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Recovery Management Checkups A Future Function of Addiction Professionals?

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A quiet revolution is unfolding that could fundamentally redefine the character, scope and duration of addiction treatment services. This article reports on the shift from acute care (AC) models of intervention into alcohol and other drug problems to models of sustained recovery management (RM) and summarizes the first research study testing the effects of proactive recovery management checkups on treatment outcomes.

Historical Context

Addiction has been characterized as a chronic disease for more than 200 years, but it is most often treated in acute episodes of care. This acute care model is characterized by: 1) serial episodes of self-contained, unlinked interventions (ever-briefer detoxification and psychosocial stabilization), 2) the expectation that complete and sustained recovery will follow a single episode of care, and 3) minimal resources devoted to post-treatment continuing care (aftercare as an afterthought). In short, treatment for addiction has resembled treatment of a broken arm or a bacterial infection. An expert diagnoses and treats the problem. The service relationship ends via “graduation” and “discharge” with (at best) a few “aftercare visits,” and the patient is expected to go on with his or her life without further need of professional assistance. Arguments over whether persons in inpatient addiction treatment should stay twenty-eight days or five days, whether outpatient treatment should be five sessions or twenty sessions, or consist of Twelve Step Facilitation or Cognitive Behavioral therapy are all arguments inside this acute care paradigm. The bias towards acute models of care is so pervasive that approaches that have sought more extended periods of support (Alcoholics Anonymous, long-term therapeutic communities, and methadone maintenance) have often been criticized for this very quality. Moreover, attempts to provide more sustained monitoring and support face significant barriers from managed care limits and service financing models that typically exclude payment for post-treatment monitoring and support services.

The acute care model of intervention is being challenged by an accumulation of scientific data that is sparking calls for models of sustained recovery management. This latter approach emphasizes the similarities between addiction and other chronic health problems, calls for a shift in emphasis from recovery initiation to recovery maintenance, and wraps traditional treatment in a more extended continuum of recovery management support services and monitoring across episodes of care ((McLellan, O'Brien, Lewis and Kleber, 2000; White, Boyle, Loveland, 2003).

Scientific Context

The scientific building blocks of the recovery management model are the product of more than three decades of research on the course of addiction and the effects of addiction treatment. The most critical of these findings include the following.

Pattern Variability Alcohol and other drug (AOD) problems present in varying degrees of severity, complexity and chronicity. Most people who experience less severe AOD problems are able to stop or decelerate use without the assistance of mutual aid groups or professional treatment (King and Tucker, 1998), while others resolve these problems following a single episode of brief professional intervention (Bien, Miller & Tonigan, 1993). Of those whose problem severity reaches the level of AOD “dependence”, about half eventually achieve a state of recovery (i.e., no symptoms for 12 or more months) (Kessler, 1994), with most reaching recovery after participating in AOD treatment (Cunningham et al., 1999, 2000).

Determinants of Chronicity Those for whom AOD problems tend to be more enduring are distinguished by greater personal vulnerability (family history of AOD problems, early age of AOD onset, developmental victimization), greater AOD problem severity, greater problem complexity (e.g., co-occurring psychiatric, behavioral, legal, health, and social problems), and lower “recovery capital” (internal and external resources to initiate and sustain recovery) (Granfield and Cloud, 1999).

Cycle of Relapse, Treatment Re-entry and Recovery A sizeable portion of persons entering addiction treatment in the United States are experiencing problems that constitute a chronic AOD condition that typically require multiple episodes of care . Of those entering the public treatment system, 60% report prior treatment (23% 1 time; 13% 2 times, 7% 3 times, 4% 4 times and 13% 5 or more times)(OAS, 2001). Twenty-five to thirty-five percent are readmitted to treatment within twelve months, 50% within 2-5 years (Hubbard, Marsden, Rachal, Harwood, Cavanaugh, & Ginzburg, 1989). Only 1 in 5 clients discharged from addiction treatment participates in any post-discharge continuing care (McKay,

2001). Continuing care consists mostly of passive referral to mutual aid groups, but exposure to such groups without ancillary supports results in high attrition rates (50% in first three months) (Mäkelä, et al, 1996). In short, most clients are precariously balanced between recovery and relapse in the weeks and months following acute treatment, and have few pro-recovery professional or peer supports during this period. Post-treatment relapse and treatment readmission are the most common outcomes.

Addiction and Recovery Careers Of those treated for substance dependence who go on to achieve sustained abstinence, most will experience 3-4 episodes of acute care over a span of eight years before reaching this goal (Anglin, Hser, & Grella, 1997; Dennis, Scott, & Funk, 2003). Addiction recovery begins prior to the cessation of drug use; is marked in its earliest stages by extreme ambivalence, involves age-, gender-, and culture-mediated change processes; and involves predictable stages, processes, and levels of change (Prochaska, et al., 1992). Those factors that maintain recovery over the long run are often different than those factors that initiate recovery (Humphreys, Moos & Finney, 1995). Recovery is enhanced by processes of social support (Humphreys, Mankowski, Moos & Finney, 1999), participation in recovery support groups, (Emrick, Tonigan, Montgomery, & Little, 1993), and by sobriety-conducive living environments (Jason, Davis, Ferrari & Bishop, 2001). Recovery durability (point at which risk of future lifetime relapse drops below 15%) is not reached until 4-5 years of sustained remission (Jin, Rourke, Patterson, Taylor & Grant, 1998).

Cumulative/Timing Effects of Treatment Long-term recovery outcomes are influenced by the age of first treatment admission (the earlier the age of first treatment and the lower the years of regular use, the better the long term outcome) (Dennis, Scott, & Funk., under review), the total amount of treatment received (particularly when the total period of service contact exceeds 90 days) (NIDA, 1999; Simpson et al 2002), and the speed with which re-engagement and readmission to treatment occurs (Scott, Foss & Dennis, 2003). Recovery outcomes can be enhanced through post-treatment follow-up interviews (conducted as part of treatment outcome studies) (Sobell and Sobell, 1981), recovery checkups (Dennis, Scott, & Funk, 2003) and participation in assertive continuing care programs (Godley, Godley, Dennis, Funk & Passetti, 2002).

Chronic Disease Management Service models involving sustained tracking, monitoring (via regular checkups), patient motivation and support, and early re-intervention and service linkage play a central role in the management of such chronic conditions as asthma, cancer, diabetes mellitus, hypertension and severe mental illness. These conditions are similar to addiction in their etiological complexity (interaction of genetic, biological, psychological and physical/social environmental factors), course, and clinical outcomes. There are increasing calls

to apply technologies used in the management of such disorders to the treatment of severe and persistent AOD problems (McLellan, et al, 2000; White, et al, 2003).

These cumulative research findings suggest redesigning addiction treatment to speed problem identification and engagement, reduce attrition during treatment, increase participation in continuing care, and provide a proactive approach to post-treatment monitoring, stage-appropriate recovery education, sustained recovery support, active linkage to local communities of recovery and early re-intervention. It will be up to the addictions research infrastructure to judge whether such innovations significantly enhance long-term treatment and recovery outcomes.

A Clinical Test

A just-published scientific study tested the effects of a quarterly Recovery Management Checkup (RMC) model over a two-year period with a group of clients entering a central intake unit in Chicago (Dennis, Scott & Funk, 2003). These clients brought many risk factors for post-treatment relapse, e.g., psychiatric co-morbidity (77%), substance use by others in the home (40%), regular substance use by peers (84%), and history of homelessness (54%). A total of 448 clients (59% female; 85% African American; primarily dependent upon cocaine, opiates and alcohol) were randomly assigned to the recovery management checkup (RMC) protocol or a control condition. Those in the RMC group were interviewed quarterly and, when determined to be in need of treatment, were provided a Linkage Manager who conducted a motivational interview and assisted with re-entry into treatment. The control group received only quarterly interviews but no active linkage to treatment.

The study found that those clients assigned to RMC were more likely than those in the control group to return to treatment (64% vs. 51%), to return to treatment sooner (376 vs. 600 days), and to spend more subsequent days in treatment (mean of 62 vs. 40 days). RMC participants also experienced significantly fewer total quarters in need of treatment and were less likely to need treatment 2 years after intake (43% vs. 56%). The study offers support to calls to shift addiction treatment from acute episodes of care to long-term recovery management across episodes of care. Recovery checkups constitute a means of linking and improving such episodes of care. This experimental evaluation of RMC tested three specific elements of the larger model of recovery management – monitoring, motivational interviewing and linkage assistance. While the results are positive, they also indicate areas for further improvement. For instance, only 60% of the linked participants remained in treatment 14 or more days. Given that individuals who stayed 14 or more days were significantly more likely to end the quarter in recovery (26% vs. 16%), improving engagement and retention rates is clearly one of the challenges for a second experiment currently under way. Other

possibilities might include a separate recovery management treatment track (versus recycling clients through the same “program”), use of recovery coaches, and linkage to a broader spectrum of recovery support services (e.g., active linkage to communities of recovery, recovery homes).

Recovery Management and the Future of Addiction Treatment

The goal of recovery management is the optimum level of global health and functioning of individuals experiencing alcohol and other drug dependence—a goal achieved by many through full and sustained symptom remission and for others through decreased frequency and intensity of AOD use and related problems and strengthened periods of remission and recovery. The vision is one of empowering individuals, families and service professionals to proactively manage such disorders over their entire course.

A significant number of citizens with chronic AOD disorders are being offered brief interventions that, as currently designed, do little to alter their addiction careers or empower them to achieve stable recovery. There are growing challenges to this acute intervention model and calls for models of sustained recovery management that more closely resemble the sustained care and support afforded other chronic medical and mental disorders. These new models call for integrating recovery support services across the continuum of care, with a particular emphasis on sustained monitoring, stage-appropriate recovery education, recovery coaching and, when necessary, early re-intervention.

For those with the most severe AOD problems, multiple episodes of detoxification and stabilization are more likely to constitute brief respites within their addiction careers than a doorway to long-term recovery. Changing that will require fundamentally rethinking how and when addiction professionals intervene in the lives of those suffering from these disorders. If the addiction treatment field really believed that addiction was a chronic disorder, addiction counselors would be encouraged to function as long-term professional allies in the recovery process, and recovery management checkups would be a routine component of a sustained continuum of recovery support services.

For the frontline addiction professional, studies such as the one described here suggest a greater emphasis on building sustained recovery support from the treatment setting into the client’s natural environment. This could be achieved in four ways: 1) advocating for models of sustained recovery management, 2) expanding one’s knowledge of culturally indigenous recovery support structures, 3) using more assertive methods of linking clients to post-treatment recovery support resources, and 4) (where possible) providing post-treatment monitoring, stage appropriate recovery coaching and early re-intervention. The challenge for addiction professionals working within acute intervention models is to find

creative ways to extend the continuity of recovery support beyond the ever-briefer episodes of care that currently characterize addiction treatment.

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