DAS focus is on chronic care, 'recovery zone' supports

By Raquel Mazon Jeffers

For many people, drug addiction is a chronic disorder, with relapses possible even after long periods of abstinence[1]. Addiction can cause permanent changes in brain structure and chemistry. This has been compellingly and repeatedly demonstrated through three decades of scientific research and clinical practice that have yielded a variety of effective approaches to drug addiction treatment[2]. Addiction is an illness that requires a continuum of care much like diabetes, asthma or hypertension. As is often the case with other chronic diseases, a single course of treatment is unlikely to result in a complete and permanent "cure". The treatment of addiction should be approached with the same considerations that drive the treatment of other chronic illnesses. The system of care, including treatment and funding mechanisms, must adapt to provide comprehensive care using evidence-based methods and practices to manage acute addiction and foster sustained symptom remission[3].

The prevailing acute care addictions treatment model is structured to provide an encapsulated set of specialized service activities (assess, admit, treat, discharge, terminate the service relationship). A professional expert drives the process and services transpire over a short (and ever-shorter) period of time. In this model, individuals, families, and communities are given the impression at discharge that recovery is now self-sustainable[4].

This acute care model does work for many individuals, especially those with high "recovery capital", which refers to aspects of well-being like stable housing, employment, and strong social networks. For those individuals who complete treatment, one-third experience remission of symptoms. Alcohol and drug use has been shown to decrease by 87 percent following treatment and substance-related problems decrease by 60 percent following treatment completion[5]. The lives of individuals and families are transformed by addiction treatment.

However, only 10 percent of those needing treatment in our nation received it [6] and only 25 percent will receive such services in their lifetime[7]. Based on New Jersey's Household Survey, 6 percent of adults who needed treatment in 2003, received it. For those who had a need for treatment during their lifetime, 22.5 percent received it. The majority of people who do enter treatment do so at late stages of problem severity and under external coercion[8]. The acute care model does not voluntarily attract the majority of individuals with low recovery capital, i.e., people who experience co-occurring issues of poverty, homelessness, unemployment, mental illness and poor physical health. These are the very individuals the public sector dollars are targeted to serve.

The current treatment system has historically had low engagement rates and high attrition rates. Dropout rates between the call for an appointment at an addiction treatment agency and the first treatment session range from 50-64 percent[9]. Nationally, more than half of clients admitted to addiction treatment do not successfully complete treatment (48 percent "complete"; 29 percent leave against staff advice; 12 percent are administratively discharged for various infractions; 11 percent are transferred)[10]. In New Jersey, 52 percent complete treatment, 27 percent leave against staff advice, 7 percent are administratively discharged, 5 percent are transferred and 9 percent leave for other reasons.

Existing research indicates that substance-dependent individuals with prompt access to a full continuum of care driven by the client's clinical needs which implements evidenced-based practices and addresses a client's co-morbidities consistently yields positive recovery outcomes. Kirk (2007) described this disease management process as one that addresses a client's individual recovery needs in a manner that facilitates a client's entry and stabilization in the "recovery zone" as quickly as possible following an acute episode (See Figure). **The "recovery zone" is a term used to describe a state of sustained recovery characterized by long periods of abstinence, gainful employment, stable housing, and supportive social and spiritual connectedness.**

In a recovery-oriented system of care (ROSC) approach, the treatment agency is one of many resources needed for a client's successful integration into the community. No one source of support is more dominant, or more important, than another. Various supports need to work in harmony with the client's recovery plan, so that all possible supports are working for and with the person in recovery. A ROSC supports person-centered and self-directed approaches to care that build on the personal responsibility, strengths, and resilience of individuals, families and communities to achieve health, wellness, and recovery from alcohol and drug problems.

According to White and Davidson, "Recovery refers to the ways in which persons with or affected by addiction tap resources within and beyond the self to move beyond experiencing these disorders to managing them and their residual effects to build full, meaningful lives in the community.[11]"

A recovery-oriented model has a different composition of the service team than does the acute care model, and an emphasis on supports needed to sustain long term recovery. Motivation is important, but as an outcome of a service process, not a pre-condition for entry into treatment. A strong therapeutic relationship can overcome low motivation for treatment and recovery[12]. Motivation for change can no longer be seen as the sole province of an individual, but as a shared responsibility with the treatment team, family and community institutions[13].

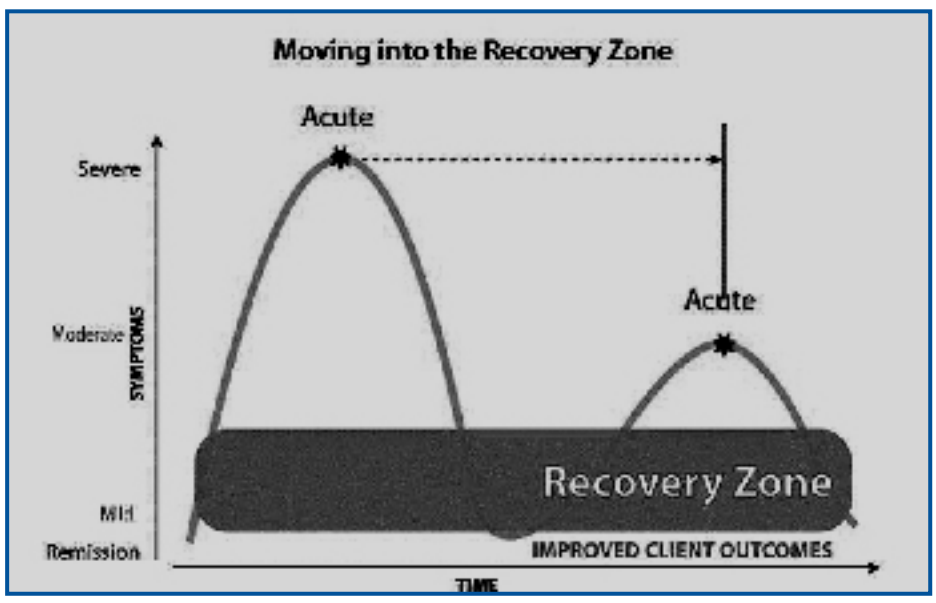
"Recovery management" (RM) is a philosophical framework for organizing addiction treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality of life enhancement for individuals and families affected by severe substance use disorders.

While recovery alleviates many of the family's historical problems, this early period can also be referred to as the "trauma of recovery": a time of great change, uncertainty and turmoil. The unsafe, potentially out-of-control environment continues as the context for family life into the transition and early recovery stages...as long as 3-5 years."[14] This inherent vulnerability compels the system to develop supportive services such as stable housing and recovery coaches to both buttress the gains achieved in treatment and inspire consumers to seek needed services.

The systems changes required to support clients' ability to enter and sustain life in the "recovery zone" is the guiding principle for all the work that DAS is invested in. In the next three years DAS will be working on some hallmark changes encapsulated in our "Recovery Zone Plan" to facilitate client movement into the "recovery zone".

These steps include: 1) Adding two new services (targeted case management and a wellness and recovery coach) to the array of services supported by DAS and drawing down new Medicaid revenue for Medicaid eligible clients to help finance these services; 2) Designing and implementing a fuller array of supportive housing options for individuals in early recovery; 3) Promoting wider implementation of the NIATX process to support client engagement and retention in treatment; and 4) Endorsing the use of evidence based practices system wide.

1) Targeted case management and Medicaid recovery support services. Targeted case management seeks to encourage a client's mastery over their substance use disorder; thus increasing the likelihood of the individual's staying in the Recovery Zone. DAS proposes the inclusion of targeted case management within our current system of care to reduce service fragmentation, promote service continuity, and increase clients' capacity to manage their chronic health condition. Targeted case management is also a fundamental, critical component of a successful "healthcare" or "medical home" approach to providing comprehensive medical and behavioral health care that facilitates partnerships between individual patient, their caregivers, and, when appropriate, the patient's family. Healthcare homes offer well-coordinated care supported by multidisciplinary teams, expanded use of health information technology, implementation of evidence-based and best practices, and financial reform that sustains these processes and aligns fiscal incentives with healthcare goals. The healthcare home offers a single point of access through which patients receive acute, chronic, and preventive services.



Targeted case management interventions that support clients' initiation and maintenance in the recovery zone not only improves the quality of life for substance-dependent individuals but reduces the cost of their care by promoting access to outpatient treatment and recovery support services which are less costly than acute residential care.

As a complement to targeted case management, we are also interested in pursuing the addition of another new Medicaid supported service to provide individual recovery support services via recovery support specialists or "coaches". A recovery coach is a person who helps remove personal and environmental obstacles to recovery, links the newly recovering person to the recovery community and his or her broader community, and serves as a personal guide and mentor in the management of personal and family recovery. The recovery coach may or may not themselves be a person in recovery. The recovery coach supports the newly recovering person as he or she develops, implements, revises, and evaluates their personal recovery plan, which covers life domains beyond those addressed within traditional behavioral healthcare.

2) Develop a continuum of supportive housing services. Supportive housing is a critical recovery support that may help treatment-resistant clients take the first step in their recovery process, as well as help to support sustained recovery. It is a successful, cost-effective combination that joins affordable housing with services that help people live more stable, productive lives. It offers permanent housing with services that work for individuals and families who face complex challenges such as homelessness and/or have serious and persistent issues that may include substance use, mental illness, and HIV/AIDS. A limited but growing body of research suggests that stabilizing individuals in supportive housing can reduce their use of expensive public crisis services such as emergency rooms, psychiatric hospitals, and jails. Studies indicate that supportive housing has positive impacts on reducing or ending substance use.

3) Continued work with NIATx on engagement in treatment. Recovery-oriented practitioners promote access to and engagement in care by removing barriers to entering treatment and "meeting clients where they are." NIATx (The Network for the Improvement of Addiction Treatment.) is a learning collaborative that works with substance abuse and behavioral health organizations across the country to teach them to use a simple process improvement model to improve access to and increase engagement and retention in treatment in order to achieve better outcomes and more efficient use of resources.

Because of our belief in the promise of the process improvement approach DAS engaged NIATx to deliver the learning collaborative model to selected contracted substance abuse treatment agencies in New Jersey. The intent of the NIATx Quality Improvement Capacity Building Program is to develop a core group of treatment agencies and staff that can provide leadership and serve as mentors for other NJ substance abuse treatment agencies that wish to improve performance and attain meaningful, client-centered treatment outcomes.

In 2009, NJ DAS initiated its first performance-based contract. Contracted providers are required to participate in NIATx in order to improve their attainment of the performance targets and report data. DAS is contracting with NIATx to provide the Quality Improvement Capacity Building Program for those Drug Court providers that did not participate in the first project, and is seeking additional support to provide meaningful support to enable the pilot participants to provide this leadership in our system of care.

4) Support adoption of evidence-based practices (EBPs). DAS has included the increased use of evidence-based practices in the licensed treatment system as one of its three-year strategic plan goals. To meet this ambitious goal, DAS will recruit providers that have successfully implemented EBPs to inspire, mentor and coach agencies that hope to embark on the process, will set up a learning collaborative of interested providers and will focus training efforts that support fidelity to EBP and measure outcomes of these efforts.

In conclusion, the measurable outcomes we will be trying to achieve with these changes are:

- Reduction in frequency of admissions to long term residential, detoxification and short term residential
- Increase in frequency to outpatient levels of care
- Reduced cost per client
- Decrease in the unmet need for treatment in NJ
- Increased retention rates
- Decrease in number of clients who are homeless at discharge

It will take years to transform addiction treatment from an acute care model of intervention to a recovery management model of sustained recovery support. That process will require what is already underway; a tremendous effort to align concepts, contexts (infrastructure, policies and system-wide relationships) and service practices to support long-term recovery.

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(Endnotes)

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