Recovery Management: Premises, Promises & Pitfalls

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Presentation Goals

1. Highlight the shift in addiction treatment from models of acute care (AC) to models of sustained recovery management (RM)
2. Outline 10 areas of frontline service practices that are changing in this transition
3. Discuss pitfalls related to RM & its implementation

Primary Resources

- White, W. (2008). *Recovery management and Recovery-oriented Systems of Care: Scientific Rationale and Promising Practices*.
- Kelly, J. & White, W. (Eds., 2011) *Addiction Recovery Management: Theory, Science and Practice*.

Primary Resources

- White, W. (2009). *Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation.*
- White, W. & Torres, L. (2010). *Recovery-oriented Methadone Maintenance*.
- White, W. & Kurtz, E. (2006). *Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches*.

Signs of a Paradigm Shift

- Science-based conceptualizations of addiction as a chronic disorder (Hser, et al, 1997; McLellan et al, 2000; Dennis & Scott, 2007, Kelly & White, 2011)
- Accumulation of systems performance data on limitations of acute care (AC) model of addiction treatment (White, 2008)

Signs of a Paradigm Shift

- *Recovery* as an organizing construct for behavioral health care policies & programs (e.g., IOM, 2006; CSAT, 2010)
- "Recovery-focused systems transformation" efforts (Clark, 2007; Kirk, 2011; Achara & Evans, 2011)

Signs of a Paradigm Shift

- Calls for a recovery-focused research agenda
- A new and newly nuanced language, e.g., efforts to define *recovery*, *recovery management (RM), & recovery-oriented systems of care (ROSC) (JSAT, 2007; Kelly & White, 2011)*

Recovery Management

"Recovery management" (RM) is a philosophical framework for organizing addiction treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality of life enhancement for individuals and families affected by severe substance use disorders.

Recovery-oriented Systems of Care

Recovery-oriented systems of care (ROSC) are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by severe substance use disorders. The *system* in ROSC is not a treatment agency but a macro level organization of a community, a state or a nation.

The Prevailing Acute Care Model

- An encapsulated set of specialized service activities (assess, admit, treat, discharge, terminate the service relationship).
- A professional expert drives the process.
- Services transpire over a short (and ever-shorter) period of time.
- Individual/family/community is given impression at discharge ("graduation") that recovery is now self-sustainable without ongoing professional assistance (White & McLellan, 2008).

Treatment (Acute Care Model) Works!

- Post-Tx remissions one-third to one-half, decreased AOD use & substance-related problems decrease by as much as 60% following Tx (Miller, et al, 2001; White, in press).
- Lives of individuals and families transformed by addiction treatment.

Treatment Works, BUT…

AC & RM Model Review

Comparison on 10 key dimensions of service design and performance

- AC Model Vulnerability
- How RM Models are Addressing Each Area of Vulnerability

1. AC Model Vulnerability: Attraction

Only 10% of those needing treatment received it in 2002 (Substance Abuse and Mental Health Services Administration, 2003); only 25% will receive such services in their lifetime (Dawson, et al, 2005).

Why People Who Need it Don't Seek Treatment

- Perception of the Problem, e.g., isn't that bad.
- Perception of Self, e.g., should be able to handle this on my own.
- Perception of Treatment, e.g., ineffective, unaffordable, inaccessible or "for losers"
- Perception of Others, e.g., fear of stigma and discrimination

Source: Cunningham, et, al, 1993; Grant 1997

Coercion vs. Choice

- The majority of people who do enter treatment do so at late stages of problem severity/complexity and under external coercion (SAMHSA, 2002).
- The AC model does not voluntarily attract the majority of individuals who meet diagnostic criteria for a substance use disorder.

RM Model Strategy: Attraction

- Recovery-focused anti-stigma campaigns, e.g., Recovery is Everywhere campaign, Ann Arbor, MI
- Early screening & brief intervention programs
- Assertive models of community outreach
- Non-stigmatized service sites, e.g., hospitals & health clinics, workplace, schools, community centers

Principle: Earlier the screening, diagnosis & Tx initiation, the better the prognosis for long-term recovery

2. AC Model Vulnerability: Access & Engagement

- Access to treatment is compromised by waiting lists (Little Hoover Commission, 2003).
- High waiting list dropout rates (25-50%) (Hser, et al, 1998; Donovan et al, 2001).
- Special obstacles to treatment access for some populations (e.g., women) (White & Hennessey, 2007)

Weak Engagement & Attrition

Dropout rates between the call for an appointment at an addiction treatment agency and the first treatment session range from 50-64% (Gottheil, Sterling & Weinstein, 1997).

Nationally, more than half of clients admitted to addiction treatment do not successfully complete treatment (48% "complete"; 29% leave against staff advice; 12% are administratively discharged for various infractions; 11% are transferred) (OAS/SAMHSA 2005).

RM Model Strategy:

- Assertive waiting list management
- Streamlined intake
- Lowered thresholds of engagement
- Pain-based (push force) to hope-based (pull-force) motivational strategies
- Warm welcome and enhanced alliance (e.g. motivational interviewing)
- Appointment prompts & phone follow-up of missed appointments
- Institutional outreach for regular re-motivation
- Radically altered AD polices (White, et al, 2005)

Altered View of Motivation

- Motivation seen as important, but as an outcome of a service process, not a pre-condition for entry into treatment. A strong therapeutic relationship can overcome low motivation for treatment and recovery (Ilgen, et al, 2006).
- Motivation for change no longer seen as sole province of individual, but as a shared responsibility with the treatment team, family and community institutions (White, Boyle & Loveland, 2003).

3. AC Model Vulnerability: Assessment & Tx Planning

- Categorical
- Pathology-focused, e.g., problem list to treatment plan
- Unit of assessment is the individual
- Professionally-driven
- Intake function

RM Model Strategy: Assessment & Recovery Planning

- Global rather than categorical (e.g., ASI, GAIN)
- Strengths-based (emphasis on assessment of recovery capital) (Granfield & Cloud, 1999)
- Greater emphasis on self-assessment versus professional diagnosis
- Scope of assessment includes individual, family and recovery environment
- Continual rather than intake activity
- Rapid transition from Tx plans to recovery plans (Borkman, 1998)

4. AC Model Vulnerability: Service Elements

- Widespread use of approaches that lack scientific evidence for their efficacy and effectiveness (in spite of recent advances)
- Minimal individualization of care, e.g., reliance on going through the "program"
- Only superficial responsiveness to special needs, e.g., specialty appendages rather than system-wide changes

RM Model Strategy: Service Elements

- Emphasis on evidence-based, evidence-informed & promising practices
- High degree of individualization, e.g. from "programs" to service menus whose elements are uniquely combined, sequenced & supplemented
- Emphasis on mainstream services that are gender-specific, culturally competent, developmental appropriate, and trauma-informed

5. AC Model Vulnerability: Composition of Service Team

AC Model often uses medical (disease) metaphors but utilizes a service team made up almost exclusively of non-medical personnel.

AC model uses a recovery rhetoric but representation of recovering people in Tx milieu via staff and volunteers has declined via professionalization.

RM Model Strategy: Composition of Service Team

- Increased involvement of primary care physicians
- New service roles, e.g., recovery coaches
- Utilization of new service organizations, e.g. community recovery centers (White, 2009; White & Kurtz, 2006; Valentine, White & Taylor, 2007)
- Renewed emphasis on volunteer programs, consumer councils/ alumni associations, Inclusions of “indigenous healers” (White, 2009; White & Sanders, 2008)

6. AC Model Vulnerability: Locus of Service Delivery

- Institution-based
- Weak understanding of physical and cultural contexts in which people are attempting to initiate recovery
- AC Model question: "How do we get the individual into treatment"--get them from their world to our world?

RM Strategy: Locus of Service Delivery

- Home-, neighborhood- & community-based
- RM question: "How do we nest recovery in the natural environment of this individual or create an alternative recovery-conducive environment?" (White, JSAT 2009)

7. AC Model Vulnerability: Service Dose and Duration

One of the best predictors of treatment outcome is service dose (Simpson, et al, 1999). Many of those who complete treatment receive less than the optimum dose of treatment recommended by the National Institute on Drug Abuse (NIDA, 1999; SAMHSA, 2002)

AC Model Vulnerability: Frequency of Discharge, Relapse, Re-admission

The majority of people completing addiction treatment resume AOD use in the year following treatment (Wilbourne & Miller, 2002).

Of those who consume alcohol and other drugs following discharge from addiction treatment, 80% do so within 90 days of discharge (Hubbard, Flynn, Craddock, & Fletcher, 2001).

Fragility of Early Recovery

Individuals leaving addiction treatment are fragilely balanced between recovery and re-addiction in the hours, days, weeks, months, and years following discharge (Scott, et al, 2005; Dennis et al, in press).

Recovery and re-addiction decisions are being made at a time that we have disengaged from their lives, but that many sources of recovery sabotage are present.

AC Model Vulnerability: Timing of Recovery Stability

- Durability of alcoholism recovery (the point at which risk of future lifetime relapse drops below 15%) is not reached until 4-5 years of remission (Jin, et al, 1998).
- 20-25% of narcotic addicts who achieve five or more years of abstinence later return to opiate use (Simpson & Marsh, 1986; Hser et al, 2001).

“Aftercare” as an Afterthought

- Post-discharge continuing care can enhance recovery outcomes (Johnson & Herringer, 1993; Godley, et al, 2001; Dennis, et al, 2003; McKay, 2009).
- But only 1 in 5 (McKay, 2001) to 1 in 10 (OAS, SAMHSA, 2005) adult clients receive such care (McKay, 2001) and only 36% of adolescents receive <u>any</u> continuing care (Godley, et al, 2001)

AC Treatment as the New Revolving Door

Of those admitted to the U.S. public treatment system in 2003, 64% were re-entering treatment including 23% accessing treatment the second time, 22% for the third or fourth time, and 19% for the fifth or more time (OAS/SAMHSA, 2005).

RM Model Strategy: Assertive Approaches to Continuing Care

- Post-treatment monitoring & support (recovery checkups) (Dennis, et al, in press)
- Stage-appropriate recovery education & coaching
- Assertive linkage to communities of recovery (White & Kurtz, 2006; White, 2009)
- If & when needed, early re-intervention Focus not on service episode but managing the course of the disorder to achieve lasting recovery.

RM Model Strategy: Assertive Approaches to Continuing Care

1. Provided to all clients not just those who "graduate"
2. Responsibility for contact: Shifts from client to the treatment organization/professional

RM Model Strategy: Assertive Approaches to Continuing Care

3. Timing: Capitalizes on critical windows of vulnerability (first 30-90 days following Tx) and power of sustained monitoring (Recovery Checkups)
4. Intensity: Ability to individualize frequency and intensity of contact based on timing of personal vulnerability

RM Model Strategy: Assertive Approaches to Continuing Care

5. Duration: Continuity of contact over time with a primary recovery support specialist for up to 5 years
6. Location: Community-based versus clinic-based
7. Staffing: May be provided in a professional or peer-based delivery formats
8. Technology: Increased use of telephone- & Internet-based support services

8. AC Model Vulnerability: Relationship with Recovery Communities

Participation in peer-based recovery support groups (AA/NA, etc.) is associated with improved recovery outcomes (Humphreys et al, 2004; White, 2009).

This finding is offset by low Tx to community affiliation rates and high (35-68%) attrition in participation rates in the year following discharge (White, 2009)

Passive/Active Linkage

- Active linkage (direct connection to mutual aid during treatment) can increase affiliation rates (Weiss, et al 2000),
- But studies reveal most referrals from treatment to mutual aid are passive variety (verbal suggestion only) (Humphreys, et al 2004)

RM Model Strategy

- Staff & volunteers knowledgeable of multiple pathways/styles of long-term recovery, local recovery community resources and Online recovery support meetings and related services (White & Kurtz, 2006)
- Direct relationship with H & I committees and comparable service structures
- Recovery coaches provide assertive linkages to support groups and larger communities of recovery

9. AC Model:
Service Relationship

Dominator-Expert Model: Recovery is based on relationships that are hierarchical, time-limited, transient and commercialized.

RM Model:
Service Relationship

- Partnership Model: Recovery is based on imbedding the client/family in recovery supportive relationships that are natural, reciprocal, enduring, and non-commercialized.
- RM is focused on continuity of contact in a recovery supportive service relationship over time comparable to role of primary physician.

10. AC Model Vulnerability: Evaluation

Historical focus on measurement of short-term outcomes of a single episode of care at a single point in time following treatment; outcome is measured by pathology reduction.

RM Model Strategy: Evaluation

- Focus on effect of interventions on long-term addiction/treatment/recovery careers (McLellan, 2002; Kelly & White, 2011)
- Focus on long-term recovery processes and quality of life in recovery (Laudet & White, 2009).
- Greater involvement of clients, families & community elders
- Search for potent service combinations and sequences.

RM Implementation Obstacles & Potential Pitfalls

1. Denial

   Tx Works: we're already doing recovery-focused treatment; RM is old stuff with a new name

2. Projection of Blame

   We can't do any of this because no one will pay for it

3. Very real fiscal/regulatory barriers

RM Implementation Obstacles & Potential Pitfalls

4. Integrated care in a categorically segregated service world
5. Weak organizational infrastructures of Tx agencies, e.g., supervision, staff turnover
6. Technology Deficits

   --Evidence-based models of peer-based recovery support

   --Resource/Caseload Management

   -- Ethical/Boundary Issues

RM Implementation Obstacles & Potential Pitfalls

7. Stigma/hope
8. Model Misapplication & financial exploitation e.g. low-severity AOD problems

Closing Thoughts

1. ROSC and RM represent not a refinement of modern addiction treatment, but a fundamental redesign of such treatment.
2. ROSC and RM represent new approaches to behavioral health care and cost management

Closing Thoughts

3. It will take years to transform addiction treatment from an AC model of intervention to a RM model of sustained recovery support.
4. That process will require aligning concepts, contexts (infrastructure, policies, financing models and system-wide relationships) and service practices to support long-term recovery.
5. Our next seminar will focus on nesting RM within recovery-oriented systems of care (ROSC).