RECOVERY MAINTENANCE SERVICES:
Continuing Care in the Treatment of Substance Use Disorders

Concept Paper

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Introduction

The Santa Cruz County Health Services Agency (HSA) Alcohol and Drug Programs has indicated an interest in developing a pilot initiative on the development of Recovery Maintenance Services. These are services that are provided to participating clients after their primary treatment for substance use disorders. As a concept, continuous recovery maintenance has shown to be effective in helping persons sustain recovery principles learned during treatment. Research has shown that continuous recovery management yields longer periods of sustained functionality (ASAM, 2010; Dennis et al., 2013; Humphreys & Tucker, 2012; McKay, 2010; McLellan et al., 2008; Simpson, 2014). This paper provides a partial literature review on recovery maintenance services and outlines the key discussion concepts in the development of a pilot study using post-treatment continuing care.

Over the next several years, the Santa Cruz County Health Services Agency (HSA) Alcohol and Drug Programs envisions a transition to a comprehensive and integrated recovery-oriented system of care for substance use disorders built on coordination and collaboration across problem substance abuse prevention and substance abuse treatment. To be effective, the system of care must be a partnership that encompasses community partners, prevention and treatment providers, the recovery community, and other stakeholders.

Population based projections estimate that by 2020, behavioral health disorders will surpass all physical diseases as a major cause of disability world-wide. Almost half the 500,000 deaths per year related to tobacco use occur among people with substance use disorders. A current estimate puts the total economic cost of mental, emotional, and behavioral disorders among youth in the United States at approximately $247 billion per year (Center for Disease Control, 2010).

As effective as good prevention is, it can't stop all addiction from occurring. And when addiction does occur, research shows it is a chronic illness and that recovery is a long-term process. Too often, this chronic illness is addressed by a treatment system based on an acute care model that seems to move rapidly from crisis, to assessment, to treatment, and to discharge. Many factors, not the least of which has been funding, have led to fewer treatment services spread over shorter lengths of time with less family and community involvement and limited opportunities for recovery support. Recovery Maintenance Services adds a critical piece to the existing continuum of care.

Research outcomes data confirms that prevention works, treatment is effective and people recover. Many Santa Cruz residents who need services don't get them, too many people who start treatment leave

early, and many people who complete treatment don't get the community-based services and supports that can help them sustain their recovery over time.

The primary task in recovery maintenance services over the next decade is further work on the development of more effective post-treatment services that are both accessible and attractive to a wide variety of individuals with addiction problems, utilize a number of service delivery systems and methods, promote sustained participation in ongoing disease management, are responsive to changes in symptoms and functioning over time, are economically feasible, and are able to incorporate medications as well as other therapeutic supports.

Background and Rationale for Recovery Maintenance Services

- The highest percentage of clients relapsing is in the first 30 days after discharge. Recidivism can be as high as 70% within the first 30-60 days of discharge from treatment
- Passive referrals to aftercare and/or community support groups do not work well
- Best practice guidelines call for continuing care following primary treatment;
- Telephone counseling for continuing care is as effective as face-to-face or peer facilitated services, but contingency planning is important
- E-counseling for post treatment check-ups is a promising practice

There is convincing evidence that continuing care can be effective in sustaining the positive effects of the initial phase of care and reducing recidivism rates by greater than 50%.

In the addictions field, there is growing interest in the development and implementation of treatment protocols and systems that address the full continuum of care, from detoxification to extended recovery monitoring and recovery maintenance services These new models have the potential to bring addiction treatment into a new era, in which care will be provided in contemporary patient-centered models designed to effectively manage chronic disorders (IOM, 2006; Wagner et al., 2010). This would represents a major shift, given that virtually all addiction treatment is currently provided in time-limited specialty programs that employ a limited modalities of therapy, usually without access to approved medications, alternative treatment approaches, or options for other support services

These changes are being driven by a number of factors, including progressive leadership at the state and local level, greater open-mindedness and pragmatism among treatment providers, increasing insistence from all stake holders for better outcomes, and a series of influential publications that have pointed out the similarities between addiction and other chronic disorders and the limitations of the addiction treatment system as currently constituted (McLellan et al). In addition, there is a growing research literature on continuing care that has provided important information on the effectiveness on various interventions and management practices, ranging from more traditional 12-step focused group counseling approaches to flexible extended care models (McKay j. et al, 2009).

Several Models – Three Recommended Approaches

There are 20 various models of recovery maintenance services that have shown efficacy in formal research and randomized controlled trials. Of these, 3 that have shown to be the most provocative in terms of helping clients sustain recovery over time post treatment:

1. Addiction Recovery Peer Service Roles: Recovery Management in Health Reform (Faces and Voices of Recovery)
2. Telephone-based Continuing Care (McKay et al)
3. Continuous Recovery Management (Stanford, et al)

Addiction Recovery Peer Service Roles: Recovery Management in Health Reform
Peer-based recovery support is the process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term recovery from severe alcohol and/or other drug-related problems. This support is provided by people who are experientially credentialed to assist others in initiating recovery, maintaining recovery and enhancing the quality of personal and family life in long-term recovery (William White, 2009). Peer recovery support services are strengths-based, build recovery-oriented systems and offer hope. They are adaptable across the continuum of care and are distinguished from professional treatment and mutual aid support groups. In the Peer Recovery Support Services model, there are peer recovery coaches who may or may not be part of a peer-operated recovery community center. Peer recovery coaches are supervised by an addiction specialist to help navigate through often complex issues patients can present after formal treatment.

There is a robust body of research on the value and effectiveness of peer supports for a number of chronic health conditions such as diabetes, cancer, obesity, HIV/AIDS and mental illness. This research has identified the value of services delivered by peers at the community level and the usefulness of a wide variety of social and other supports. There has been some research on the effectiveness of addiction peer recovery support services. For example, a June 2008 study of Texas drug court participants who received services through Access to Recovery found that "among the specific types of recovery support services, those that were most closely related to the process of recovery such as individual recovery coaching, recovery support group, relapse prevention group and spiritual support group, were more strongly associated with successful outcomes." In a December 2008 study of the Texas Co-occurring State Incentive Grant Project, it was found that "completers were more likely to receive peer mentoring in combination with other social support services provided by the voucher." **www.facesandvoicesofrecovery.org)**

Telephone Based Continuing Care
A previous randomized trial with 224 alcohol and/or cocaine addicts who completed an initial phase of treatment indicated 12-weeks of telephone-based continuing care yielded higher abstinence rates over 24-months than group counseling continuing care. In this article we examined mediators of this treatment effect. Results suggested that self-help involvement during treatment, and self-efficacy and commitment to abstinence 3 months after treatment, **mediated subsequent abstinence outcomes**. These analyses controlled for substance use prior to the assessment of mediators. Conversely, there was no evidence that self-help beliefs or social support mediated the treatment effect. These results are consistent with a model in which treatment effects are first accounted for by changes in behavior, followed by changes in self-efficacy and commitment to abstinence (McKey J, et al. *J Consult Clin Psychol*. 2007 October ; 75(5): 775–784. doi:10.1037/0022-006X.75.5.775.

Continuous Recovery Management
Professionally directed, post-discharge continuing care can enhance recovery outcomes, but only one in five clients actually receive such care. Therefore, once acute treatment issues have been stabilized (treatment completion), moving the patient to continuing care services with instructions for sustained

recovery management seems the logical next step. It is time to start defining treatment completion beyond acute care conditions and bring in sustained recovery support resources as an integral part of a treatment episode.

As the drug and alcohol field moves its clinical practice from an acute-care to a chronic-care or continuing-recovery model, it will come up against the vast array of regulatory, fiscal, and policy systems based on the acute-care model. Federal and most state regulations require that client cases must be closed when there has been no contact for 30 days. In a continuing-recovery model, contact may be less frequent. The type of contact will also change, and this will require a change in what is considered a billable service. Current funding regulations cover such basic services as individual counseling for one hour and group counseling for one to two hours. Under a continuous recovery model, services such as telephone contacts, brief interventions, a range of case management functions, family counseling, and others are all covered.

Finally, in the current acute-care system, there is a focus on treatment completion and "graduation," usually after 90 to 180 days of treatment. In a continuing-recovery model, the very concept of graduation or treatment completion will have to change. State and federal authorities need to review the entire range of fiscal, regulatory, and policy requirements to identify where changes need to be made to reflect and support a continuing recovery model in the treatment of the chronic condition of drug addiction. (Stanford M, et al. Chronic Care and Addictions Treatment *Journal of Psychoactive Drugs* 302 SARC Supplement 6, September 2010).

The Difference between Passive Aftercare and Active Recovery Maintenance

Because of the relapsing nature of all chronic disorders, some form of continuing care is usually recommended following completion of an initial phase of treatment. Despite the potential benefits of continuing care, many clients either do not attend any continuing care or stop attending after a relatively small number of sessions. From a systems perspective, continuing care and aftercare are generally passive referrals from primary treatment as part of a discharge plan. The treatment provider usually has little to do with continuing care. Recovery Maintenance**,** on the other hand, is the active follow-up to see how the patient is doing with their recovery and determines a disposition for subsequent contacts, frequency and level of care.

There is very little published work on mediators of continuing care effects, including participation in self-help programs and other sources of social support. Such work is needed to better understand the heterogeneity of response to continuing care interventions and strengthen active therapeutic components. The degree to which formal continuing care facilitates participation in self-help is a particularly important issue, given that many patients will spend considerably more time in self-help meetings and related activities than in formal continuing care sessions (Witbrodt et al., 2007).

Implementation Considerations for the Pilot Initiative

- ***Incentivizing agency participation***: Participating agencies of the Recovery Maintenance Services pilot study can be part of a bidding process where there are grant monies to help offset program costs. Additionally, participating agencies can have their contract productivity levels adjusted to account for time spent on implementing Recovery Maintenance Services.

- **Minimum duration of pilot study:** Regardless of the model chosen for study, research indicates the post-treatment services must be for at least 12 months duration to best determine outcomes and efficacy.

- **Continuous quality improvement**: Rapid quality improvement methods must be part of the initial planning and implemented throughout the pilot study. Use of PDSA and/or NiaTX can be used for this.

- **Data collection plan:** At a minimum, data for this pilot initiative must include client discharge data into recovery maintenance; time from treatment discharge to recovery maintenance enrollment; client demographics on who accept continuing care services; comparative analysis of relapse rates between cohorts who accept referral to recovery maintenance and those who do not; client data on what factors helped sustained recovery versus those associated with early and frequent lapse or relapse behaviors; and multiple process evaluation measures for implementation fidelity.

- **Alternative service delivery sites and methods**: Although some patients do well in traditional, specialty care settings, there are many others who are either unwilling to attend specialty care at all, or want to "complete treatment: as soon as possible in order to stop coming to the clinic. Some of this reflects stigma that is still associated with going to "drug rehab." However, there is increasing recognition that many individuals simply do not like some aspects of traditional treatment programs, including the emphasis on total abstinence, pressure to embrace the AA program, reliance on group therapy, and so forth. Conversely, some patients would be willing to attend treatment in specialty care sessions, but are unable to do so because of family responsibilities, transportation problems, and so forth. Therefore, patient preference needs to be taken seriously and not simply seen as indicative of resistance or denial.

- **Design study model approach through stakeholder collaboration:** Develop a series of meetings with HSA Alcohol and Drug Program staff, Probation staff, and contracted SUD treatment providers to develop a shared understanding of recovery maintenance best practices; co-create the design of the recovery maintenance pilot project through contracted and/or county-operated services; develop contract amendment financial incentives; and establish benchmark indicators of implementation to determine project's progress and success.

Summary

There are several important key points about the type of continuing care likely to be most effective. First, interventions with a longer planned duration of therapeutic contact appear to hold an advantage over shorter interventions. Second, interventions that feature more active and direct attempts to bring the treatment to the patient, either through aggressive outreach attempts or the use of low burden service delivery systems such as the telephone, seem to have a clear advantage over more traditional approaches.

Perhaps still more important is the recognition that even with effective interventions, wide variation in patient response is still the rule rather than the exception. Moreover, many patients - perhaps the majority - do not engage in standard continuing care when it is available to them (McKay, Foltz et

al., 2010). These factors make a strong case for the importance of new continuing care models that can supplement and in some cases replace the traditional clinic-based approach.

The key components of these new models are aggressive attempts to stay in contact with the patient for extended periods of time, systematic monitoring of treatment response, incorporation of adaptive algorithms that guide ongoing modifications to treatment in response to progress or the lack thereof, use of service delivery approaches that are of lower burden and greater convenience for the patient, provision of choice to the patient regarding treatment type and setting, and use of some forms of incentives to patients and counselors that promote sustained participation in continuing care.

The use of medications to reduce alcohol and drug use may become an increasingly important component of continuing care treatments in the future. At this point, there are only three medications approved to treat alcohol dependence (e.g., naltrexone, acamprosate, and disulfiram), and none are yet approved for the treatment of stimulant dependence. There are only two published studies of the use of these medications within the context of a continuing care model. In one study, extended naltrexone was effective in patients receiving treatment in a primary care model, but not for those receiving CBT (O'Malley et al., 2003). In the second study, a protocol that provided 12 months of naltrexone to patients with chronic, severe alcohol dependence who were also receiving weekly behavioral treatment did not produce better 12 month drinking outcomes than a protocol that provided 3 months of naltrexone followed by 9 months of placebo. Moreover, neither naltrexone condition was more effective than 12 months of placebo (Krystal, Cramer, Krol, & Kirk, 2001). However, a recent re-analysis of this trial indicated that naltrexone doubled the odds of being categorized in an “abstainer” trajectory vs. in a “consistent drinker” trajectory (Gueorguieva et al., 2007).

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