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

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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
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

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

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

Recovery

Vision 1963-1970

Treatment

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)

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!”