

Behavioral Health Recovery Management: Moving from Theory to Practice

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Barriers to Effective Treatment

- High attrition between help seeking and service initiation
- High attrition/extrusion prior to treatment completion
- Low aftercare participation following intensive treatment

Barriers to Effective Treatment

- Lack of systematic follow-up
- High rates of re-admission
- Evidence based practices not utilized
- Segregation of addiction, mental health and primary care

Failure to Attract/Limited Access

- Only 10% of those needing treatment received it in 2002 (Substance Abuse and Mental Health Services Administration, 2003).
- Access to treatment is compromised by waiting lists (Little Hoover Commission, 2003).
- High waiting list dropout rates (25-50%) (Hser, Maglione, Polinsky, & Anglin, 1998; Donovan, Rosengren, Downey, Cox, & Sloan, 2001).

Attrition

- Nationally, more than half of clients admitted to addiction treatment do not successfully complete treatment (24% leave against staff advice; 18% are administratively discharged for various infractions; 9% are transferred) (Substance Abuse and Mental Health Services Administration, 2002; Stark, 1992).

Inadequate Dose

- Many of those who complete treatment receive less than the optimum dose of treatment recommended by the National Institute on Drug Abuse (National Institute on Drug Abuse, 1999; SAMHSA, 2002)

Post-treatment Relapse

- 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).

Prior Treatment among Admission to Public Treatment

60% have prior treatment episodes

- Second admission 23%
- Third admission 13%
- Fourth admission 7%
- Fifth admission 4%
- Sixth or more 13%

Source: SAMHSA Office of Applied Studies, 2000

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

Behavioral Health Recovery Management Project

- Joint Venture: Fayette Companies, Chestnut Health Systems and Northwestern University Center for Psychiatric Rehabilitation
- Initial focus on development of BHRM principles, concept papers and evidence-based guidelines
- Piloting new models at Fayette and Chestnut
- Training and consultation with state and national agencies

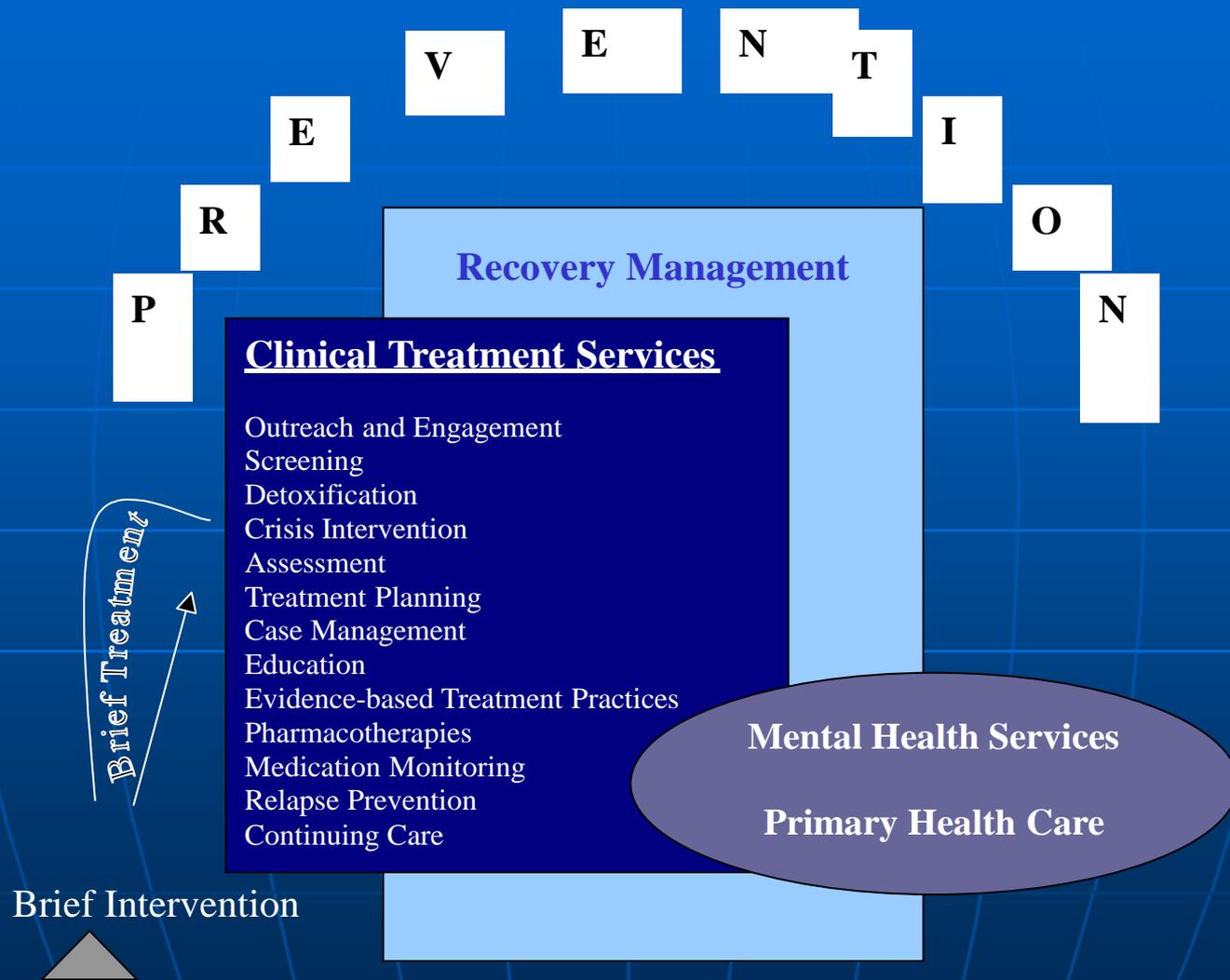
“Chronic diseases require chronic cures”

Kain, H.H. (1828) On Intemperance Considered as a Disease and Susceptible of Cure. American Journal of Medical Science 2:291-295.

Behavioral Health Recovery Management Definition

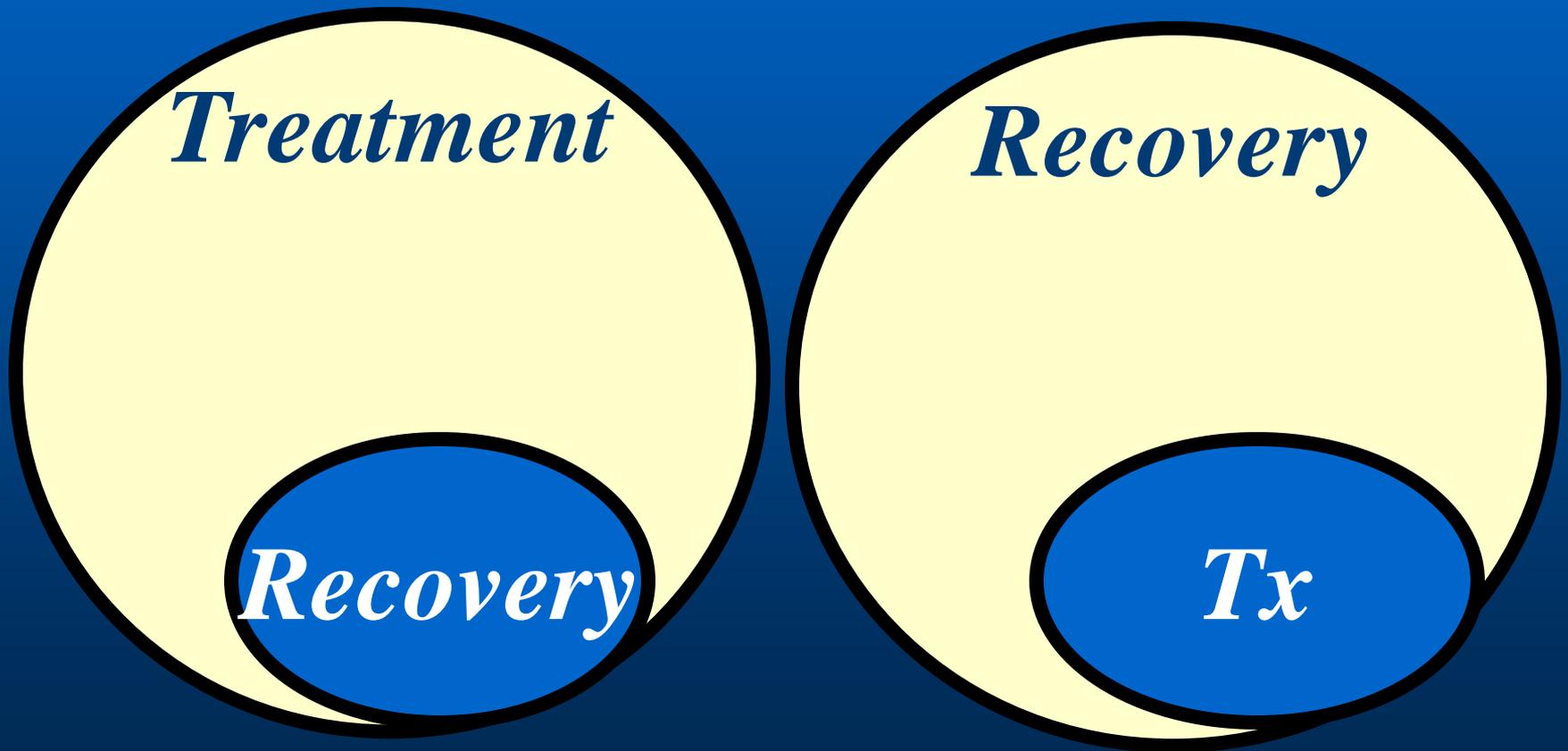
BHRM is the time-sustained stewardship of personal, family and community resources to achieve the highest level of global health and functioning of individuals and families impacted by severe behavioral health disorders. It is a collaborative model between service consumers and traditional and non-traditional service providers aimed at stabilizing and then actively managing, the ebb and flow of chronic behavioral health disorders.

SAMHSA Integrated Systems of Care



Principles of Behavioral Health Recovery Management

Recovery/Treatment Focus



Principles of Behavioral Health Recovery Management

1. Recovery Focus: Instill hope, support person's strengths and abilities.
2. Individual Empowerment: The individual must be assisted in assuming long term responsibility in managing their recovery; in developing their own personal recovery plan.

Principles of Behavioral Health Recovery Management

3. **Fighting Stigma:** At both the community and personal levels. Promoting positive images of recovery.
4. **Utilization of Evidence Based Practices:** Learning and adopting treatment and other recovery support techniques that have proven through research to be the most effective tools.

Evidence-Based Practices

- Motivational Enhancement and Interviewing
- Contingency Management and Behavioral Contracting (positive reinforcement)
- Community Reinforcement Approach (CRA) and Family Training (CRAFT)
- Cognitive Behavioral Therapy (Skills training)
- Naltrexone, Buprenorphine, Acomprosate

Principles of Behavioral Health Recovery Management

5. **Service Integration:** Addiction, mental health and primary health problems are often all present. Each may impact the other and all should be addressed in an integrated manner.
6. **Recovery Partnership:** Moving the professional relationship from an expert treater to a recovery consultant. Continuity of relationship over time.

Principles of Behavioral Health Recovery Management

7. Developing and Utilizing Recovery Support in the Community:
Families, social networks, faith based institutions, cultural movements, employers, junior and four year colleges.

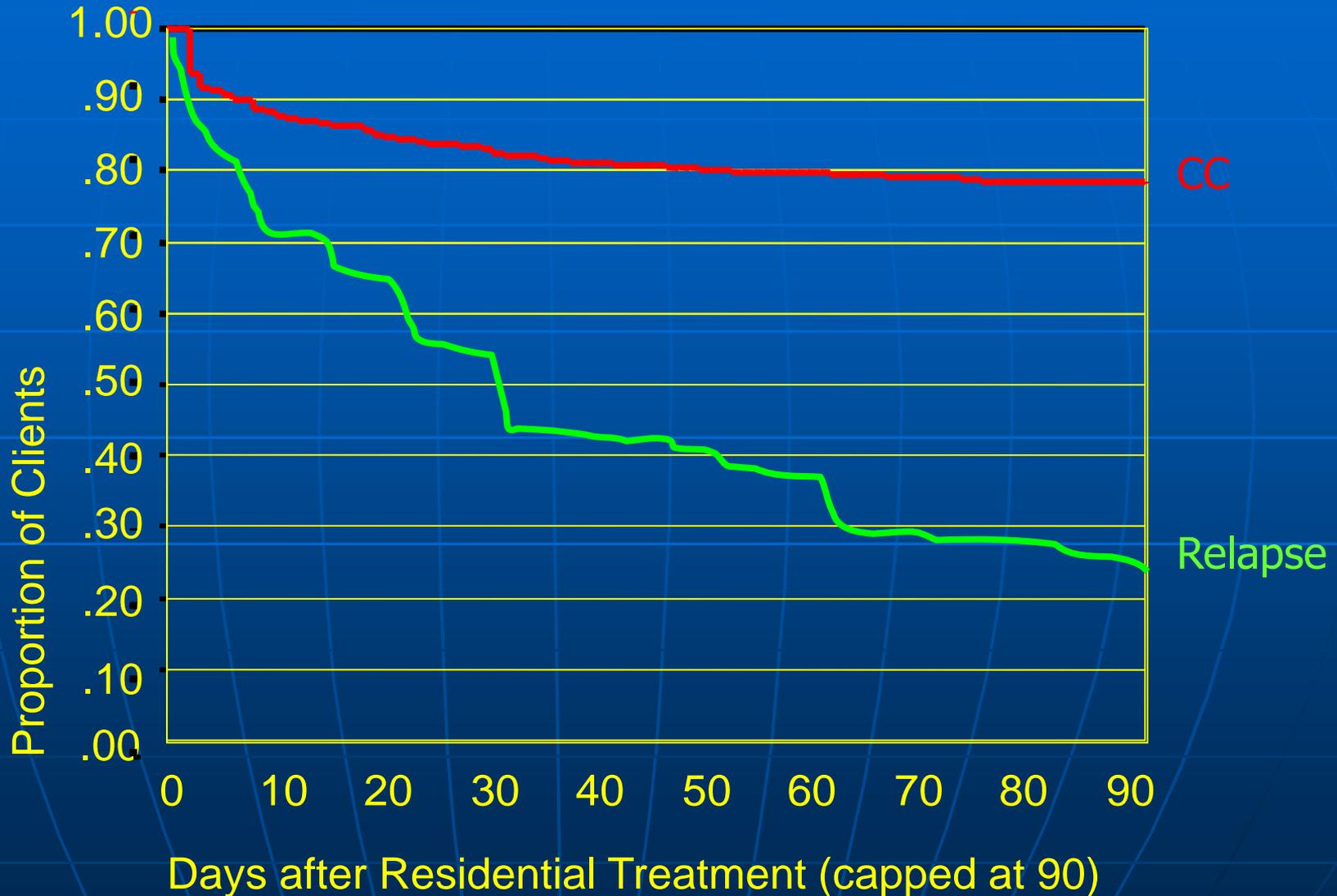
PARTNERING TO SUPPORT RECOVERY



Principles of Behavioral Health Recovery Management

8. Ongoing Support and Monitoring:
Eliminating “discharge”, continued support of recovery and growth, monitoring need for “early re-intervention”.

Time to Enter Continuing Care and Relapse after Residential Treatment (Age 12-17)



Principles of Behavioral Health Recovery Management

9. **Continual Evaluation:** Assessment and evaluation is an ongoing activity. Consumer must be involved in the design and evaluation of their own services and systems of supports.

Three Overlapping Phases of Recovery Management

- Pre-Treatment Engagement
- Treatment and Expansion of Recovery Network
- Post-Treatment Recovery Maintenance

Pre-treatment and Engagement

- Provide brief, educational interventions (e.g., brief phone interventions, pre-tx groups, and information)
- Provide motivational enhancement interventions (e.g., in drug courts, drop-in centers, homeless shelters, CMHCs, & schools)
- Remove barriers to recovery initiation (e.g., child care or obtaining Medicaid)
- Link to community resources (e.g., housing, legal services, & social security administration)

Pre-treatment and Engagement

- Identify individual strengths (in addition to risk factors and current patterns of substance use)
- Provide community outreach services (e.g., drug courts, high schools, & homeless shelters)
- Recruit family, friends, and other individuals in the community that can help in the recovery process

Treatment and Expansion of Recovery Network

- Provide hope and focus on strengths: recovery is a building process
- Bring the person's community into treatment (e.g., bring in the family, clergy, & healthy friendships)
- Use a biopsychosocial model of tx (treat the whole person, not just the addiction)

Treatment and Expansion of Recovery Network

- Integrate in or link to mental health, social services, & primary care services, as needed
- Develop a personal recovery plan: place the responsibility for recovery in the hands of the individual
- Support transitioning through levels of care, but maintain the relationship with one primary service provider

Treatment and Expansion of Recovery Network

- Incorporate healthy family/friends, clergy, and others into the treatment program
- Identify community supports and activities to sustain recovery (e.g., housing, self-help, church, & vocational services)
- Learn about and provide evidence-based practices

Treatment and Expansion of Recovery Network

- Incorporate the cultural, ethnic, and religious needs of consumers in the service delivery model
- Provide both gender specific and neutral services (women and men have different tx needs)
- Provide services that are sensitive to the tx needs of gay and lesbian clients

Post-Treatment Recovery Maintenance

- Establish a primary service provider: maintain an ongoing relationship with people after each phase of treatment
- Develop and update a personal recovery plan before the tx phase ends: keep the person in charge of their recovery
- Assign a case manager, staff clinician, or peer recovery coach to work with people in the community (do it before tx ends)

Post-Treatment Recovery Maintenance

- Provide scheduled telephonic recovery checkups on a weekly or monthly basis (obtain multiple phone numbers for tracking)
- Monitor and assess slips and use “pro-lapse” or early re-intervention techniques, especially during the early stages of relapse
- Assign responsibilities in the recovery plan to family, friends, and relevant others

Post-Treatment Recovery Maintenance

- Provide flexible opportunities for people to reconnect with counselors (e.g., onsite recovery groups, quarterly check-ups & opportunities for phone calls)
- Establish and use alumni meetings to encourage people to come back and share their progress and successes
- Provide ongoing help for people to identify and access needed supports and services

Implementation Issues and Planning

Implementation Issues

Ethics and Boundary Issues:

- What values, standards, or guidelines (perceived, institutionalized, or written) apply and can they be modified?
- Do traditional professional values conflict with the adoption of a peer/family support model of service delivery?

Implementation Issues

Relationships with Treatment Staff:

- Will existing staff accept the new peer positions and roles?
- How can you overcome inertia and tokenism (i.e., the name changes, but nothing else does)?
- How can you prevent role confusion or worse, resentment among different staff?

Implementation Issues

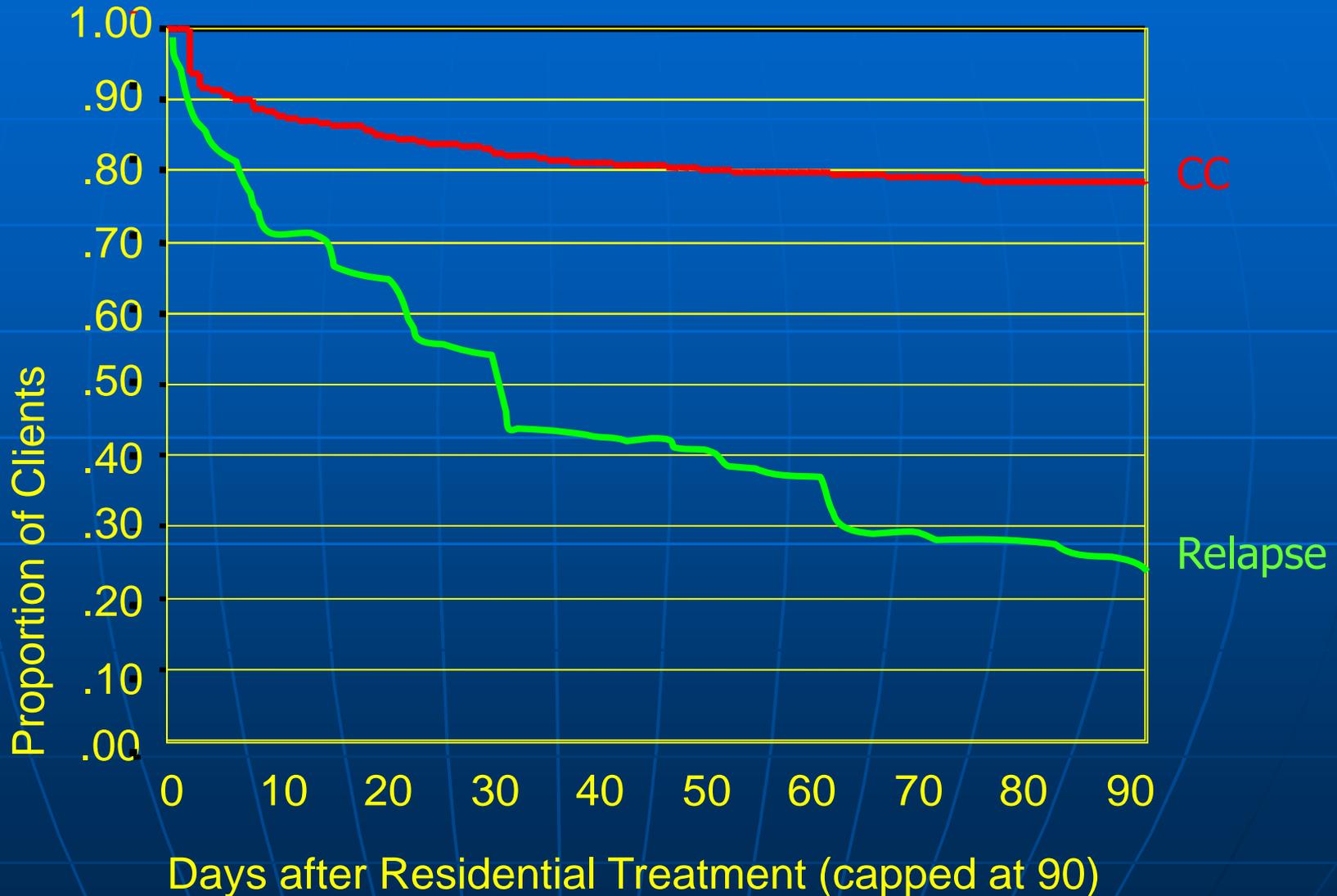
Integration/Separation from treatment:

- Can professional- and consumer-driven models successfully coexist?
- Who will provide supervision: clinical staff or peers with peers; can it be done in group or individual settings; and what legal issues exist?

Implementation Plan

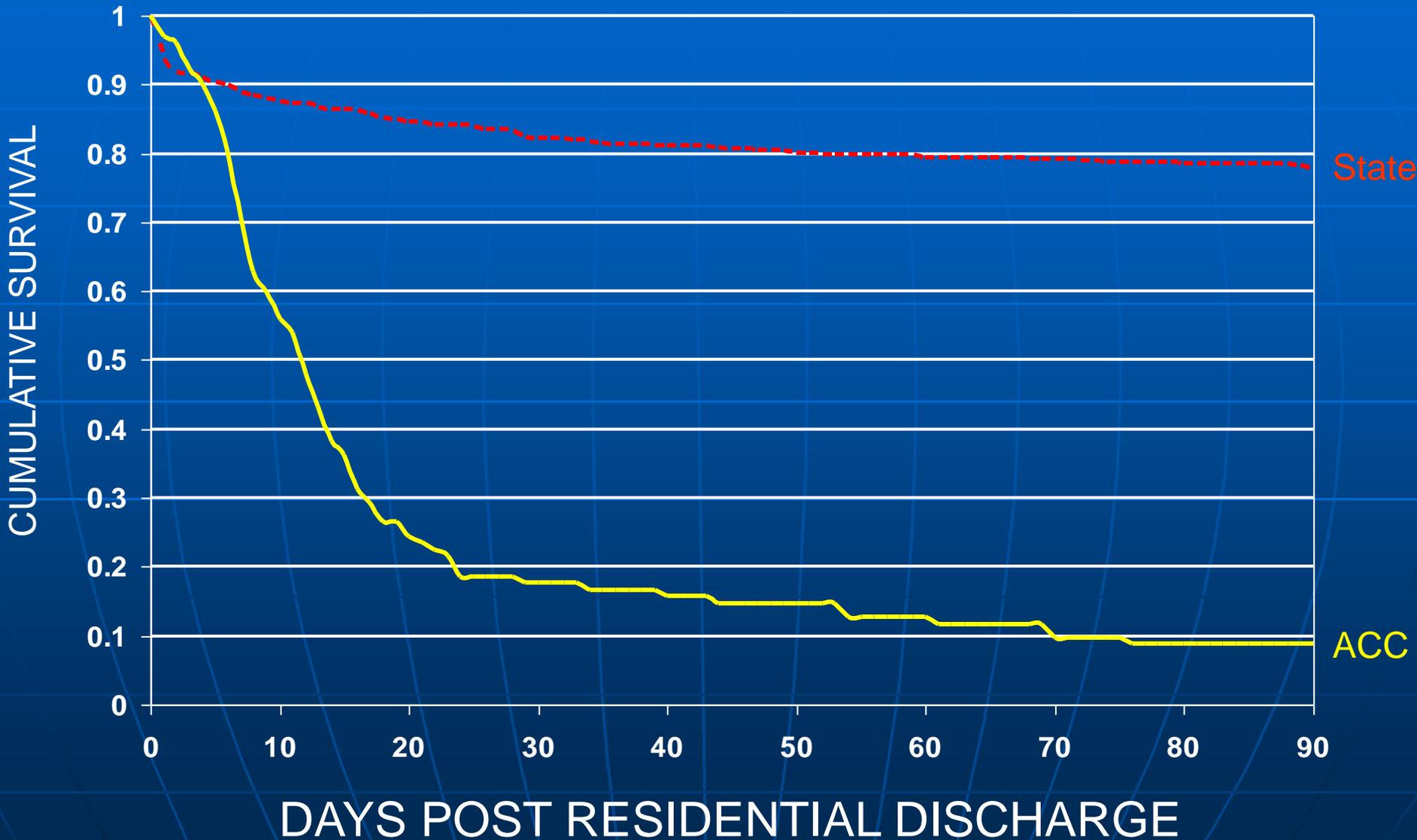
- Create an advisory committee comprised of professional staff (administration and clinical), other community providers, peers, and primary consumers (past and present) to oversee the project
- Manualize and operationalize a distinct recovery management program or intervention (i.e., put it in writing)
- Clearly delineate the job roles of peer coaches and existing staff in a manual and in all trainings

Time to Enter Continuing Care and Relapse after Residential Treatment (Age 12-17)

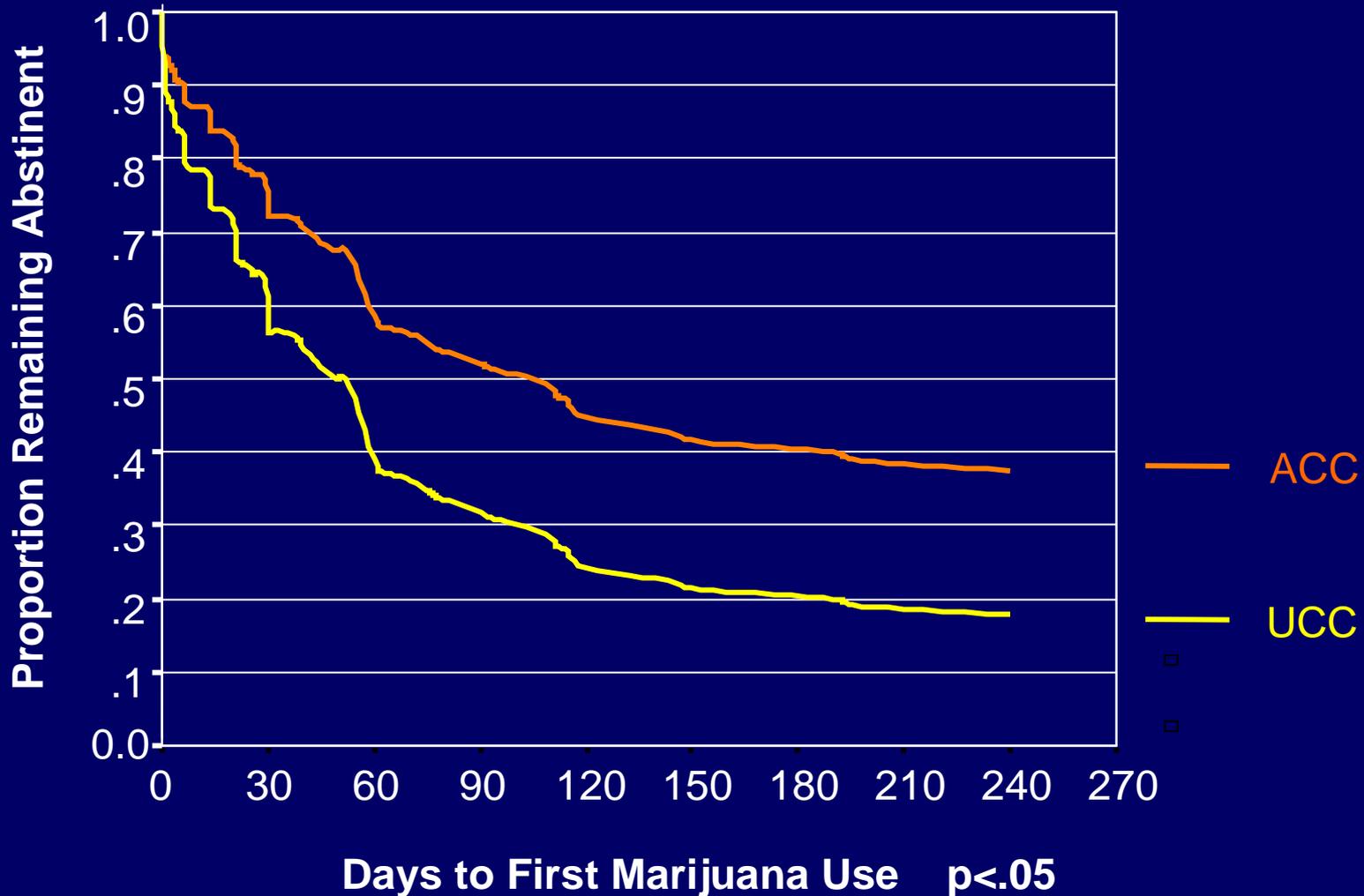


DAYS TO CONTINUING CARE

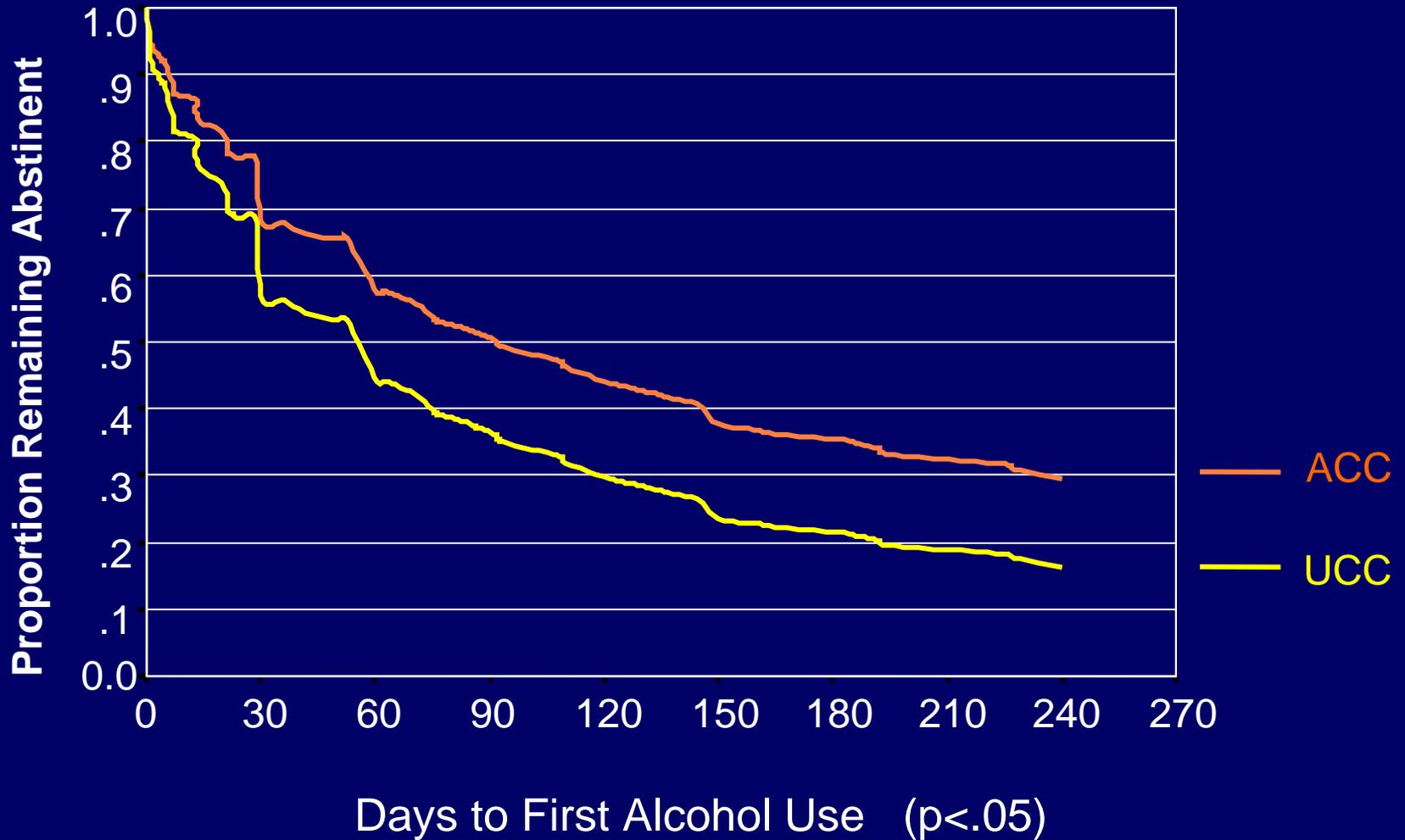
State 1999
ACC (N=102)



Reduced Relapse: Marijuana



Reduced Relapse: Alcohol



Effect of Recovery Management Check-ups on Outcomes

Findings:

1. 82% transitioned at least once;
62% multiple times over the 2
years

Effect of Recovery Management Check-ups on Outcomes

4. Those assigned to RMC more likely to return to Tx sooner, spend more days in Tx, & less likely to be in need of Tx at 24 months

Sample: 448 individuals randomly assigned to receive over 2 yrs either quarterly assessment interviews or quarterly recovery management (assessment with re-intervention and linkage to Tx)

Scott, Dennis, & Foss (in press); Dennis, Scott & Funk (2003)

Resources

- White, W., Boyle, M., Loveland, D. (2002). *Addiction as a Chronic Disease, From Rhetoric to Clinical Reality*. *Alcoholism Treatment Quarterly*, 20 (3/4), 107-130
- White, W., Boyle, M., Loveland, D. (May/June 2003). *A Model to Transcend the Limitations of Addiction Treatment*. *Behavioral Health Management*, 23 (3), 38-44

Resources

- McLellan, A.T., Lewis, D.C., O'Brien, C.P. and Kleber, H.D. (2000). *Drug Dependence, A chronic Medical Illness; Implications for Treatment, Insurance and Outcome Evaluation*. Journal of the American Medical Association, 284 (13), 1689-1695.
- Hester, R.K. and Miller, W.R. (2003) *Handbook of Alcoholism Treatment Approaches; Effective Alternatives, 3rd Ed*, Boston, Mass: Allyn and Bacon.

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