percent of people would be willing to work closely on a job with someone with a drug addiction, and 64 percent said employers should be able to refuse to employ people with a drug addiction. Forty-three percent said people with drug addiction should not be given the same health insurance benefits as the general public.
About 30 percent of respondents believed that recovery from drug addiction is impossible.

"The more shame associated with drug addiction, the less likely we as a community will be in a position to change attitudes and get people the help they need," study co-author Beth McGinty, an assistant professor in the department of health policy and management at Hopkins.13

These programs all require the victim of addiction to experience withdrawal and the cravings that follow completion of rehab. To outsiders, this almost seems as if this necessary experience was a kind of “penance.”

However, this only occurs in programs that consider addiction recovery to be a matter of willpower, rather than as a medical condition that can be treated medically.

But make no mistake – addiction is a medical condition.

The American Society of Addiction Medicine defines addiction as follows:

**Addiction is a primary, chronic disease** of brain reward, motivation, memory and related circuitry.14

Addiction and Recovery.org reports that:

- Addiction is like most major diseases – like heart disease, diabetes and cancer, addiction has both genetic components and lifestyle choice components
- Addiction is not a weakness – if it were a weakness, only unsuccessful and unmotivated people would have an addiction, yet 10 percent of high-functioning executives have an addiction15

Returning again to the article in the Washington Post, August 8, 2010, Dr. Johnson makes this clear, and points in the direction of where real recovery can be found:

*Alcoholism is an illness. But although those in the rehab business sometimes use that word, the 12-step approach they advocate is weak*
medicine. When any other illness causes great suffering, our society devotes time and money and effort to studying it and to developing treatments that are empirically found to work.

Alcoholism and drug addiction should be no exception. Recent advances in neuroscience have led to a greater understanding of how alcohol and other drugs affect the brain. They have, in turn, allowed medical researchers, myself included, to begin to approach alcohol dependence as we would any other disease: by searching for effective medicine.10

As such, it should be treated medically and scientifically, rather than as a condition requiring willpower. However, old-school approaches to rehab focus on willpower while tending, as Dr. Johnson explained,10 to ignore an effective FDA-cleared and National Institutes of Health-recognized medical solution to this life-altering medical condition.

Here’s the bottom line on addiction as an illness: once true addiction takes hold, the condition can be as firmly rooted as other chronic diseases, like diabetes or high blood pressure.17

Medical Links to Addiction

What makes addiction a medical problem, rather than as a personal weakness requiring willpower to overcome? First, there is a clear genetic component to addiction. According to Addiction and Recovery.org, citing several independent research studies:

• Addiction is due 50 percent to genetic predisposition and 50 percent to poor coping skills – this was established in double-blind studies of identical twins and fraternal twins, among other studies

• The children of addicts are eight times more likely to develop an addiction15

Neuroscientists like Dr. Andrew Saxon, MD, Director of the Addiction Psychiatry Residency Program at the University of Washington report that some people have a genetic predisposition to addiction. There’s something different in their brains to begin with, and prolonged drug abuse creates further chemical changes.17
Other studies confirm that genetic factors account for roughly half the risk of addiction.\textsuperscript{16, 17}

But perhaps even more telling, research cited by Consumer Reports in their major July, 2014 exposé on prescription painkillers shows that 60 percent of those addicted to prescription painkillers became addicted while taking exactly what their doctor prescribed, in exactly the right dosage.\textsuperscript{18}

According to Dr. Richard Blondell, Director of the National Center for Addiction Training at the State University of New York in Buffalo, it is a sad fact that as many as 25 percent of all those who are prescribed addictive prescription painkillers do become addicted – even while taking no more than a medically-appropriate and physician-prescribed dose of opiate-based painkillers. Dr. Blondell also noted that while fewer women tend to become addicted to painkillers, they become addicted much more quickly.\textsuperscript{18}

There is another medical component to the science of addiction, one that is still being researched – the link between addiction and mild-to-moderate traumatic brain injury (TBI). While those who are intoxicated are obviously much more likely to receive a TBI because of impaired judgment and motor coordination, there seem to be other linkages as well, including a sharp increase in the likelihood to become addicted following a TBI, for reasons that remain speculative, ranging from self-medication to the injury itself, increasing the odds of addiction.\textsuperscript{19}

Recent clinical studies have demonstrated that more than 90 percent of those who are addicted to alcohol or prescription painkillers have experienced a mild-to-moderate traumatic brain injury at some point in their lives.

This injury either lowered the addicts’ threshold of addiction, or pushed them into a pattern of self-medicating.

Medical Solutions to Addiction Recovery

As a medical condition, addiction recovery does lend itself to a medical solution. This solution involves both the use of ultra-rapid detoxification while under anesthesia and the use of a non-addictive prescription medication to block re-addiction while blunting the cravings.
The anesthesia-based detoxing allows the patient to “withdraw” while asleep and unable to feel the ill-effects of withdrawal. The medical suppression of the risk of re-addiction through a one-time slip – while suppressing the cravings that often trigger those “slips” – allows recovering addicts to live normal lives free from both risk and physical temptation.

Does this approach work? Research published by the National Institutes of Health suggests that it is. Because this is a new approach – some consider it radical – rather than citing opinions, a review of NIH-published studies can shed real light on the impact of ultra-rapid detox as a means of fighting addiction to opiates.

In addition, earlier this year (2014), the CDC announced that the procedure had, after in-depth medical tests, also been cleared for use with alcohol addiction.

One NIH-published report states:25

*Rapid opiate detoxification under general anesthesia is a safe and efficient method to suppress withdrawal symptoms. This treatment may be of benefit in patients who particularly suffer from severe withdrawal symptoms during detoxification and who have failed repeatedly to complete conventional withdrawal. Methadone patients have more withdrawal symptoms than other opiate addicts.*

Another NIH study described the process – and its impact, as follows:26

*Ultra rapid opioid detoxification (UROD) is one of the new methods of (medical) detoxification. This method of detoxification involves putting patients under general anesthesia and actively giving them opioid antagonists. Results of this study on 60 patients showed that, in standard settings:

- UROD is a safe method for detoxification
- It has low complications
- The withdrawal symptoms during and after anesthesia are low
- Shortening the duration of anesthesia has no affect on severity of withdrawal syndrome during and after anesthesia*
Another study on the effects of ultra-rapid opiate detox on withdrawal concluded that this procedure was safe and effective.27

The aim of study was determine the effect of ultra-rapid opiate detoxification (UROD) on the presence or absence of withdrawal syndrome in a group of patients with opiate dependency. In this study, withdrawal syndrome of 173 patients with opiate addiction was evaluated before and after UROD using the Objective Opioid Withdrawal Scale. UROD can be applied for detoxification of patients with opioid dependency with safety.27

Because recovery from an addiction is, in effect, a life-long medical condition, the NIH also looked at longer-term recovery trends. In a study covering 120 addicts – 93 men and 27 women, these individuals were screened six months after treatment to determine if they remained drug-free.28

As you reflect on this study, consider how far from a 100 percent success rate conventional rehab programs tend to be:

RESULTS: One hundred percent successful detoxification with UROD with low morbidity and no mortality. Relapse data was available for 61 patients, who reported relapse free status at the six month follow up interval.

CONCLUSIONS: For individuals who are addicted to opioids, the Ultra Rapid Opiate Detoxification method appears to be a viable treatment option.28

It is worth noting that this group did receive naltrexone, a non-addictive prescription medicine that both prevents re-addiction and blunts cravings. This is a supportive treatment that is increasingly common among ultra-rapid detox programs.

Another NIH study looked at the use of naltrexone 18 months following ultra-rapid detox to determine its efficacy. Eighty-three out of 113 patients who were detoxified, and who received naltrexone following detoxification in the follow-up, 57 percent reported no relapse – a figure remarkable when compared with the results generated by conventional rehab, which averages a 75 percent failure rate (a 25 percent success rate) vs. 57 percent success.30
Another NIH study concluded that, despite concerns voiced by proponents of conventional rehab programs:

*Rapid opioid detoxification under general anesthesia is a safe and efficient method to suppress withdrawal symptoms. This treatment may be of benefit in patients who particularly suffer from severe withdrawal symptoms and who have failed repeatedly to complete conventional withdrawal.*

It is perhaps instructive to note that the “considerable objections to opioid detoxification during general anesthesia” referenced in this study all focused on factors irrelevant to actual recovery. These include the supposed higher cost – though in fact, ultra-rapid detox programs are far less costly than average 28-day conventional rehab programs – and the presumed lack of “psycho-social support.”

That latter objection presumes that all ultra-rapid programs do not include follow-up support. This concern is – at best – only partially correct. Some programs do focus exclusively on detox, returning patients to their own plans for post-detox recovery. However, the “gold standard” among anesthesia-facilitated ultra-rapid detox programs includes not only post-treatment counseling to help patients plan out and live a post-treatment life free from that addiction, but also offer other support, such as ongoing naltrexone prescriptions to block re-addiction and blunt physical cravings.

In fact, the NIH describes the process as follows:

*The technique for ultra rapid opioid detoxification is designed to shorten the detoxification period by precipitating withdrawal by the administration of opioid antagonists such as naloxone or naltrexone. This procedure is performed under deep sedation or general anesthesia to ensure that the patient does not consciously experience the acute withdrawal phase.*

*Ultra rapid detoxification entails general anesthesia in conjunction with large boluses of narcotic antagonists. This combination allows the individual to completely withdraw from the opiate without suffering the
discomfort of the withdrawal syndrome. Ultra rapid opiate detoxification, performed under the proper circumstances, is associated with few adverse events and is relatively comfortable for patients who seek treatment for their addiction.\\footnote{36}

Rapid and ultra-rapid opioid detoxification (ROD and UROD) centers promise quick, painless, same-day detoxification treatment for patients with opioid addiction. The goal of ROD and UROD is to provide a rapid transition from opioid dependency to oral naltrexone therapy. The patient is given general anesthesia and high-dose opioid antagonists. This induces a severe withdrawal but spares the patient the experience. In theory, the process is complete within four to five hours. The patient awakens without opioid dependency and is started on oral naltrexone.\\footnote{32}

As always, long-term success is dependent largely on patient compliance with the post-detox recovery program. A study reported by the NIH of 640 patients who had received this treatment followed 83 patients 18 months after treatment. Of these, 47 had not relapsed, and on average, they had continued their naltrexone use for two months longer than those 36 patients who had relapsed.

Fifty-five percent of the relapsed patients stopped using naltrexone within three months after treatment, while a similar number of still-drug-free patients remained on naltrexone for at least five months, while the other 50 percent of those who remained drug-free continued to use naltrexone for seven or even nine months post-treatment.

This study demonstrated the efficacy of long-term post-treatment naltrexone use, as well as the importance of patient compliance with the treatment regimen.\\footnote{35}

This seems at odds with the published criticisms of ultra-rapid detox programs. These criticisms tended to focus on one of three general “issues”:

- They made the assumption that no follow-up support would be provided, or
• They cited the risks of anesthesia as part of detoxification – which research has shown is no greater than the underlying risk of anesthesia for any procedure; or

• They were published under the auspices of more traditional rehab programs, generally without any citations or third-party support for their conclusions

With few exceptions, these critiques do not appear to be tied to clinical, peer-reviewed research.

Medical Science vs. Personal Willpower

Despite this convincing evidence, a significant number of conventional hospital-based addiction rehab programs continue to be committed to a willpower-based treatment protocol, rather than treating the disease of addiction as a medical condition which responds to medical therapies.7,8,9,10

Many of the conventional inpatient rehab facilities neither look for nor treat the underlying causes of addiction, such as genetic predisposition to addiction or to underlying traumatic brain injuries.11,12

Worse, instead of treating the addiction using sound, FDA-cleared medical solutions which medically detox patients then – again medically – block re-addiction,13 these conventional rehab programs follow the 12-step model, based on willpower.

This has the unfortunate side effect of asking recovering addicts to continue a life-long one-day-at-a-time program of addiction self-management, one in which a single momentary lapse can return the individual to a life controlled by addiction, requiring another round of rehab treatments.12

Revolving Door or Medical Solution?

The New York Times described conventional addiction rehab is a revolving door of addiction, withdrawal-and-craving, failure, re-addiction and another round of treatment.12 Other neutral observers – including medical addiction specialists – concur that this is a medical condition which responds best to a medical solution.7,8,9,10,11,12,13
However, victims of addiction have another choice. This is a medical solution that does not depend on willpower, nor does it require recovering addicts to experience the awful suffering of withdrawal or the uncontrollable temptation of cravings.\textsuperscript{12,13}

What follows is a series of head-to-head comparisons between the old-school conventional rehab approach that has been the “gold standard” for the past fifty years,\textsuperscript{7,8,9,10,11} and the emerging medical-science approach to helping addicts to alcohol and prescription painkillers overcome their addictions.\textsuperscript{12,13}

First, I'll review traditional rehab's approach to recovery – then I'll review the scientific medical alternative.

**Traditional 12-Step-Based Rehab**

The comparison is illuminating.

1. Conventional rehab programs have a very high failure rate. The most optimistic government study reports a 40-60 percent success rate, and this rate represents people who've gone through conventional rehab programs at least several times.\textsuperscript{8}

   The one-time failure rate for a 30-day inpatient program runs from 75% (the best programs) to around 90%.\textsuperscript{10,11}

2. Even the most famous and well-regarded residential programs, such as Betty Ford,\textsuperscript{20} depend on willpower for meaningful recovery. While they provide medications to take the edge off of the withdrawal process, each addict still has to experience the side-effects which accompany detoxing their bodies. It is common for people to be afraid of dealing with withdrawal symptoms.\textsuperscript{24}

   Then, these gold-standard conventional rehab programs provide an impressive array of coaching and support, each recovering addict – upon completion of the program of recovery – still has to overcome the cravings that naturally follow.\textsuperscript{20}
3. Most traditional opiate addiction recovery programs also rely on an approach that has the addict “tapering off” their current addiction by using another addictive drug. This approach, as noted earlier, has a time-honored role in addiction recovery. Both morphine and heroin were originally developed to help opium addicts beat their addiction – before it was realized that those medications were also addictive.5

Today, these recovery programs prescribe suboxone21 or methadone, then direct the recovering addict to take a smaller dose each day, easing the impact of withdrawal.21

However, in all too many cases, opiate or opioid addicts – when faced with even the moderated suffering caused by their withdrawal – find that their willpower fails them. Instead of tapering off, they take more of the suboxone or methadone – which, when taken improperly, can induce an addictive high.23 Even many of those who avoid that trap feel as if they have become hooked on Suboxone, trading one addiction for another.22

Regarding the efficacy of methadone tapering as a means of moderating withdrawal, a study published by the National Institutes of Health noted that:

> Approximately 400,000 patients are enrolled in or are actively seeking methadone therapy. While many of these individuals want to undergo detoxification, traditional techniques, including methadone tapering are usually unsuccessful. The withdrawal syndrome is extremely unpleasant, may be fatal, and deters patients from completing the detoxification process.36

4. A major barrier to rehab success is the fact that a single slip-up – one just one drink or one pill – can reignite the addiction, thrusting the “in recovery” addict back into the downward cycle of chemical dependency. There is no grace period, no second chance, no option but failure.24

5. Even the best of the conventional rehab programs – those with a 20-to-25 percent one-time success rate – require the recovering addict to remain in an inpatient recovery hospital facility for from 30 to 90 days. This extended time is needed for several reasons.
First, the isolation gets the patient out of the lifestyle of addiction, away from “drinking buddies” or fellow opiate addicts. Next, this time is needed to get patients completely through the withdrawal phase. Finally, this time is needed provide these recovering addicts with the tools they need to find the inner strength to resist future cravings.

Not everyone can afford to (or are willing to) spend that amount of time in rehab. Instead, they either forego treatment, or they try outpatient treatments which keep them in the world and around those still drinking or using drugs, with predictably poor results.

Regardless of any success rate, this long-term stay disrupts lives, usually making it impossible for addicts to keep their addiction a secret. Few people can just disappear for 30, 60 or even 90 days without raising questions. So, for those not willing to “go public” with their addiction, this can be a deterrent to even seeking treatment.

6. To sum this up, even among the best and most successful addiction treatment programs, the biggest barriers to real and permanent recovery are:

- The physical suffering imposed by withdrawal
- The risk of a single momentary lapse that triggers a recovering addict’s fall back into re-addiction
- The hard-to-fight temptation created by unavoidable cravings
- The recovery failure caused by substituting one addiction for another
- The extensive calendar time away from home and work that make keeping things confidential very difficult

Despite these barriers, inpatient long-term recovery treatment programs have, until recently, been the best and most reliable means of helping those addicted to alcohol or opiates to recover from their addiction.
However, despite this relative effectiveness, the National Institute on Drug Abuse reports that success rates at even the best facilities hover around 50 percent, and that is for patients who keep going through rehab until it “takes.”

**Scientifically-Valid Medical Rehab and Recovery**

Having reviewed the conventional rehab program’s strengths and weaknesses – especially their reliance on willpower, here are the benefits of the medical approach to the treatment of this disease.

It should be noted here that not all anesthesia-facilitated treatment programs are the same – what is described here is the optimal solution, which involves both ultra-rapid detox, along with post-treatment palliative care such as IV-Hydration, post-treatment addiction counseling and – perhaps most important – ongoing treatment with a non-addictive prescription such as oral naltrexone or injected vivitrol.

a. Ultra-rapid detox offers victims of addiction a sound medical solution to their medical condition. Anesthesia-Facilitated Ultra-Rapid Detox has been cleared by the FDA and, as previously noted, has been recognized by the National institutes of Health as a safe and effective means for treating both opiate addiction and alcohol addiction.

*Rapid opiate detoxification under general anesthesia is a safe and efficient method to suppress withdrawal symptoms. This treatment may be of benefit in patients who particularly suffer from severe withdrawal symptoms during detoxification and who have failed repeatedly to complete conventional withdrawal. Methadone patients have more withdrawal symptoms than other opiate addicts.*

This optimal and effective solution is delivered in three steps.

- First by detoxing addicts while under anesthesia, ultra-rapid detox programs medically prevent the suffering of withdrawal
- Second, using one of two non-addictive prescriptions, ultra-rapid detox programs medically block even the chance of re-addiction.
This block remains in force for as long as the former addict continues to take this non-addictive prescription. As with any recovery program, patient compliance remains at the heart of success – however, instead of having to deal with cravings “one day at a time,” the recovering ultra-rapid detox patient merely takes one pill per day, or has one injection every 28 days.$^{30,32,33,36}$

- Finally, using that same non-addictive prescription addiction blocker, ultra-rapid detox programs also eliminate cravings.

Bottom line: instead of relying primarily on willpower to ensure patient compliance, state-of-the-art ultra-rapid detox programs provide a sound and medically-safe solution to addiction, allowing patients to go on to live addiction free lives.

This final step was affirmed in the previously cited “Revolving Door” article published in the New York Times:

“Among the therapies (which give users their best chance to break a habit) are prescription drugs like naltrexone ... which studies find can help people kick their habits.”$^{12}$

b. Where the best conventional rehab programs require anywhere from 30 to 90 days in a treatment hospital, ultra-rapid detox patients complete their out-patient program generally in three to seven days. That’s a time span so short that anyone with vacation time available can slip away and become addiction-free without making it obvious what they’re really doing.

So take a look at this comparison:

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<td>Four to six hours while under anesthesia</td>
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<td>“Tapering off” to reduce the suffering – and</td>
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**Further Supportive Treatments**

As the “gold standard” of ultra-rapid detox programs, the most comprehensive ultra-rapid detox programs also provide patients with a range of helpful supportive treatments.

These supportive treatments often include IV Hydration Therapy. This is used to restore vitamins and electrolytes lost due either to addiction or to anesthesia. Supportive treatments continue with one-on-one addiction counseling to help our patients begin a life free from addiction.

**Clear Comparison**

The comparison is clear. For more than half a century, even the best conventional treatment programs have treated addiction as if it was a matter to be controlled – after experiencing the pangs of withdrawal – by willpower, supported by counseling. That need for one-day-at-a-time willpower continues for the rest of the patient’s life.

However, ultra-rapid detox programs recognize that addiction is a medical condition, to be treated with state-of-the-art medical science. This sparing the victim of addiction from the physical suffering during detox and later, during the “craving” phase of recovery.
Sources and References

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The Medical Definition of Addiction


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About Alcohol Abuse and Addiction


**Relapse Prevention**


**Addiction and TBI**


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