The New Recovery Paradigm:The Coming Transformation of Addiction Treatment in America

William L. White
Chestnut Health Systems
(bwhite@chestnut.org)

Presentation Goals

1. Describe the shift in governing models in addition treatment from pathology and intervention paradigms to a recovery paradigm
2. Outline a series of recommendations that will help shift addiction treatment from a model of acute stabilization to a model of sustained recovery management, with a particular focus on post-treatment recovery support services

Perspective: Multiple Roles

- Personal recovery & recovery advocacy
- 36 years in the addictions (early years as a clinician, clinical director & trainer)
- Past 20 years in clinical research
- Treatment & recovery historian
- An epiphany in Dallas, Texas

The Pathology Paradigm

Focus: Etiology and course of AOD problems

Assumption: Sources of AOD problems will reveal their potential solution

Contributions of Model: Charting of multiple pathways into AOD problems , new medications in treatment of addiction, etc.

Limitations: Health defined as absence of illness.

The Intervention Paradigm

Assumptions: Using and evaluating multiple treatment interventions will eventually reveal the most successful solutions to AOD problems

Contributions: hundreds of thousands of people in recovery through Tx pathway

Limitations: Focus on short term stabilization rather than long-term recovery

The Recovery Paradigm

- Solutions to AOD problems already exist in lives of millions of individual/families. Improved strategies can come from the experience, strength & hope of those already in recovery.
- Confluence of Recovery as an Organizing Concept in Addictions and Mental Health Fields

New Recovery Advocacy Movement

Organization (NCADD, FaVoR, JI, LAC, grassroots recovery advocacy organizations)

Action Agendas

- Transform public opinion & public policy
- Pursue recovery research
- Enrich recovery resources
- Transform addiction treatment into a recovery-oriented system of care

The Acute Care Model of Addiction Treatment

- Encapsulated set of service activities (assess, admit, treat, discharge /brief continuing care, termination of service relationship).
- Professional expert drives the process.
- Service episodes transpire over a relatively short period of time (most less than 90 days).
- Individual/family is given impression at discharge (“graduation”) that recovery is now self-sustainable without ongoing professional assistance.

Treatment (Acute Care Model) Works!

- Post-Tx remissions one-third, AOD use decreases by 87% following Tx, & substance-related problems decrease by 60% following Tx (Miller, et al, 2001).

- Lives of individuals and families transformed by addiction treatment.

Treatment Works, BUT

LOW ATTRACTION

Only 10% of those needing treatment received it in 2002 (SAMHSA, 2003) & access compromised by waiting lists (Donovan, et al, 2001).

HIGH ATTRITION

More than half of clients admitted to addiction treatment do not successfully complete treatment

Treatment Works, BUT...

LOW SERVICE DOSE

Inadequate doses of Tx contribute to risk of relapse & future readmissions

LACK OF CONTINUING CARE

Only 1 in 5 adult clients participated in continuing care (McKay, 2001) and only 36% of adolescents received any continuing care (Godley, Godley & Dennis, 2001)

Role of Recovery Mutual Aid

Participation in peer-based recovery support groups (AA/NA, etc.) is associated with improved recovery outcomes (Humphreys et al, 2004), but is offset by high (35-68%) attrition in participation following treatment (Makela, et al, 1996; Emrick, 1989)

Treatment Works, BUT...

POST-TREATMENT RELAPSE

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).

Acute Care Treatment as a 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).

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).

Fragility of Early Recovery

Most individuals leaving addiction treatment are fragilely balanced between recovery and re-addiction in the hours, days, weeks, months, and years following discharge.

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

Scott, Foss & Dennis Chicago Study (2005)
Recovery & Relapse Cycling over 3 years

Sample: 1,326 adults treated in Chicago Tx facilities

Measurement: Interviews at 6 months; 24 months; 36 months following index Tx

Status: in community using, incarcerated, in treatment, or in community not using

Finding: 83% changed status at least once during 3 years; 36% 2 times; 14% 3 times

Scott, Foss, & Dennis (2005)

Recovery Prevalence

Studies of people meeting lifetime criteria for a DSM-IV Substance Use Disorder in community and treatment samples reveal that 58-60% eventually achieve sustained recovery (i.e., no dependence or abuse symptoms for the past year) (Kessler, 1994; Dawson, 1996; Robins & Regier, 1991; Dennis et al, 2005).

Questions: How do we convey the reality of recovery? How do we increase the prevalence of recovery?

Addiction/Treatment/Recovery Careers

Stable substance dependence recovery among Tx populations usually follows multiple Tx episodes over years (Anglin, et al, 1997; Dennis, Scott, & Hristova, 2002).

Question: How do we shorten addiction careers and extend the length and quality of recovery careers.

Calls for a New Model of Treatment: Many Names

- Chronic Disease Management (O'Brien & McLellan, 1996; McLellan, et al, 2000)
- Extending Case Monitoring (Stout, et al, 1999)
- Recovery Management (White, Boyle & Loveland 1998, 2002; Dennis, Scott & Funk, 2003)
- Assertive Continuing Care (Godley, Godley & Dennis, 2001)

Emerging (rediscovered) Strategies to Enhance Recovery Outcomes

1. Post-treatment monitoring
2. Sustained recovery coaching
3. Stage-appropriate recovery education
4. Assertive linkage to communities of recovery
5. When needed, early re-intervention
6. Recovery community resource development

Dennis, Scott & Funk Chicago Adult Study (2003)

- Effect of Recovery Management Checkups on Cycle
- Sample: 448 individuals randomly assigned to receive over 2 yrs either quarterly assessment interviews or quarterly recovery management (assessment with re-intervention and linkage to Tx)

Recovery Management Checkups

Study Findings

Those assigned to RMC more likely to return to Tx sooner, spend more days in Tx, & less likely to be in need of Tx at 24 months

Godley, Godley, Dennis, et al, Adolescent Study (2002)

Sample: 114 adolescents discharged from IP Tx randomly assigned to aftercare as usual or assertive continuing care (ACC)

ACC Intervention: Home visits, sessions for adolescents, parents and joint sessions, case management

Effects of Assertive Continuing Care

Findings at 3 months

1. ACC group had a significantly higher engagement/retention rate
2. ACC group averaged more than twice the continuing care sessions as the control group
3. ACC group showed lower relapse rates for alcohol and cannabis; days to first use longer in ACC group members who did use

Other Studies are Confirming the Clinical and Cost Effectiveness of:

- Telephone-based post-treatment monitoring and support (McKay, 2005)
- Internet-based recovery support services (Virtual Recovery) (White & Nicolaus, 2005)
- Recovery Homes and Voluntary Recovery Communities (Jason, et al, in press)

Future of Post-Treatment Monitoring and Support

10 Recommendations

1. Tell the Truth about Treatment Outcomes

Challenge the expectation that full recovery should be achieved from a single Tx episode. Educate staff, clients, families, employers and allied professionals on the need for sustained recovery management similar to that applied to the management of such illnesses as diabetes and heart disease.

2. Change our attitudes toward individuals with prior treatment

Prior Tx is not an indicator of poor prognosis and should not be grounds for service exclusion. Confront any perception of returning clients as "losers" who are taking up space that others deserve. We need to welcome returning clients, praise them for service re-initiation, offer immediate support, and help them extract lessons from their relapse experiences.

Rethinking Recidivism

Bill Wilson (Co-founder of AA) & Marty Mann (Alcoholism Public Health pioneer) had 10 prior Tx episodes between them before the Txs that led to their permanent recoveries and their historical contributions.

How might history have been different if they had been treated as “losers” or “retreads” and denied access to treatment?

3. Stop Providing Serial Episodes of the Same Tx

Re-examine the practice of repeatedly providing the same treatment services that have failed to generate sustained recovery.

All Tx methods have optimal responders, partial responders, & non-responders. We must search for potent combinations and sequences of Tx and recovery support services by giving staff permission to rethink assumptions/methods and combine service/support elements in new ways.

4. Promote a Philosophy of Choice

Acknowledge the legitimacy of multiple pathways and styles of recovery and promote a philosophy of choice in post-treatment recovery support resources.

We must all become experts on the varieties of recovery pathways/experiences. We have been trained as addiction experts; it is time we became recovery experts!

5. Integrate Multiple Tx Episodes within a Long-term Recovery Plan

Link episodes of past and future treatment by conceptualizing the overall course of recovery management. Shift the service emphasis from detoxification and stabilization (early recovery initiation) to long-term recovery consolidation and maintenance. Conceptualize and implement multi-year service plans for clients with high problem severity/complexity and low recovery capital.

6. Replace “Aftercare as an Afterthought” with Sustained and Assertive Continuing Care

- Abandon use of the term “aftercare”; ongoing recovery management is the essence of Tx, not an optional adjunct.
- Abandon “discharge planning” and provide sustained continuing care as an expected component of treatment for individuals with high problem severity & complexity.
- Design and implement systems of assertive continuing care

Assertive Continuing Care vs. Traditional Aftercare

1. Provided to all Clients not Just Those Who “Graduate”
2. Responsibility for Contact: Shifts from Client to the Treatment Organization/Professional (like my dentist office)

Assertive Continuing Care vs. Traditional Aftercare

3. Timing: Capitalizes on Critical Windows of Vulnerability (first 30-90 days following primary Tx) and Power of Sustained Monitoring (Recovery Checkups)
4. Intensity: Ability to Individualize Frequency and Intensity of Contact based on Clinical Data

Assertive Continuing Care vs. Traditional Aftercare

5. Duration: Continuity of Contact over Time with a Primary Recovery Support Specialist (Recovery checkups over 2-5 years or longer)
6. Location: Community-based versus Clinic-based
   (Focus on the ecology of recovery)
   (Integration of clinical and community development models)
7. Staffing: May be Provided in a Professional or Peer-based Delivery Format

7. Shift Service Relationships from Brief Expert Model to Sustained Partnership/Consultation Model

Promote service relationships that are less hierarchical (partnership model) and less transient. Promote a sustained recovery support relationship that is analogous to service relationships crucial to the long-term management of diabetes, hypertension, asthma and other chronic primary health conditions.

8. Explore Creative Strategies for Telephone- & Internet-based Recovery Support Services

Uses of Telephone & Internet-based Systems of ACC

Current Models: Betty Ford Center, Hazelden

1. Maintaining the recovery relationship/partnership (Scott's concept pf "creating valued space" in the client's life)
2. Monitoring & feedback
3. Recovery coaching
4. Early Re-intervention

9. Facilitate Client Involvement in Voluntary Communities of Recovery

- More effective use of sober housing
- Nurture the development and diversity of peer-based recovery support groups & permanent recovery communities
- Strengthen relationships with local recovery support groups
- Rebuild volunteer and alumni programs
- Develop protocol for assertive linkage (e.g., matching to groups, meetings, individuals)

10. Design & Implement Peer-based Recovery Support Models

Increased use of Recovery Coaches (also called recovery assistants, recovery support specialists, peer mentors)

Future

- Pre-Tx Recovery Priming
- In-Tx Recovery Support Services
- Post-Tx Recovery Support Services

Recovery: A Conceptual & Human Bridge

- Historical Conflict between addictions and mental health fields
- Battles over problem ownership, theories of causation & treatment methods.
- Trapped in our own historical models

  Addictions—Pathology focus, time-limited service

  Mental Health—Pathology focus, time-sustained service

  Both have lacked a fully developed, vibrant recovery concept as their organizing center

Recovery: A Conceptual & Human Bridge

- Recovery as an emerging organizing concept has enormous potential for person-centered models of service integration.
- Recovery advocates from these two fields are meeting with increased frequency and finding common ground. They will exert a significant influence on service systems in the coming decade.

Recovery: A Conceptual & Human Bridge

- The voices of advocates from both fields are clear: Recovery is more than the absence of disease. It is about a meaningful & purposeful life, autonomy & choice, safety & security, friendship & love, family participation, productivity & play and it is about citizenship and service to others.

New Guiding Visions

Recovery by Any Means Necessary!

Continuity of Contact in a Sustained Recovery Support Relationship

Primary Resources

- www.bhrm.org
- White/Boyle/Loveland (2003) *Alcoholism Treatment Quarterly*, 3/4:107-130; *Behavioral Health Management* 23(3):38-44.
- White, W. (2005). Recovery Management: What if we <u>really</u> believed addiction was a chronic disorder? *GLATTC Bulletin*. September, pp. 1-7.
- White, W. & Kurtz, E. (in press) The Varieties of Recovery Experience GLATTC Monograph