What if . . . We Really Treated Addictive Disorders as a Chronic Disease?

Bill White

Chestnut Health Systems

Two Movements

Treatment Renewal Movement

1. **Bridge gap between research & practice**
2. **Re-link treatment and indigenous community resources**
3. **Re-connect treatment to recovery**

(White, W. (2002. February) Counselor, pp 59-61)

Two Movements

New Recovery Advocacy Movement

1. **Grassroots organizations**
2. **Strategies: recovery community mobilization, needs assessment, resource development, policy advocacy, recovery education, recovery support services, recovery research**

(See www.recoveryadvocacy.org; White, W. (2001, December) Counselor, pp.64-67)

Intersection of These Two Movements

- **Push for treatment institutions to become "Recovery-oriented Systems of Care"**
- **Shift from acute models of intervention to models of recovery management**

Presentation Goals

1. Describe the emerging recovery management (RM) Model and contrast it with traditional treatment
2. Identify the forces pushing the field toward a RM model
3. Describe how the RM model will change clinical practice
4. Discuss potential pitfalls of the RM model

Resources

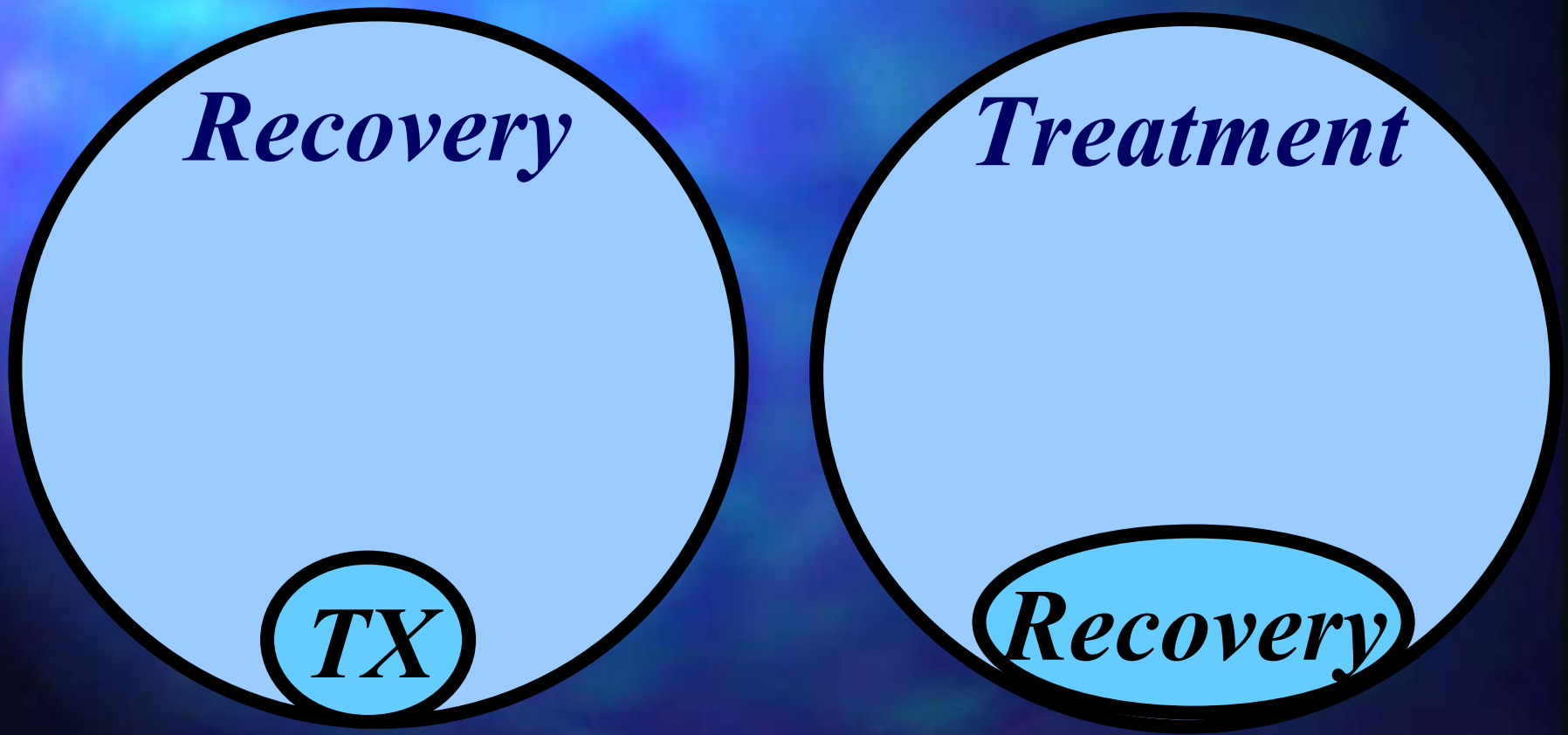
- www.bhrm.org
- Alcoholism Treatment Quarterly Articles: White, 2001, 19(4):1-32; White, et al, 2002/in press.

Two Traditions:

- Addiction: McLellan, Lewis, O'Brien, Kleber, Borkman
- Mental Health: Anthony, Campbell, Deegan, Crowley, Drake, Minkoff, Rapp, Ralph

Factors Pushing Recovery Focus

1. Consumer Movement



Vision 1963-1970 **Reality 2001**

Factors Pushing Recovery Focus (cont.)

2. Managed Care Organizations
   - Depression studies
   - Transfer of knowledge from treatment of chronic disorders in primary health care to addiction treatment
   - "Disease Management" (Focus on managing costs of disease)
   - "Recovery Management" (Focus on global health of individual/family)

Clinical Research

- AOD problems
- Transient and chronic forms
- Most people with AOD problems do not seek help from mutual aid societies or professional treatment
- Transient disorders: Natural recovery and brief intervention

Clinical Versus Community Populations

1. **Higher personal vulnerability (e.g., family history, lower age of onset)**
2. **Higher severity (acuity & chronicity)**
3. **Higher rates of co-morbidity**
4. **Greater personal and environmental obstacles to recovery**
5. **Lower recovery capital (personal assets / family and social supports)**

Evidence of Chronicity

- **High attrition between point of help-seeking and admission (waiting lists)**
- **Prior treatment (Of 1,346,759 public Tx admissions in 1999, 58% had prior treatment (23% 1; 23% 2-4; 12% 5+)**
- **High attrition during treatment (59% of clients in public Tx in Illinois fail to complete TX)**

Sources: Office of Applied Studies, 2001; FY00 Data Book, 2001.

Evidence of Chronicity

- **Low percentage of aftercare participation and low dose of aftercare (less than 30% participate in 5 or more sessions)**
- **Re-admission within twelve months (1/3 of clients treated in the Cannabis Youth Treatment Study were re-admitted to treatment within 12 months)**

Clinical Research (Treatment Outcome Studies)

- Sustained symptom suppression
- Symptom continuation (no measurable effect of treatment)
- Early suppression followed by clinical deterioration
- Early deterioration followed by sustained symptom suppression
- Cycles of suppression and deterioration

If we really believed addiction was a chronic disorder, we would not:

1. **Create expectation that full recovery should be achieved from a single Tx episode (Demoralization of clients/families, staff, policy makers, community)**
2. **View prior Tx as indicative of poor prognosis**
3. **Extrude clients for becoming symptomatic (confirming their diagnosis)**

If we really believed addiction was a chronic disorder, we would not:

4. **Treat addiction in serial episodes of disconnected TX**
5. **Relegate aftercare to an afterthought**
6. **Terminate the service relationship following brief intervention**

Recovery Management Experiments

- **If we really believed that addiction was a chronic disorder, what would treatment look like? Or,**
- **How would we treat addiction if we were paid only for successful recovery outcomes?**
- **The Behavioral Health Recovery Management project**
- **CSAT's RCSP Peer-Driven Recovery Support Services Pilots**

Recovery Concepts

- **Stages of Change: Developmental Models of Recovery**
- **Stages of Recovery and Service Needs**
- **Recovery Priming/Initiation versus Recovery Maintenance**
- **Serial Recovery: Accepting, Managing & Transcending Multiple Wounds/Limitations**
- **Peer-driven Models of Recovery Support**

Acute Treatment Model Emerging Recovery Management Model

16 major differences in service design and delivery

- **Compare and contrast**
- **Desirability and effectiveness of each model varies across clinical populations**

1. Engagement

- **Traditional Model: High threshold of engagement, crisis intervention, isolated outreach, high extrusion**
- **Recovery Management Model: Low threshold (welcoming), emphasis on outreach, pre-treatment recovery support services; low extrusion**

2. View of Motivation

- **Traditional Model: Pre-condition for treatment, absence defined as "resistance", responsibility/blame-- client**
- **Recovery Management Model: Seen as outcome of services, emphasis on pre-action stages of change ("recovery priming") responsibility/blame--service milieu**

3. Screening/Assessment

- **Traditional Model: Categorical, Intake Activity, Deficit-based (problems to treatment plan)**
- **Recovery Management Model: Global, Continual (stages of change assumptions), Strength-based (assets to recovery plan); Inclusion of family/kinship network: Consumer defines family.**

4. Service Goals

- **Traditional Model: Professionally defined in treatment plan; focus on reducing pathology.**
- **Recovery Management Model: Consumer-defined in recovery plan; focus on building recovery capital and meaningful life (Borkman, 1998).**

5. Service Timing

- **Traditional Model: Focus on crisis/problem resolution; reactive**
- **Recovery Management Model: Focus on post-crisis recovery support activities; proactive; commitment to continued availability; continuum of recovery support services**

6. Service Emphasis

- **Traditional Model: Detoxification and stabilization**
- **Recovery Management Model: Sustained recovery coaching, monitoring with feedback and support, linkage to communities of recovery; early re-intervention**

7. Locus of Services

- **Traditional Model: Institution-based--"How do we get the client into Treatment?"**
- **Recovery Management Model: "How do we nest the process of recovery within the client's natural environment?"**

8. Service Technologies

- **Traditional Model: Focus on "programs"; limited individualization; biomedical stabilization**
- **Recovery Management Model: Focus on service and support menus; high degree of individualization; greater emphasis on physical/social ecology of recovery**

9. Management of Co-morbidity

- **Traditional Model: Exclusion, extrusion, recidivism, iatrogenic injury; experiments with parallel/sequential Tx**
- **Recovery Management Model: Concept of "serial recovery"; integrated model of care, multi-unit/agency models, inclusion of indigenous healers/institutions**

10. Service Roles

- **Traditional Model: Specialization of clinical roles, emphasis on academic/technical expertise; resistance to prosumer movement**
- **Recovery Management Model: "Adisciplinary"; role cross-training; prosumers in paid and volunteer support roles; emphasis on mutual aid; role of primary care physician**

11. Service Relationship

- **Traditional Model: (Dominator-Expert Model). Hierarchical, time-limited, transient (staff turnover), and often commercialized.**
- **Recovery Management Model: (Partnership-Consultant Model). Less hierarchical, potentially time-sustained, continuity of contact, less commercialized.**

12. Consumer Involvement

- **Traditional Model: Passive role--professionally prescribed; consumer dependency.**
- **Recovery Management Model: Consumer involvement/direction of service policies, goal-setting, delivery, and evaluation. Focus on illness self-management. Consumers as volunteers & employees. Consumer-led support groups/services.**

13. Relationship to Community

- **Traditional Model: Community defined in terms of other agencies**
- **Recovery Management Model: Focus on how to diminish need for professional services; emphasis on hospitality and supports within the natural community; emphasis on indigenous supports; "the community is the treatment center"**

14. View of Aftercare

- **Traditional Model: Aftercare as an afterthought (less than 30%) or maintenance for life.**
- **Recovery Management Model: Eliminate concept of "aftercare": all care is continuing care; emphasis on community resources; Role of guide or recovery coach.**

15. Service Evaluation

- **Traditional Model: Focus on professional review of short-term outcomes of single episodes of care; recent emphasis on social cost factors--impact on hospitalizations, arrests, etc.**
- **Recovery Management Model: Focus on long term effects of service combinations & sequences on client/family/community; Consumer-defined outcomes & review**

16. Advocacy

- **Traditional Model: Advocacy often limited to that related to institutional funding; Marketing and PR approach.**
- **Recovery Management Model: Emphasis on policy advocacy, community education (stigma) and community resource development; activist/community organization approach.**

Recovery Model Pitfalls

- **Out of the Box: Conceptual resistance, fiscal/regulatory barriers**
- **Whole Person: Integrated care in a categorically segregated service world**
- **Resource/caseload management**
- **Escape from accountability / exploitation**
- **Ethical/Boundary issues & model misapplication**

Closing

Prospects for Integration of Treatment and Recovery Management Models

"Whatever it takes, Recovery by any means necessary!"