



HHS Public Access

Author manuscript

Addict Prof. Author manuscript; available in PMC 2019 January 11.

Published in final edited form as:

Addict Prof. 2004 September ; 2(5): 33–39.

Recovery Management Checkups: A Future Function of Addiction Professionals?

Christy K. Scott, Ph.D., Michael L. Dennis, Ph.D., and William L. White, M.A.

Lighthouse Institute, the research division of Chestnut Health Systems in Bloomington, Ill

Abstract

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 of 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 28 days or 5 days, whether outpatient treatment should be 5 sessions or 20 sessions, or whether it should consist of 12-Step facilitation or cognitive-behavioral therapy are all arguments inside this acute care paradigm. The bias toward 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. The 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 and 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 & 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 et al., 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,” or internal and external resources to initiate and sustain recovery (Granfield & 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 requires multiple episodes of care. Of those entering the public treatment system, 60 percent report prior treatment — 23 percent one time, 13 percent two times, 7 percent three times, 4 percent four times and 13 percent five or more times (OAS, 2001). Twenty-five to 35 percent are readmitted to treatment within 12 months, and 50 percent within two to five years (Hubbard, Marsden, Rachal, Harwood, Cavanaugh & Ginzburg, 1989). Only one in five 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 percent in the 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 three to four 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 from 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 sobriety-conducive living environments (Jason, Davis, Ferrari & Bishop, 2001). Recovery durability (point at which risk of future lifetime relapse drops below 15 percent) is not reached until four to five 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), 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 & 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 link-age 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 comorbidity (77 percent), substance use by others in the home (40 percent), regular substance use by peers (84 percent), and history of homelessness (54 percent).

A total of 448 clients (59 percent female; 85 percent 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 percent vs. 51 percent), to return to treatment sooner (376 days vs. 600 days), and to spend more subsequent days in treatment (mean of 62 days vs. 40 days). RMC participants also experienced significantly fewer total quarters in need of treatment and were less likely to need treatment two years after intake (43 percent vs. 56 percent).

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 percent 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 percent vs. 16 percent), 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 (vs. 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 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 manage such disorders proactively 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 front-line 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 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. ■

Acknowledgments

This work was supported by the National Institute on Drug Abuse Grant No. DA 11323. The opinions expressed here are those of the authors and do not reflect official positions of the government.

References

- Anglin MD, Hser YI, Grella CE. 1997; Drug addiction and treatment careers among clients in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*. 11(4):308–323.
- Bien TH, Miller WR, Tonigan JS. 1993; Brief interventions for alcohol problems: a review. *Addiction*. 88:315–336. [PubMed: 8461850]
- Cunningham JA. 1999; Resolving alcohol-related problems with and without treatment: The effects of different problem criteria. *Journal of Studies on Alcohol*. 60:463–466. [PubMed: 10463801]
- Cunningham JA. 2000; Remissions from drug dependence: Is treatment a prerequisite? *Drug and Alcohol Dependence*. 59:211–213. [PubMed: 10812281]

- Dennis ML, Scott CK, Funk R. 2003; Main findings from an experimental evaluation of recovery management checkups and early re-intervention (RMC/ERI) with chronic substance users. *Evaluation and Program Planning*. 26:339–352. [PubMed: 30034059]
- Dennis ML, Scott CK, Funk R. The duration and correlates of substance abuse treatment careers among people entering publicly funded treatment in Chicago.
- Emrick, DC, Tonigan, JS, Montgomery, H, Little, L. Alcoholics Anonymous: What Is Currently Known?. In: McCrady, B, Miller, WR, editors *Research on Alcoholics Anonymous: Opportunities and Alternatives*. 1993. 41–78.
- Godley MD, Godley SH, Dennis ML, Funk R, Passetti L. 2002; Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*. 23:21–32. [PubMed: 12127465]
- Granfield, R, Cloud, W. *Coming Clean: Overcoming Addiction Without Treatment*. New York: New York University Press; 1999.
- Hubbard, RL, Marsden, ME, Rachal, JV, Harwood, HJ, Cavanaugh, ER, Ginzburg, HM. *Drug abuse treatment: A national study of effectiveness*. Chapel Hill, N.C: University of North Carolina Press; 1989.
- Humphreys K, Moos RH, Finney JW. 1995; Two pathways out of drinking problems without professional treatment. *Addictive Behaviors*. 20(4):427–441. [PubMed: 7484324]
- Humphreys K, Mankowski E, Moos R, Finney J. 1999; Do enhanced friendship networks and active coping mediate the effect of self-help groups on substance abuse? *Annals of Behavioral Medicine*. 21(1):54–60. [PubMed: 18425655]
- Jason L, Davis M, Ferrari J, Bishop P. 2001; Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education*. 31(1):1–27. [PubMed: 11338963]
- Jin H, Rourke SB, Patterson TL, Taylor MJ, Grant I. 1998; Predictors of relapse in long-term abstinent alcoholics. *Journal of Studies on Alcohol*. 59:640–646. [PubMed: 9811085]
- Kessler RC, McGonagle KA, Shanyang Z, Nelson CB, Hughes M, Eshleman S, et al. 1994; Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry*. 51:8–19. [PubMed: 8279933]
- King MP, Tucker JA. 1998; Natural resolution of alcohol problems without treatment: Environmental contexts surrounding the initiation and maintenance of stable abstinence or moderation drinking. *Addictive Behaviors*. 23(4):537–541. [PubMed: 9698982]
- Mäkelä, K, Arminen, I, Bloomfield, K, Eisenbach-Stangl, I, Bergmark, K, Kurube, N. , et al. *Alcoholics Anonymous as a Mutual-Help Movement: A Study in Eight Societies*. Madison: University of Wisconsin; 1996.
- McLellan AT, Lewis DC, O'Brien CP, Kleber HD. 2000; Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association*. 284(13):1689–1695. [PubMed: 11015800]
- McKay JR. 2001; Effectiveness of continuing care interventions for substance abusers: Implications for the study of long-term effects. *Evaluation Review*. 25:211–232. [PubMed: 11317717]
- NIDA. *Principles of Drug Addiction Treatment*. Rockville, MD: National Institute on Drug Abuse; 1999. NIH Publication No. 00-4180(available at <http://www.nid.nih.gov/PODAT/PODATIndex.html>)
- Office of Applied Studies. *Treatment Episode Data Set (TEDS) 1994–1999: National Admissions to Substance Abuse Treatment Services*. Rockville, MD: U. S. Department of Health and Human Services; 2001. DASIS Series S1 4, DHHS Publication No. (SMA)01-35502001:Substance Abuse and Mental Health Services Administration. (Table 4.16.01) [online] available at <http://www.DrugAbuseStatistics.samhsa.gov>
- Prochaska J, DiClemente C, Norcross J. 1992; In search of how people change. *American Psychologist*. 47:1102–1114. [PubMed: 1329589]
- Scott CK, Foss MA, Dennis ML. Pathways in the relapse, treatment, recovery cycle over 3 years. *Journal of Substance Abuse Treatment*.
- Sobell L, Sobell M. 1981; Frequent follow-up as data gathering and continued care with alcoholics. *International Journal of the Addictions*. 16(6):1077–1086. [PubMed: 6281201]

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.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript