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Behavioral Health Recovery Management: Transcending the Limitations of Addiction Treatment

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Abstract

The acute model of intervention into substance use disorders is being challenged by models that wrap episodes of professional treatment within a sustained continuum of pre-treatment, in-treatment, and post-treatment recovery support services. This article discusses this shift from acute treatment to sustained recovery management and how this shift will transform the practice of addiction treatment.

I. Introduction

Alcohol and other drug (AOD) problems present in both acute and chronic forms. For most people, these problems are of low duration and low to moderate severity, and resolve themselves naturally or through brief professional intervention—often outside the world of specialized addiction treatment. Many of these problems fade in the passage through adolescence into adult family and occupational responsibilities or in the resolution of a later developmental crisis, e.g., divorce, occupational displacement, or death of a loved one. Those with the more chronic form of these problems are distinguished by greater personal vulnerability (family history of such problems, lowered age of onset of regular use), greater problem severity, a cluster of co-occurring interlocked problems, and less "recovery capital" (personal, family and social recovery support resources) (Granfield & Cloud, 1999).

The field of addiction treatment has long characterized addiction as a "chronic, progressive disease," but its treatment methods more closely resemble those of the emergency medicine specialist than the chronic disease specialist. If the addiction treatment field truly believed and acted as if addiction constituted a chronic disorder, its practitioners would not:

- cultivate the expectation among clients and family members that full and enduring symptom remission should be achieved from a single episode of treatment,
- view prior treatment "failure" as an indicator of poor prognosis (and historically, grounds for denial of treatment admission),

- “administratively discharge” clients for exhibiting symptoms of the disorder for which they are being treated (e.g., inability to abstain and loss of control over substance use),
- relegate post-treatment aftercare services to an afterthought,
- terminate the service relationship following brief intervention,
- treat serious and persistent alcohol and other drug (AOD) problems in serial episodes of self-contained, unlinked interventions, or
- treat individuals in isolation from the family and social networks that provide the most sustainable support for the management of chronic health problems.

They also would not criticize the few modalities that do offer the option of time-sustained recovery supports (e.g., Alcoholics Anonymous, methadone maintenance) for that very quality. What the field of addiction treatment would do if they really believed addiction was a chronic disorder is the subject of this article.

A series of recent articles (Lewis, 1993; O’Brien & McLellan, 1996; McLellan, Lewis, O’Brien, & Kleber, 2000; White, Boyle, & Loveland, 2002) have challenged the acute intervention model utilized in the treatment of substance use disorders. These articles contend that treating substance use disorders marked by high severity and chronicity via serial, self-contained episodes of screening, assessment, admission, brief treatment followed by discharge and even briefer aftercare is ineffective and results in shaming and punishing clients for failing to respond to a an intervention design that is inherently flawed. More specifically, these articles argue that:

- alcohol and other drug dependencies resemble chronic disorders such as type 2 diabetes mellitus, hypertension and asthma in their etiological complexity (interaction of genetic, biological, psychological and physical/social environmental factors), course, and clinical outcomes;
- personal choice and lifestyle decisions affect the outcomes of all chronic disorders, suggesting the potential application of strategies used to treat other chronic disorders to the treatment of alcohol and drug dependence;
- treating alcohol and other drug dependence via repeated episodes of detoxification and brief stabilization is ineffective and contributes to the therapeutic pessimism of clients, service providers, policy makers and the public; and
- alcohol and other drug dependencies are best treated via models of sustained medical monitoring and continuing care.

Applying the slogan “treatment works” to single episodes of addiction treatment makes no more sense that applying such a slogan to the acute stabilization of a diabetic coma or a hypertensive crisis. The larger question is how such episodes of crisis intervention affect the overall course and outcome of the disorder. For those presenting with the most severe and complex substance use disorders, brief episodes of detoxification and stabilization are more likely to constitute brief respites within one’s addiction career than a milestone of entrance into long-term recovery. Changing that status will require fundamentally rethinking how service professionals intervene in the lives of those suffering from these disorders. It calls not for a vision of higher dose crisis intervention (more days/sessions), but a vision of sustained *recovery management*.

Behavioral Health Recovery Management

Behavioral Health Recovery Management (BHRM) is the time-sustained stewardship of personal, family and

community resources to achieve the optimal health and functioning of those experiencing severe addiction and/or serious mental illness. As applied to alcohol and drug dependence, the goal of recovery management (RM) is the optimum level of global health and functioning of individuals experiencing such dependence—a goal that for many is achieved by full and sustained symptom remission and for others is achieved by decreasing the frequency and intensity of alcohol and other drug use and its related problems in tandem with lengthened and strengthened periods of remission and recovery. The focus of RM is to empower individuals/families to proactively manage such disorders over their entire course.

The term *recovery management* was coined to depict the process of sustained support through the developmental stages of addiction recovery. This concept grew out of and shares much in common with "disease management" approaches to other chronic health problems, but use of the term recovery management is intended to emphasize the focus on quality of life outcomes as defined by the individual and family. Recovery management shares the disease management goal of effective stewardship of health care resources, but it places a greater value on the achievement of global health and the quality of life of the individual and family. Heavily influenced by new grassroots recovery advocacy organizations, it balances the focus on cost liabilities with the experiences, needs and aspirations of those living with and recovering from addictions. Lowered health care costs, which might well be achieved with this model, are not the primary reason such a model is being advocated.

The principles of recovery management (See Sidebar) mark a shift in how services are designed and delivered, including the timing and duration of such services, the nature of the service continuum, the composition of the service delivery team, and how such services are evaluated.

The Timing and Duration of Service

There is a collision going on between clinical characteristics of persons seeking addiction treatment and the administrative/fiscal structures governing such treatment. The multiple problem client/family is becoming the norm, particularly within publicly funded programs. The greater number of presenting problems, the synergistic interaction of these problems, the frequent intergenerational transmission of such problems, and the degree of personal and environmental obstacles to successful recovery would all seem to dictate integrated models of greater service intensity and duration. Yet these clients find not an integrated system of support for initiating and maintaining global health, but a categorically segregating service system whose interventions are becoming ever more brief and fragmented. In this collision between personal needs and systems design, clients are placed in modalities that have little chance of permanently altering the trajectory of their problems and are then blamed for the failures of the systems in which they are enmeshed. This collision also contributes to the demoralization and flight of service staff who feel they have become paper-processors rather than people-helpers. And we have rising therapeutic pessimism fed by the growing number of clients with multiple treatment episodes. (Sixty percent of those admitted to public treatment in the U.S. have been in treatment before, including 24 percent who have been in treatment 3 or more times) (Office of Applied Studies, 2000). The current system of brief intervention with chronic substance use disorders is analogous to treating a bacterial infection with half the needed dose/duration of antibiotic therapy. It may produce temporary symptom suppression, but it can lead to a later resurgence of symptoms, often in a more virulent and treatment-resistant form.

Recovery management reconfigures services by offering an expanded range of services earlier than traditional intervention

occurs and sustaining them long after traditional treatment services have been terminated. Recovery management is not a new rationale for larger doses of residential/inpatient treatment or more outpatient counseling sessions. It is instead a call to wrap these traditional services in a larger web of pre-treatment, in-treatment, and post-treatment recovery support services that are delivered in the community. This is not to say that treatment and recovery support services cannot be delivered in a residential or outpatient setting, but that eventually, people must apply and refine the skills of recovery management in their natural living environments. Recovery management, with its emphasis on building and preserving recovery capital, extends the time over which services are delivered, but shifts the emphasis of these services from high intensity, high cost crisis stabilization services to proactive, lower intensity, and more sustained recovery support services.

Expanding the Service Continuum

Recovery management models extend the current continuum of care for addiction by including: 1) pre-treatment (recovery priming) services, 2) recovery mentoring through primary treatment, and 3) sustained post-treatment recovery support services.

As with any chronic disorder, it is assumed that successful self-management of addiction is more likely at earlier than later stages of the disorder. Given the potential for self-acceleration of problem severity and the progressive erosion of internal and external resources, changing the timing of intervention is an important element of the long-term vision of how recovery management might re-shape the current treatment system. The future technologies to achieve this might include primary physician screening, advice, monitoring, feedback and recovery coaching and the mainstream use of outreach services focused on identification, engagement, removing personal and environmental obstacles to recovery, and sustained recovery coaching.

Only a small percentage of people with severe AOD problems seek treatment and of those who do there is a high attrition from initial contact through screening, assessment and admission and even greater attrition when this process involves a waiting list for services. The RM model seeks to infuse front-end, or pre-treatment recovery support services into the community. The goals of such pre-treatment services are to: 1) encourage the self-resolution of AOD problems through natural or mutual aid resources as an alternative to professionally directed treatment, 2) intervene at early stages of problem development before high intensity services are needed, 3) intervene in severe forms of AOD problems before recovery capital is fully depleted, 4) reduce the attrition in sobriety-seeking and help-seeking experiments, 5) help individuals utilize community support systems, and 6) engage individuals within their current developmental stage of change. These services are in short designed to jump-start the recovery process via motivational interventions—what we have come to call *recovery priming*.

There is a high attrition rate among individuals who seek help for AOD-related problems both in professional and mutual aid settings, and it is possible that recovery support specialists could play a role in lowering such attrition. What we are proposing for the professional setting is a form of outreach inside the treatment milieu—the use of recovery support specialists to resolve problems that stand in the way of continued treatment participation. The function would not be treatment per se but the continual re-motivation and re-engagement of those experiencing the ambivalence that is so typical of early recovery.

RM models challenge two dimensions that most represent the acute care model: the concept of discharge (which may occur through "graduation," administrative discharge, or client

discontinuation of services) and either the lack of post-treatment support services or the utilization of only brief aftercare services. The most dynamic parts of recovery management begin when traditional treatment ends. In the RM model, today's concepts of "discharge" and "aftercare" become anachronistic, as all care is part of the continuity of contact over time between an individual and his or her recovery management team. We know that a significant percentage of clients are precariously balanced between stable recovery and reactivation of addiction in the weeks, months and early years following treatment. What RM models do is place a recovery "coach" in the life of the client at the very time the scales of recovery or re-addiction are being tipped. The service technologies involved in this process include sustained monitoring (including the potential of regular "check-ups"), stage-appropriate recovery education, recovery coaching and problem solving, linkage to relationships within one or more communities of recovery, lapse management, and, when necessary, early re-intervention.

Expanding the Service Team

We envision a time when one would pick a recovery management specialist/team like someone with other chronic disorders selects a professional (and, in many cases, a peer system of support) as an ally in the long-term management of the disorder. The size and composition of this recovery management team would be determined by the severity and complexity of the disorder and the unique characteristics and needs of the individual/family. There are three ways that the RM model will change the service team composition. First, it will include the primary care physician as a central member of the recovery management team. One of the first tasks for patients with no primary care physician will be to establish such a relationship. In this way, recovery can be medically monitored within the context of the overall management of global health and integrated within the treatment of collateral health problems. Second, the RM model, by seeking to anchor recovery in the natural environment of the client, involves indigenous institutions and healers within the recovery management team. In Native American communities, tribal elders and traditional healers may become part of this recovery management team. In other ethnic communities, church pastors and elders may be similarly involved. Third, RM models emphasize the value of peer-based recovery support services. These peer mentors may work as volunteers or paid recovery support specialists within a treatment agency or within an independent recovery support agency.

Recovery management seeks to build recovery-focused expertise in two ways. First, it intensifies the recovery education of all staff and builds recovery support functions into all service roles. The focus here is both on the use of evidence based practices in treatment and the structures (pathways), styles, stages and experiences of long-term recovery. Secondly, it re-integrates recovering individuals and family members into the service team as paid or volunteer recovery support specialists (also called recovery coaches/mentors/guides). The goal here is not to replace professional helpers (e.g., the addictions counselor) or replace natural supports in the larger recovery community (e.g., the Twelve Step sponsor), but to expand the range of problem-solving and recovery support resources available to clients/families over the long course of the recovery process. The function of recovery support specialists is not to provide professional treatment services (such would be beyond the boundaries of their education, training and experience), but to: 1) expose people seeking recovery to living proof of the potential for long-term recovery, 2) illustrate the varieties of recovery experience, 3) deliver stage-appropriate recovery education, 4) help remove environmental and personal obstacles to recovery, 5) link clients to the natural resources of the recovery community, and 6) provide a bridge of friendship toward the development of a sobriety-based social network. The intent is

not to professionalize the recovery support specialist role or de-professionalize addiction treatment, but to re-introduce the positive functions that were lost in the modern professionalization of the addiction counselor.

New Service Evaluation Methodologies

Our traditional method of evaluating addiction treatment is to study the effects of single episodes of intervention, comparing those interventions to either no intervention or different interventions in the months and (at most) few years following the treatment episode. Such methods, while a very reasonable way to assess the treatment of acute disorders where outcomes can be quickly determined, fails to grasp the very essence (the ebb and flow and ever-present nature) of a chronic disorder. The problem with using this evaluation scheme to assess chronic disorders is that what appears to work in the short run (both in terms of health and cost indicators) may not work in the long run, and what appears to not work in the short run may have delayed or cumulative effects over multiple service interventions. Moreover, the current evaluation model focuses predominately on the biomedical realm of addiction (i.e., the elimination of symptoms) without examining many of the other aspects of a person's life that are involved in the process of recovery.

Recovery management models will shift the evaluation focus from short term to long term outcomes, will shift the focus from single service episodes to evaluating combinations and sequences of services and supports (e.g., combining pharmacological adjuncts, psychosocial treatment, sober housing and recovery supports services) (McLellan, 2002), and will include consumers (individuals and families) in the evaluation process at levels that are unprecedented within the history of the field. They will also shift the measure of achievement from the suppression of biomedical symptoms of the individual to the global health of the individual and family. RM evaluation models will measure the extent to which service designs affect the whole person and his or her concurrent or sequential recovery from multiple co-occurring disorders. To that end, evaluation activities will need to assess the extent to which RM models are able to enhance community integration of a broad spectrum of services and support structures.

Summary

Recovery management wraps the existing acute model of addiction treatment in a resource-rich continuum of pre-treatment, in-treatment and sustained post-treatment recovery support services. Time will tell whether recovery management constitutes the next incremental step in the evolution of addiction treatment or whether it will mark a fundamental shift in how such problems are addressed. Claims of bold new paradigms are often simply a rearrangement of the furniture inside the same conceptual box, while changes viewed as minor innovations can sometimes reflect a major conceptual breakthrough. We suspect that recovery management will turn out to fit this latter pattern masked behind such comments as, “We’ve always known that,” or “We’re already doing that.”

The Illinois Office of Alcoholism and Substance Abuse has funded a multi-year Behavioral Health Recovery Management project to explore the concept of recovery management and pilot test service and support innovations that flow out of it. Preliminary papers, a recovery resource guide, and clinical guidelines produced by this project can be found at www.bhrm.org. This coming shift from acute treatment to recovery management has many potential benefits but will face many obstacles and pitfalls related to its design and operation. (See White, Boyle, & Loveland, 2002 for a discussion of these.)

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Behavioral Health Recovery Management: A Statement of Principles

Behavioral Health Recovery Management is a model of intervention for severe mental illness and severe substance use disorders that shifts the focus of care from professional-centered episodes of acute symptom stabilization toward client-directed management of long-term recovery. The following eight principles distinguish the Behavioral Health Recovery Management (BHRM) model.

1. Recovery Focus: Full and partial recoveries from severe behavioral health disorders are living realities evidenced in the lives of hundreds of thousands of individuals in communities throughout the world. Where complete and sustained remission is not attainable, individuals can actively manage these conditions in ways that transcend the limitations of these disorders and allow a fulfilled and contributing life. The BHRM model emphasizes recovery processes over disease processes by affirming the hope of such full and partial recoveries and by emphasizing client strengths and resiliencies rather than client deficits. Recovery re-introduces the notion that any and all life goals are possible for people with severe behavioral health disorders.

2. Client empowerment: The client, rather than the professional, is at the center of the BHRM model. The goal is the assumption of responsibility by each client for the management of his or her long-term recovery process and the achievement of a self-determined and self-fulfilling life. Client empowerment involves not just self-direction of one's own recovery, but opportunities for involvement in the design, delivery, and evaluation of services provided by behavioral health organizations and involvement in shaping public attitudes and public policies regarding behavioral health disorders.

3. The Destigmatization of Experience: The BHRM model seeks to "normalize" or otherwise respect a person's experiences with

behavioral health disorders and subsequent services. In this way, the person escapes attacks on self-esteem and self-efficacy that often accompany the stigma of mental illness. Moreover, the public begins to endorse positive images of behavioral health that undermine the prejudice and discrimination that frequently accompanies services.

4. Evidence-based Interventions: The BHRM model emphasizes the application of "evidence-based" interventions at all stages of the disease stabilization and recovery process. The "evidence" under girding such interventions includes scientific studies (randomized clinical trials, clinical field experiments) and inter-disciplinary professional consensus regarding promising approaches, but the ultimate evidence is the fit between the intervention and the client at a particular point in time as judged by the experience and response of the client.

5. Service Integration: Based on the recognition that severe disorders heighten vulnerability for other disorders and problems, the BHRM model seeks to coordinate categorically segregated services into an integrated response focused on the person rather than territorial ownership of the person's problems. The goal is to mesh these historically isolated services into an integrated, recovery-oriented system of care. The BHRM model advocates multi-agency, multidisciplinary service models that can provide less fragmented and more holistic care.

6. Recovery Partnership: In the BHRM model, the traditional professional role of "expert" and "treater" progressively shifts to a recovery management partnership with the client. Within this partnership, the professional serves primarily as a "recovery consultant." The service relationship within the BHRM model is marked by continuity of contact in a primary service relationship (with a recovery consultant) over time—a relationship analogous to that between a physician and patient managing any health care problem characterized by chronicity and episodic acuity.

7. The Ecology of Recovery: The family (as defined by the client) and community constitute a reservoir of support for long-term recovery from behavioral health disorders. The BHRM model seeks to enhance the availability and the support capacities of family, intimate social networks and indigenous institutions (e.g., mutual aid groups, churches) to persons recovering from behavioral health disorders. The BHRM model also extends the locus of service delivery from the professional environment to the natural environment of the client. One of the major goals of the BHRM model is to create the physical, psychological and social space within which recoveries can flourish in local communities.

8. Monitoring and Support Emphasis: The BHRM model emphasizes the need for on-going monitoring, feedback and encouragement, linkage to indigenous supports and, when necessary re-engagement and early re-intervention. This model of sustained monitoring and recovery support services contrasts with models that provide repeated episodes characterized by "assess, admit, treat, and discharge," as is traditional in the treatment of substance use disorders. It also contrasts with mental health programs that focus on stabilization and maintenance of symptom suppression rather than on recovery and personal growth.

9. Continual Evaluation: Service and support interventions must be matched not only to the unique needs of each client but to the stage-specific needs of each client as these needs evolve through the stages of recovery. In the BHRM model, both assessment and evaluation become continual activities rather than activities that mark the beginning and conclusion of a service episode. There is also a shift from evaluating single episodes of care to evaluating the effect of particular combinations and sequences of interventions on the course of behavioral health disorders and on recovery careers.