CENTER FOR EVIDENCE-BASED PRACTICES

A partnership between the Mandel School of Applied Social Sciences & Department of Psychiatry at the School of Medicine

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A Technical-Assistance Center

Providing consultation, training, and evaluation for the implementation of integrated behavioral healthcare services
Service innovations for people with mental illness, substance use disorders

- **SAMI**
  - Substance Abuse & Mental Illness
  - Strategies for co-occurring disorders

- **IDDT**
  - Integrated Dual Disorder Treatment
  - The evidence-based practice

- **DDCAT**
  - Dual Diagnosis Capability in Addiction Treatment
  - An organizational assessment & planning tool

- **DDCMHT**
  - Dual Diagnosis Capability in Mental-Health Treatment
  - An organizational assessment & planning tool

- **MI**
  - Motivational Interviewing
  - The evidence-based treatment

- **SE**
  - Supported Employment
  - The evidence-based practice

- **TRAC**
  - Tobacco: Recovery Across the Continuum
  - A stage-based motivational model

- **IPB**
  - Integrated Primary Health and Behavioral Health

*Case Western Reserve University*
Recovery Management & The Opiate Epidemic: A Paradigm Whose Time Has Come

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the Center for Evidence Based Practices is a partnership between the Mandel School of Applied Social Sciences and the Department of Psychiatry, CWRU School of Medicine, Case Western Reserve University in collaboration with the Ohio Department of Mental Health and Addiction Services
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.
Model Principles

Several cornerstone beliefs distinguish the Recovery Management model from acute models of addiction treatment.

- Emphasis on resilience and recovery processes (as opposed to pathology and disease processes)

- Recognition of multiple long-term pathways and styles of recovery
Model Principles

• Empowerment of individuals and families in recovery to direct their own healing

• Development of highly individualized and culturally nuanced services

• Heightened collaboration with diverse communities of recovery

• Commitment to best practices as identified in the scientific literature and through the collective experience of people in recovery.
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)

• Accumulation of systems performance data on limitations of acute care (AC) model of addiction treatment (White, 2009)

• Recovery as an organizing construct for behavioral health care policies & programs (e.g., IOM, 2006; CSAT’s RCSP & ATR programs)

• “Recovery-focused systems transformation” efforts (Clark, 2007; Kirk, 2007; Evans, 2007)
Chronic Illness Conundrum

- Severe and persistent AOD problems have been collectively depicted as a “chronic, progressive disease”, but their treatment more closely resembles interventions into acute health conditions (e.g., traumatic injuries, bacterial infections).

- Acute models of treatment are not the best frameworks treating severe and persistent AOD problems.
If we really believed addiction was a chronic disorder...

We would not:

• view prior treatment as predictor of poor prognosis (and grounds for denial of treatment admission)

• convey the expectation that all clients should achieve complete and enduring sobriety following a single, brief episode of treatment

• punitively discharge clients for becoming symptomatic
If we really believed addiction was a chronic disorder...

We would not:

- relegate post-treatment continuing care services to an afterthought
- terminate the service relationship following brief intervention
- treat serious and persistent AOD problems in serial episodes of self-contained, unlinked interventions
A Fundamental Flaw

• Repeated episodes of brief interventions have little ability to fundamentally alter the course of substance dependence and its related consequences.

• Failure does not result from client or the inadequate execution of clinical protocol by service professionals.
A Fundamental Flaw

• It flows instead from a fundamental flaw in the design of the intervention - an acute-care model of treating addiction that is analogous to treating diabetes or asthma through a single, self-contained episode of inpatient stabilization.

• In the Acute Care model, brief symptom stabilization is misinterpreted as evidence of sustainable recovery.
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, 2009).
Acute Care & Recovery Management Model Review

Let’s compare 10 key dimensions of service design and performance

• AC Model Vulnerability

• How RM Models are Addressing Each Area of Vulnerability
1. Acute Care 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).
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 Acute Care model does not voluntarily attract the majority of individuals who meet diagnostic criteria for a substance use disorder.
Recovery Management 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 & treatment initiation, the better the prognosis for long-term recovery
2. Acute Care Model Vulnerability: Access & Engagement

- Access to treatment is compromised by waiting lists (Little Hoover Commission, 2003).


- 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).
High Extrusion as a Motivational Filter

High AMA and AD rates constitute a form of “creaming” e.g., view that “Those who really want it will stay.”

The reality: those least likely to complete are not those who want it the least, but those who need it the most—those with the most severe & complex problems, the least recovery capital, and the most severely disrupted lives (Stark, 1992; Meier et al, 2006).
Recovery Management
Model Strategy: Access & Engagement

• Assertive waiting list management
• Streamlined intake
• Lowered thresholds of engagement
• Pain-based (push-force) to hope-based (pull-force) motivational strategies
• Appointment prompts & phone follow-up of missed appointments
• Institutional outreach for regular re-motivation (long term care implications)
• Radically altered Administrative Discharge 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. Acute Care Model Vulnerability: Assessment & Tx Planning

- Categorical (vs. client centered)

- Pathology-focused, e.g., problem list to treatment plan

- Unit of assessment is the individual

- Professionally-driven

- Intake function
Recovery Management Model Strategy: Assessment & Recovery Planning

• Global rather than categorical (e.g., ASI, GAIN)

• Strengths-based (emphasis on assessment of recovery capital) (Granfield & Cloud, 1999)

• *Continual rather than intake activity*

• Greater emphasis on self-assessment versus professional diagnosis

• Scope of assessment includes individual, family and recovery environment

• Rapid transition from Tx plans to recovery plans (Borkman, 1998)
4. Acute Care 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
Recovery Management 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. Acute Care 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 treatment milieu via staff and volunteers has declined via professionalization.
Recovery 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 & Kurtz, 2006; Valentine, White & Taylor, 2007)

• Renewed emphasis on volunteer programs, consumer councils/ alumni associations

• Inclusions of “indigenous healers” in multidisciplinary teams, e.g., faith community
6. Acute Care 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?
Recovery Management 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?”

- The Healing Forest: One tree cannot heal in a sick forest. If you take a tree from the forest to mend it, then return it to the forest that is not well, the mending will not last...
7. Acute Care 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)
Acute Care 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).
Acute Care Model Vulnerability: Failure to Manage Addiction/Tx/Recovery Careers

- Most persons treated for substance dependence who achieve a year of stable recovery do so after multiple episodes of treatment over a span of years (Anglin, et al, 1997; Dennis, Scott, & Hristova, 2002).
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).

• Recovery and re-addiction decisions are being made at a time that we have disengaged from their lives, but many sources of recovery sabotage are present.
Acute Care Model Vulnerability: Timing of Recovery Stability

- Durability of 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


• 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 any continuing care (Godley, et al, 2001)
Acute Care 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

• 19% for the fifth or more time

(OAS/SAMHSA, 2005)
Recovery Management Model Strategy: Assertive Approaches to Continuing Care

- Post-treatment monitoring & support (recovery checkups)
- Stage-appropriate recovery education & coaching
- Assertive linkage to communities of recovery
- If and when needed, early re-intervention & re-linkage to Tx and recovery support groups

- *Focus not on service episode but managing the course of the disorder to achieve lasting recovery.*
Recovery Management 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
Recovery Management Model Strategy: Assertive Approaches to Continuing Care

3. Timing: Capitalizes on critical windows of vulnerability (first 30-90 days following treatment) and power of sustained monitoring (Recovery Checkups)

4. Intensity: Ability to individualize frequency and intensity of contact based on clinical data
Recovery Management 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 format

8. Technology: Increased use of telephone- & Internet-based support services
8. Acute Care 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).

• This finding is offset by low Tx to community affiliation rates and high (35-68%) attrition in participation rates in the year following discharge (Makela, et al, 1996; Emrick, 1989)
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)
Recovery Management
Model Strategy: Active Linkage

• 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 committees and comparable service structures

• Recovery coaches provide assertive linkages to support groups and larger communities of recovery
9. Acute Care Model: Service Relationship

• Dominator-Expert Model: Recovery is based on relationships that are hierarchical, time-limited, and transient.
Recovery Management Model: Service Relationship

- Partnership Model: Recovery is based on embedding 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.
  - Will require stabilization of field’s workforce

- Philosophy of Choice / Consultation Role
10. Acute Care 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.

(Or more recently, on retention/completion...)

Recovery Management Model Strategy: Evaluation

- Focus on effect of interventions on addiction/treatment/recovery careers at multiple points in time (McLellan, 2002)
- Focus on long-term recovery processes and quality of life in recovery.
- Greater involvement of clients, families & community elders in design, conduct and interpretation of outcome studies (White & Sanders, in press).
- Search for potent service combinations and sequences.
Policy Implications

• All of the reimbursement and regulatory systems that govern addiction treatment are based on the acute care model.

• These structures, originally designed to elevate the consistency and quality of addiction treatment, now constitute a major barrier to shifting to more recovery-oriented systems of care.
Policy Implications

• It is tragic and ironic that the major challenges of recovery management are posed, not by the complex needs of individuals and families seeking recovery, but by the systems originally set up to help facilitate that recovery.

• The mainstream implementation of recovery management will require a major overhaul of the reimbursement and regulatory systems governing addiction treatment.
Closing Thoughts

• Recovery Oriented Systems of Care and Recovery Management represent not a refinement of modern addiction treatment, *but a fundamental redesign of such treatment.*

• Overselling what the Acute Care model can achieve to policy makers and the public risks a backlash and the revocation of addiction treatment’s “probationary status” as a cultural institution.
Closing Thoughts

• It will take years to transform addiction treatment from an Acute Care model of intervention to a Recovery Management model of sustained recovery support.

• That process will require replicating across the country what is already underway elsewhere: aligning concepts, contexts (infrastructure, policies and system-wide relationships) and service practices to support long-term recovery.
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Our Mission

The Center for Evidence-Based Practices (CEBP) at Case Western Reserve University is a technical-assistance organization that promotes knowledge development and the implementation of evidence-based practices (EBPs) for the treatment and recovery of people diagnosed with mental illness or co-occurring mental illness and substance use disorders.

Our technical-assistance services include the following:
- Service-systems consultation
- Program consultation
- Clinical consultation
- Training and education
- Program evaluation (fidelity & outcomes)
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