Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. (2006). EVIDENCE-BASED PRACTICE SERIES: Enhancing addiction recovery outcomes through post-treatment monitoring, support and early re-intervention. Posted at **www.williamwhitepapers.com**

EVIDENCE-BASED PRACTICE SERIES

Enhancing Addiction Recovery Outcomes through Post-Treatment Monitoring, Support and Early Re-intervention

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Definitions:

Post-treatment monitoring is a systematic process of evaluating the ongoing status of clients who have ended a course of primary treatment via completion, pre-mature disengagement (against medical/staff advice), or by administrative/disciplinary (so-called “therapeutic” discharge). The current trend is to move from passive models of aftercare (verbal encouragement for participation in continuing care groups or peer-based recovery support groups) toward models of assertive continuing care.

Assertive continuing care (ACC) is distinguished by the following:

- ACC encompasses all admitted clients/families, not just those who successfully “graduate,” including those who terminated treatment against staff advice or were administratively (“therapeutically”) discharged.
- Primary responsibility for post-treatment contact in ACC rests with the treatment institution, not the client.
- ACC capitalizes on temporal windows of vulnerability (saturation of monitoring and support in the first 90 days following treatment).
- ACC individualizes the duration and intensity of monitoring and support based on each client’s degree of problem severity, the depth of his or her recovery capital and the ongoing stability of his or her recovery program.
- ACC utilizes assertive rather than passive (verbal encouragement only) linkage to communities of recovery.
- ACC incorporates multiple media for sustained recovery support, e.g., face-to-face contact, telephone support and mailed and emailed communications.

- ACC may be delivered either by counselors, recovery coaches or volunteer recovery support specialists
- ACC emphasizes continuity of contact in a primary recovery support relationship over time. (excerpted from White & Kurtz, in press) (Based on conversations with Dr. Mark Godley).

This more sustained and assertive style of monitoring following completion of inpatient or outpatient treatment marks a transition between *aftercare* (*follow-up*) to *continuing care* (White and Godley, 2003) and has been referred to as *extended case monitoring* (Stout, Rubin, Zwick, Zywiak & Bellino, 1999), *assertive continuing care* (Godley, Godley, Dennis, Funk & Passetti, 2002), *recovery coaching* (White, 2004a), *post-treatment recovery support services* (White, 2004b), *recovery management checkups* (Dennis, Scott, & Funk, 2003), and *focused continuing care* (Betty Ford Center).

Post-treatment support entails several critical components: 1) stage appropriate recovery education and coaching (feedback and advice), 2) assertive linkage to communities of recovery, 3) problem-solving consultation related to personal and environmental obstacles to recovery (including linkage to broader rehabilitation resources in the community), and 4) on-going assistance in building "recovery capital" (Granfield and Cloud, 1999) via reconstruction of personal identity and a sobriety-based social network.

Post-treatment early re-intervention is the process through which an individual experiencing vulnerability for or experience of a lapse or relapse is provided an intensification of monitoring and support, reconnection to indigenous communities of recovery or professional treatment toward the goal of recovery re-stabilization and facilitation of the transition into stable recovery maintenance.

History of the Practice: Addiction has been characterized as a chronic disease for well over two centuries, but it has been most often treated in acute episodes of care resembling treatment for a broken arm or a bacterial infection. This acute care model is characterized by: 1) serial episodes of self-contained, unlinked interventions (brief 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. An expert diagnoses and treats the problem. The service relationship ends via "graduation" and "discharge" with a few "aftercare visits," after which the patient is expected to live a sober life without further need of professional assistance.

Efforts to extend care through sustained monitoring and support date to the nineteenth century expectation of sustained correspondence between inebriate asylums and their discharged patients, the establishment of outpatient clinics to provide follow-up for discharged asylum patients, the use of workers who visited discharged patients in their homes, the linkage of discharged patients to recovery mutual aid societies and the establishment of structured aftercare groups (White, 1998). Short-lived efforts to extend treatment support have inevitably dissipated into ever-briefer models of acute intervention.

Modern efforts to extend the effects of treatment have focused on strategies to increase adherence to expectations for client participation in aftercare groups—in short, to increase the act of clients returning to the treatment facility for booster doses of professional support. Strategies that were rigorously tested and proved to increase such participation include behavioral contracting (Ossip, Van-Landingham, Prue & Rychtarik, 1984), using prompts (mailed appointment reminders and telephone reminders) (Gilbert, 1988), combining prompts and feedback (Lash & Blosser, 1999), conducting a brief aftercare orientation meeting (Lash & Dillard, 1996), and having the client participate in aftercare groups while in inpatient treatment

(Vernis & Taylor, 1994). Home-based aftercare visits were also found to be effective in enhancing recovery outcomes (Gilbert, 1988). Studies of continuing care interventions using behavioral (contingency) contracting, family involvement, case management, couples relapse prevention groups, and the community reinforcement approach also showed promise (Donovan, 1998; Godley, et al., 2002). In spite of their apparent effectiveness, these strategies never became part of mainstream clinical practice in addiction treatment. Most of these proposed enhancements constitute an effort to extend the service dose within the acute care model.

This acute care model of intervention is being challenged by a growing call 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, Lewis, O'Brien, and Kleber, 2000; White, Boyle, Loveland, 2003).

The development and evaluation of protocol for post-treatment monitoring, support and early re-intervention is part of this broader shift toward sustained recovery management. This shift is being pushed by both recovery advocates seeking to reconnect addiction treatment to the larger and more prolonged process of addiction recovery and by a growing body of scientific studies pointing out the limitations of the acute care model. Those limitations include (See White 2004c for data references):

- Limited attraction Less than 10% of those meeting DSM-IV criteria for a substance use disorder seek treatment each year and those who do often confront and then drop out of waiting list.
- High attrition More than half of clients admitted to addiction treatment do not successfully complete treatment.
- Inadequate treatment dose Many clients received less than the optimum dose of treatment recommended by the National Institute on Drug Abuse.
- Weak linkage to peer-based recovery support groups (Inadequate initial linkage and high early dropout rates are the norm. (Emrick, Tonigan, Montgomery & Little, 1993)
- Absence of continuing care Only 1 in 5 clients actually receive any significant continuing care contact.
- High rates of post-treatment relapse The majority of people discharged from addiction treatment resume AOD use in the year following treatment, 80% of whom resume use within 90 days of discharge.
- High rates of treatment readmission 60% of those admitted to addiction treatment already have one or more prior treatment admissions and 24% have three or more prior admissions.
- Repeated treatments preceding stable remission Most treated individuals who achieve a year of stable recovery do so after multiple episodes of treatment over a span of years. (Dennis, Scott, Funk & Foss, 2005).
- Instability of early recovery The point at which risk of future lifetime relapse drops below 15% is not reached until 4-5 years of sustained remission and longer for those addicted to opiates)
- High post-treatment mortality Long-term follow-up studies of discharged clients reveal high mortality rates related to accidental poisoning/overdose, liver disease, cancer, cardiovascular disease, AIDS, suicide and homicide.

These stark findings do not mean that addiction treatment has no value. Treatment-related remissions (persons no longer meeting DSM-IV criteria for a substance use disorder

following treatment) average about one-third, substance use decreases by an average of 87% following treatment, and substance-related problems decrease by an average of 60% following treatment (Miller, Walters, & Bennett, 2001). Recent studies confirm that addiction treatment outcomes are comparable to treatment outcomes for other chronic health conditions (e.g., type I diabetes, hypertension and asthma) (McLellan, Lewis, O'Brien, & Kleber, 2000). What the literature (See later discussion) and cumulative clinical experience are demonstrating is that addiction careers can be shortened and the stability and quality of recovery enhanced by providing post-treatment monitoring, support, and early re-intervention within a framework of sustained recovery management—an approach comparable to approaches for managing other complex, chronic health problems.

Practitioner Credentials:

At the present time, post-treatment monitoring, support and early re-intervention are being conducted both by persons credentialed by education and training and by persons credentialed by experience via their own addiction and recovery careers. Service models employing the latter are often referred to as peer-based recovery support services (P-BRSS). These models deliver P-BRSS within roles bearing such titles as recovery coach, recovery support specialist, personal recovery assistant, and recovery mentor/guide. Such roles are particularly evident within two new federal initiatives—the Center for Substance Abuse Treatment's Recovery Community Support Program and the White House-initiated Access to Recovery program. There is also a trend toward the integration of recovery coaches into community-based treatment programs (see www.dawnfarm.org/articles/recoverycoach.pdf) and the development of post-treatment recovery coaching as a private business (see http://www.personalrecoveryassistants.com/ and http://www.cocaine-addiction.co.uk/recovery_coaching.htm).

Some of the key traits and areas of knowledge and skill that these programs are seeking in the recovery coaches hired to do post-treatment recovery support services include:

- Possesses credibility as a person of integrity, wisdom and compassion within the communities being served
- Knows how to make things happen even when formal resources appear to be lacking
- Exudes hope
- Possesses a deep knowledge of individual/family addiction and recovery processes
- Has a rich knowledge of the local communities and their recovery support resources
- Is knowledgeable about multiple pathways and styles of addiction recovery and their associated support structures (See White & Kurtz, 2005)
- Is capable of initiating and sustaining healthy, respectful (non-exploitive) recovery support relationships
- Is able to work from a position of collaboration and mutual respect with other service professionals
- Has good self-care rituals and the ability to ask for and utilize supervisory guidance.

Service Procedures and Guidelines: There are several sources that detail the clinical protocol used to conduct post-treatment monitoring, support and early re-intervention. The best of these resources have manualized their procedures to enhance model fidelity. Procedures involved in providing assertive continuing care to adolescents are outlined in:

Godley, S. H., Godley, M. D., Karvinen, T., & Slown, L. L. (2001). *The Assertive Aftercare Protocol: A Case Manager's Manual for Working with Adolescents after Residential Treatment of Alcohol and other Substance Use Disorders*. Bloomington, IL: Lighthouse Institute.

Procedures for post-treatment monitoring and support are outlined in:

McKay, J. R., Feeley, M., & Annis, H. M. (1993). *Manual for Individualized Relapse Prevention Aftercare*. Philadelphia, PA: University of Pennsylvania.

Loveland, D., and Boyle, M. (2005). *Manual for Recovery Coaching and Personal Recovery Plan Development*. Peoria, IL: Fayette Companies (www.bhrm.org/guidelines/Recovery%20Coach%20and%20Recovery%20Planning%20Manual.doc).

Procedures used to conduct recovery management checkups are detailed in:

Dennis. M. L., Scott, C. K., & Funk, R. (2003). An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. *Evaluation and Program Planning, 26*(3), 339-352.

Procedures for conducting telephone-based continuing care are outlined in:

McKay, J. R., Lynch, K. G., Shephard, D. S., & Pettinati, H. M. (2005). The effectiveness of telephone-based continuing care for alcohol and cocaine dependence. *Archives of General Psychiatry, 62*(2), 199-207.

Implementation Issues, Obstacles and Strategies: The obstacles to implementing more assertive systems of post-treatment monitoring and support, in particular models of P-BRSS, are substantial. Such obstacles are:

- conceptual (failure to see the need for P-BRSS services; conflicts between the P-BRSS emphasis on the ecology of recovery / recovery community building and traditional biopsychological models of problem intervention),
- emotional (failure of traditionally-trained professionals to accept P-BRSS service specialists as legitimate professional peers),
- technical (lack of empirical models of P-BRSS and P-BRSS implementation protocol),
- organizational (e.g., weak infrastructures reflected in high staff turnover)
- administrative (challenges complying with treatment-oriented licensing and reporting procedures), and
- fiscal (lack of financing models for P-BRSS; financing systems that pay for repeated episodes of expensive acute care but won't pay for sustained low cost monitoring and recovery support services) (White, 2004b).

The good news is that experiments with professional and peer-based recovery support services are underway across the country and are generating a body of knowledge about how to negotiate rule exceptions from funding and regulatory authorities, new support protocol, models for hiring, training and supervising recovery coaches, and other advances that are laying the foundation for a new model of sustained recovery management.

Representative Studies of the Intervention:

Several recent studies have confirmed the value of more assertive and sustained models of post-treatment monitoring and support.

Godley, Godley, Dennis, Funk & Passetti (2002) randomly assigned 114 adolescents discharged from IP Tx randomly assigned to aftercare as usual (aftercare groups) or assertive continuing care (ACC) (home visits, sessions for adolescents, parents and joint sessions, case management). They found that the ACC group had a higher engagement/retention rate (94%), averaged more than twice the continuing care sessions as the control group, exhibited lower relapse rates for alcohol and cannabis, and, for those who did use, more days to first use.

Dennis, Scott and Funk (2003) 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. 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, to return to treatment sooner, and to spend more subsequent days in treatment. RMC participants also experienced significantly fewer total quarters in need of treatment and were less likely to need treatment 2 years after intake. This experimental evaluation of RMC offers support for three specific elements of the larger model of recovery management – monitoring, motivational interviewing and linkage assistance.

McKay, Lynch, Shephard, and Pettinati (2005) tested the effectiveness of telephone-based, post-treatment monitoring and found that weekly 15-20 minute calls with a counselor maintained treatment gains in all but about 20% of clients—the latter constituting those with the highest problem severity. Telephone-based monitoring may be a very cost-effective and clinically effective monitoring and support tool for all but the most severe substance use disorders.

Limitations and Contraindications:

White, Boyle, and Loveland, in their overview of the recovery management model (2003), caution against the misapplication of this model to individuals with lower problem severity and high recovery capital who may not need sustained monitoring and support to achieve stable recovery initiation and maintenance. They are particularly concerned about the potential misapplication of this model to individuals (e.g., many adolescents) who are likely to resolve alcohol and other drug problems through professional maturation or brief professional intervention. The concern is that entrapping such individuals within a chronic care model could inadvertently do harm via stigma and enmeshment in an unnecessary and potentially expensive service career.

RM models may prove to be most beneficial for those individuals who present with the highest problem severity (high severity substance dependence), problem complexity (medical and psychiatric co-morbidity), and lowest recovery capital (internal and external assets for recovery initiation and maintenance).

Other Key Resources:

For general information on Recovery Management
See www.BHRM.org
See Recovery Management Monograph at www.glattc.org
See IRETA/NEATTC

For specific questions on recovery management
Bill White (bwhite@chestnut.org)
Mike Boyle (MBoyle@fayettecompanies.org)

For information about linking clients to recovery mutual aid groups
See the Mutual Support Resources Guide that is posted at the Faces and Voices of Recovery (FaVoR) Web Site (http://facesandvoicesofrecovery.org/resources/support_home.php) and updated monthly by its developers, Drs. Ernie and Linda Kurtz.

For questions on Assertive Continuing Care procedures with adolescents
Dr. Mark Godley (mgodley@chestnut,org)
Dr. Susan Godley (sgodley@chestnut.org)

For questions on Recovery Management Checkup procedures with adults
Dr. Christy Scott (cscott@chestnut.org)
Dr. Mike Dennis (mdennis@chesnut,org)

About the Author: William L. White, M.A., is a Senior Research Consultant at the Lighthouse Institute, the research division of Chestnut Health Systems. He has worked full time in the addictions field since 1969 and has published more than 220 articles/monographs and eleven books.

References

Dennis. M. L., Scott, C. K., and Funk, R. (2003). An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. *Evaluation and Program Planning, 26*(3), 339-352.

Dennis, M. L., Scott, C. K., Funk, R., & Foss, M. A. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment*, *28*(Suppl 1), S51-S62.

Donovan, D. (1998). Continuing care: Promoting the maintenance of change. In W. Miller & N. Heather (Eds.), *Treating Addictive Behaviors* (2nd ed., pp. 317-336). New York: Plenum Press.

Emrick, D. C., Tonigan, J. S., Montgomery, H., and Little, L. (1993). Alcoholics Anonymous: What Is Currently Known? In McCrady, B., and Miller, W. R. (Eds.) *Research on Alcoholics Anonymous: Opportunities and Alternatives,* (pp. 41-78). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Gilbert, F. S. (1988). The effect of type of aftercare follow-up on treatment outcome among alcoholics. *Journal of Studies on Alcohol*, *49*(2), 149-159.

Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R., & Passetti, L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, *23*(1), 21-32.

Granfield, R., and Cloud, W. (1999). *Coming Clean: Overcoming Addiction without Treatment*.

New York: New York University Press.
Lash, S. J., & Blosser, S. L. (1999). Increasing adherence to substance abuse aftercare group therapy. *Journal of Substance Abuse Treatment*, *16*(1), 55-60.
Lash, S. J., & Dillard, W. (1996). Encouraging participation in aftercare group therapy among substance-dependent men. *Psychological Reports*, *79*(2), 585-586.
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 outcomes evaluation. *Journal of the American Medical Association 284*(13), 1689-1695.
McKay, J. R., Lynch, K. G., Shephard, D. S., & Pettinati, H. M. (2005). The effectiveness of telephone-based continuing care for alcohol and cocaine dependence. *Archives of General Psychiatry, 62*(2), 199-207.
Miller, W. R., Walters, S. T., & Bennett, M. E. (2001). How effective is alcoholism treatment in the United States? *Journal of Studies on Alcohol*, *62*(2), 211-220.
Ossip, D. J., Van-Landingham, W. P., Prue, D. M., & Rychtarik, R. G. (1984). Increasing attendance at alcohol aftercare using calendar prompts and home based contracting. *Addictive Behaviors*, *9*(1), 85-89.
Stout, R. L., Rubin, A., Zwick, W., Zywiak, W., & Bellino, L. (1999). Optimizing the cost-effectiveness of alcohol treatment: A rationale for extended case monitoring. *Addictive Behaviors*, *24*(1), 17-35.
Vernis, J. S., & Taylor, J. (1994). Increasing alcoholic patients' aftercare attendance. *International Journal of the Addictions*, *29*(11), 1487-1494.
White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.
White, W. (2004a). Recovery coaching: A lost function of addiction counseling? *Counselor*, *5*(6), 20-22.
White, W. (2004b). The history and future of peer-based addiction recovery support services. Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC.
White, W. (2004c). Treatment Works! Is it time for a new slogan? Posted at http://www.bhrm.org and (Abridged). *Addiction Professional*, *3*(1), 22-27.
White, W., Boyle, M., & Loveland, D. (2003). Alcoholism/addiction as a chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly*. *20*(3/4), 107-130.
White, W., & Godley, M. (2003). The history and future of "aftercare" *Counselor 4*(1), 19-21.
White, W., & Kurtz, E. (2005). *The Varieties of Recovery Experience*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.
White, W., & Kurtz, E. (in press). Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches. IRETA/NeATTC.