New Recovery Movement: The Rationale and Science on Recovery Support Services

John F. Kelly, PhD, ABPP
Massachusetts General Hospital
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National Association of Drug Court Professionals, Anaheim, CA, June 2016
Course of Recovery from SUD
achievement of stable recovery can take a long time ...

Addiction Onset  Help Seeking  Full Sustained Remission (1 year abstinent)  Relapse Risk drops below 15%

4-5 years

Self-initiated cessation attempts

4-5 Treatment episodes/mutual-help

5 years

Continuing care/mutual-help

Opportunity for earlier detection through screening in non-specialty settings like primary care/ED

60% of individuals with addiction will achieve full sustained remission (White, 2013)
Outline

Language, terminology, and conceptualization of addiction

Rationale for Recovery Support Services

Science on Recovery Support Services
Outline

Language, terminology, and conceptualization of addiction

Rationale for Recovery Support Services

Science on Recovery Support Services
People with eating-related conditions are always referred to as “having an eating disorder”, never as “food abusers”.

So why are people with substance-related conditions referred to as “substance abusers” and not as “having a substance use disorder”? 
Language and Terminology Considerations in Addiction

• The language we use influences and reflects our policies and approaches to addiction

• Different terms convey different meanings and can affect perceptions cause and controllability, punishment or treatment

• Goes beyond mere “political correctness”

• Can implicitly affect judgment that can perpetuate stigma/discrimination against addicted individuals
What can we do about stigma and discrimination in addiction?

• **Education** about essential nature of these conditions; *but also* stress that treatment and recovery supports help sustain remission, and a majority of people make full recoveries and have productive lives

• **Personal witness** (putting a face and voice on recovery)

• **Change our language/terminology** to be consistent with the nature of the condition and the policies we wish to implement to address it
Words matter

The words we use to describe drug and alcohol use disorders contribute to stigma around the conditions, psychologist John F. Kelly told attendees at a recent White House Conference on Drug Policy Reform.
Factors that influence stigma have language that is associated with them...

<table>
<thead>
<tr>
<th>Cause</th>
<th>Controllability</th>
<th>Stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td>“It’s not their fault”</td>
<td>“They can’t help it”</td>
<td>Decreases</td>
</tr>
<tr>
<td>“It is their fault”</td>
<td>“They really can help it”</td>
<td>Increases</td>
</tr>
</tbody>
</table>
Two commonly used terms...

• Major policy approaches (“war on drugs” vs. public health approaches) has corresponding rhetoric.

• Referring to someone as...

  • “a substance abuser” – implies willful misconduct (it is their fault and they can help it); because people are choosing to do it they should be punished

  • “having a substance use disorder” – implies a medical malfunction (it’s not their fault and they cannot help it) people are choosing NOT to do it but still do it (using AGAINST their will) they should be treated

• But, does it really matter how we refer to people with these (highly stigmatized)conditions?

• Can’t we just dismiss this as a well-meaning point, but merely “semantics” and “political correctness”?
How we **talk** and **write** about these conditions and individuals suffering them does matter

Research paper

**Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms**

John F. Kelly*, Cassandra M. Westerhoff

Center for Addiction Medicine, Department of Psychiatry, Massachusetts General Hospital, 60 Stanford Street, Boston, MA 02114, United States

**ABSTRACT**

**Objective:** Stigma is a frequently cited barrier to help-seeking for many with substance-related conditions. Common ways of describing individuals with such problems may perpetuate or diminish stigmatizing attitudes yet little research exists to inform this debate. We sought to determine whether referring to an individual as “a substance abuser” vs. “having a substance use disorder” evokes different judgments about behavioral self-regulation, social threat, and treatment vs. punishment.

**Method:** A randomized, between-subjects, cross-sectional design was utilized. Participants were asked to read a vignette containing one of the two terms and to rate their agreement with a number of related statements. Clinicians (N=516) attending two mental health conferences (63% female, 81% white, M age 51; 65% doctoral-level) completed the study (71% response rate). A Likert-scaled questionnaire with three subscales (“perpetrator-punishment” (α=.80); “social threat” (α=.86); “victim-treatment” (α=.64)) assessed the perceived causes of the problem, whether the character was a social threat, able to regulate substance use, and should receive therapeutic vs. punitive action.

**Results:** No differences were detected between groups on the social threat or victim-treatment subscales. However, a difference was detected on the perpetrator-punishment scale. Compared to those in the “substance use disorder” condition, those in the “substance abuser” condition agreed more with the notion that the character was personally culpable and that punitive measures should be taken.

**Conclusions:** Even among highly trained mental health professionals, exposure to these two commonly used terms evokes systematically different judgments. The commonly used “substance abuser” term may perpetuate stigmatizing attitudes.
Compared to those in the “substance use disorder condition”, those in the “substance abuse” condition agreed with the idea that the individual was personally culpable and more in need of punishment.
Does Our Choice of Substance-Related Terms Influence Perceptions of Treatment Need? An Empirical Investigation with Two Commonly Used Terms

John F. Kelly, Sarah J. Dow, Cara Westerhoff

Substance-related terminology is often a contentious topic because certain terms may convey meanings that have stigmatizing consequences and present a barrier to treatment. Chief among these are the labels, “abuse” and “abuser.” While intense rhetoric has persisted on this topic, little empirical information exists to inform this debate. We tested whether referring to an individual as “a substance abuser (SA)” versus “having a substance use disorder” (SUD) evokes different judgments about treatment need, punishment, social threat, problem etiology, and self-regulation. Participants (N = 314, 76% female, 81% White, M age 38) from an urban setting completed an online 35-item assessment comparing two individuals labeled with these terms. Dependent t-tests were used to examine subscale differences. Compared to the SUD individual, the SA was perceived as engaging in willful misconduct, a greater social threat, and more deserving of punishment. The “abuser” label may perpetuate stigmatizing attitudes and serve as a barrier to help-seeking.
Kelly, JF, Dow, SJ, Westerhoff, C. Does our choice of substance-related terms influence perceptions of treatment need? An empirical investigation with two commonly used terms (2010) *Journal of Drug Issues*
Implications

• Even well-trained doctoral clinicians judged *same individual* differently and *more punitively depending* on to which term they were exposed

• **Use of the “abuser” term may activate an implicit cognitive bias** that perpetuates stigmatizing attitudes – these could have broad stroke societal ramifications for treatment/funding

• Let’s learn from our colleagues treating allied disorders: Individuals with “eating-related conditions” are uniformly described as “having an eating disorder” NEVER as “food abusers”

• Referring to individuals as suffering from “substance use disorders” is likely to diminish stigma and may enhance treatment and recovery


A patient with diabetes has “an elevated glucose” level. A patient with cardiovascular disease has “a positive exercise tolerance test” result. A clinician within the health care setting addresses the results. An “addict” is not “clean”—he has been “abusing” drugs and has a “dirty” urine sample. Someone outside the system that cares for all other health conditions addresses the results. In the worst case, the drug use is addressed by incarceration.

On December 9, 2013, the first ever national drug policy reform summit was held at the White House. A major thrust of this summit was to mark a philosophical shift away from the “war on drugs” and toward a broader public health approach. Much of the summit was devoted to addressing the stigma surrounding addiction and the under-recognized importance of language.

Stigma is defined as an attribute, behavior, or condition that is socially discrediting. It is important because of the 23 million Americans who meet criteria for a substance use disorder each year, only 10% access treatment, and stigma is a major barrier to seeking help.\(^1\) A World Health Organization study of the 18 most stigmatized social problems (including criminal behavior) in 14 countries found that drug addiction was ranked number 1, and alcohol addiction was ranked number 4.\(^2\) despite harmful consequences. Yet, despite evidence of a strong causal role for genetics and impairment in inhibitory control, stigma is alive and well. Research is now revealing that one contributory factor to the perpetuation of stigma may be the type of language we use.

Use of the more medically and scientifically accurate “substance use disorder” terminology is linked to a public health approach that captures the medical malfunction inherent in addiction. Use of this term may decrease stigma and increase help-seeking. In contrast, tough, punitive, language, including the word “war,” in “war on drugs,” is intended to send an uncompromising message, “You use, you lose,” in the hopes of deterring drug involvement. Accompanying this aggressive rhetoric are terms such as drug “abuse” and drug “abusers,” implying willful misconduct (ie, “they can help it and it is their fault”). This language increases stigma and reduces help-seeking.

Since the 1970s, such language has become the norm. Even our federal health institutions that address addictions have the term “abuse” in their names (eg, National Institute on Drug Abuse), and their materials often refer to affected individuals as substance “abusers.” But, does it really matter what we call it? Rhetorical opposition has persisted regarding the use of stigmatizing language, but there was

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International Society of Addiction Journal Editors Budapest

Consensus Statement adopted Sept 2015...

ADDITION TERMINOLOGY STATEMENT

The International Society of Addiction Journal Editors recommends against the use of terminology that can stigmatize people who use alcohol, drugs, or other addictive substances or who have an addictive behavior.

Rationale: Terms that stigmatize can affect the perception and behavior of patients/clients, their loved ones, the general public, scientists, and clinicians (Broyles et al., 2014; Kelly, Dow, & Westerhoff, 2010; Kelly, Wakeman, & Saiz, 2015). For example, Kelly and Westerhoff (2010) found that the terms used to refer to individuals with substance-related conditions affected clinician perceptions. Clinicians who read a clinical vignette about “abuse” and “abuser” agreed more with notions of personal culpability and an approach that involved punishment than did those who read an identical vignette that replaced “abuse” and “abuser” with “substance use disorder” and “person with a substance use disorder.”

ISAJE is aware that terminology in the addiction field varies across cultures and countries and over time. It is thus not possible to give globally relevant recommendations about the use or non-use of specific terms. “Abuse” and “abuser” or equivalent words in other languages should, however, in general be avoided, unless there is particular scientific justification (an example of scientific justification of the use of “abuse” is when referring to a person who meets criteria for a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, alcohol abuse; that person would be said to have “alcohol abuse”). Another example of stigmatizing language is describing people as “dirty” (or “clean”) because of a urinalysis that finds the presence (or absence) of a drug (Kelly, Wakeman, & Saiz, 2015). Instead, the test results and clinical condition should be described.

The above was approved by the International Society of Addiction Journal Editors at its 2015 annual meeting (Budapest, Hungary, August 31-September 2, 2015).

References


Outline

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Course of Recovery from SUD
achievement of stable recovery can take a long time ...

Addiction Onset
Help Seeking
Full Sustained Remission (1 year abstinent)
Relapse Risk drops below 15%

4-5 years
8 years
5 years

Self-initiated cessation attempts
4-5 Treatment episodes/mutual-help
Continuing care/mutual-help

Opportunity for earlier detection through screening in non-specialty settings like primary care/ED

60% of individuals with addiction will achieve full sustained remission (White, 2013)
52% remission rate for AUD

61% remission Rate for DUD
Circuits Involved In Drug Abuse and Addiction

Key:
PFC – prefrontal cortex;
ACG – anterior cingulate gyrus;
OFC – orbitofrontal cortex;
SCC – subcallosal cortex;
NAc – nucleus accumbens;
VP – ventral pallidum;
Hipp – hippocampus;
Amyg – amygdala.

Treatments can be “bottom up” (limbic system; e.g., medications)
Or, “top down” psychosocial treatments (e.g., CBT, 12-step)

All of these brain regions must be considered in developing strategies to effectively treat addiction
HUMAN BRAIN IMAGES

Moderate Drinker  Alcoholic

Axial magnetic resonance images from a healthy 57-year-old man (left) and a 57-year-old man with a history of alcoholism (right). D. Pfefferbaum
Protracted/post-acute withdrawal effects:
More stress and lowered ability to experience normal pleasures

Increased sensitivity to stress via...
- Increased activity in hypothalamic-pituitary-adrenal axis (HPA-axis) and CRF/Cortisol release

Lowered ability to experience normal levels of reward via...
- Down-regulated dopamine D2 receptor activity increasing risk of protracted dysphoria/anhedonia
Bi-axial Formulations of Addiction and Recovery

**Recovery Capital:**
Achievement of sustained recovery from alcohol or other drug use disorders is not just a function of medical stabilization (e.g. detox) or addressing short-term deficits and psychopathology, but also by building and successfully mobilizing personal, social, and environmental resources that can be brought to bear on maintaining remission and long-term recovery.

Edwards and Gross, 1976; Kelly and Hoeppner, 2014
Longer remission results in greater accrual of recovery capital; in turn, greater recovery capital increases the chances of longer remission because it reduces biological, psychological, and social stress – a major pathway to relapse. Consequently, providing more recovery support will increase the chances of remission by reducing stress.

Adapted from Kelly and Hoeppner (2014).
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Recovery Support Services

- Mutual help organizations
- Peer-based recovery support services
- Recovery supports in educational settings
- Recovery community centers
- Sober living environments
- Clinical models of long-term recovery management
Mutual help Organizations

- Recovery
- Mutual help organizations
- Recovery supports in educational settings
- Peer-based recovery support services
- Recovery community centers
- Sober living environments
- Clinical models of long-term recovery management
## Substance Focused Mutual-help Groups

<table>
<thead>
<tr>
<th>Name</th>
<th>Year of Origin</th>
<th>Number of groups in U.S.</th>
<th>Location of groups in U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholics Anonymous (AA)</td>
<td>1935</td>
<td>56,000</td>
<td>all 50 States</td>
</tr>
<tr>
<td>Narcotics Anonymous (NA)</td>
<td>1940s</td>
<td>Approx. 15,000</td>
<td>all 50 States</td>
</tr>
<tr>
<td>Cocaine Anonymous (CA)</td>
<td>1982</td>
<td>Approx. 2000 groups</td>
<td>most States; 6 online meetings at <a href="http://www.ca-online.org">www.ca-online.org</a></td>
</tr>
<tr>
<td>Methadone Anonymous (MA)</td>
<td>1990s</td>
<td>Approx. 100 groups</td>
<td>25 States; online meetings at <a href="http://methadone-anonymous.org/chat.html">http://methadone-anonymous.org/chat.html</a></td>
</tr>
<tr>
<td>Marijuana Anonymous (MA)</td>
<td>1989</td>
<td>Approx. 200 groups</td>
<td>24 States; online meetings at <a href="http://www.ma-online.org">www.ma-online.org</a></td>
</tr>
<tr>
<td>Rational Recovery (RR)</td>
<td>1988</td>
<td>No group meetings or mutual helping; emphasis is on <em>individual</em> control and responsibility</td>
<td></td>
</tr>
<tr>
<td>Secular Organization for Sobriety, a.k.a. Save Ourselves (SOS)</td>
<td>1986</td>
<td>Approx. 500 groups</td>
<td>all 50 States; Online chat at <a href="http://www.sossobriety.org/sos/chat.htm">www.sossobriety.org/sos/chat.htm</a></td>
</tr>
<tr>
<td>Women for Sobriety (WFS)</td>
<td>1976</td>
<td>150-300 groups</td>
<td>Online meetings at <a href="http://groups.msn.com/WomenforSobriety">http://groups.msn.com/ WomenforSobriety</a></td>
</tr>
<tr>
<td>Moderation Management (MM)</td>
<td>1994</td>
<td>Approx. 18 face-to-face meetings</td>
<td>12 States; Most meetings are online at <a href="http://www.angelfire.com/trek/mmchat/">www.angelfire.com/trek/mmchat/</a>;</td>
</tr>
</tbody>
</table>

Source: Kelly & Yeterian, 2008
### TSF Delivery Modes

<table>
<thead>
<tr>
<th>Stand alone Independent therapy</th>
<th>Integrated into an existing therapy</th>
<th>Component of a treatment package (e.g., an additional group)</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="TSF_Section_1" alt="Diagram" /></td>
<td><img src="TSF_Section_2" alt="Diagram" /></td>
<td><img src="TSF_Section_3" alt="Diagram" /></td>
</tr>
</tbody>
</table>

In past 25 years, MHO research has gone from contemporaneous correlational research to rigorous RCTs and …
Facilitating involvement in Alcoholics Anonymous during out-patient treatment: a randomized clinical trial

Kimberly S. Walitzer, Kurt H. Dermen & Christopher Barrick
Research Institute on Addictions/University at Buffalo, The State University of New York, Buffalo, NY, USA

Addiction (1998) 93(9), 1313–1333

RESEARCH REPORT

Network support for drinking, Alcoholics Anonymous and long-term
treatment

RICHARD LONGABAUGH¹, PHILIP W. WIRTZ², ALLEN ZWEBEN³ & ROBERT L. STOUT⁴

¹Brown University, Center for Alcohol & Addiction Studies, Providence, RI, ²George Washington University, Washington, DC, ³University of Wisconsin-Milwaukee, Center for Addiction & Behavioral Health Research, Milwaukee, WI, ⁴Brown University and Butler Hospital, Center for Alcohol & Addiction Studies, Providence, RI, USA

Abstract

Aims. (1) To examine the matching hypothesis that Twelve Step Facilitation Therapy (TSF) is more effective than a control group in facilitating Alcoholics Anonymous (AA) involvement post-treatment. TSF often produces significantly better outcomes relative to active comparison conditions (e.g., CBT). Although TSF is not “AA”, its beneficial effect is explained by AA involvement post-treatment.
Empirically-supported MOBCs through which AA confers benefit

AA participation in turn is explained by these factors which are similar to the mechanisms operating in formal treatment...
Linkage to MHO like AA can lead to much higher rates of full sustained remission

(Project MATCH, 1997)

Continuous Abstinence Rates during year following treatment (4-15 Months)

Continuous Abstinence Rates past 90 days - 3 Years

TSF treatment can lead to much higher rates of full sustained remission

<table>
<thead>
<tr>
<th>Treatment Condition</th>
<th>% Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSF</td>
<td>24</td>
</tr>
<tr>
<td>CBT</td>
<td>14</td>
</tr>
<tr>
<td>MET</td>
<td>12</td>
</tr>
</tbody>
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<tr>
<td>TSF</td>
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</tr>
<tr>
<td>CBT</td>
<td>25</td>
</tr>
<tr>
<td>MET</td>
<td>22</td>
</tr>
</tbody>
</table>
COMPILATION OF PATIENT PROTECTION AND AFFORDABLE CARE ACT

[As Amended Through May 1, 2010]

INCLUDING

PATIENT PROTECTION AND AFFORDABLE CARE ACT
HEALTH-RELATED PORTIONS OF THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010

PREPARED BY THE
Office of the Legislative Counsel
FOR THE USE OF THE
U.S. HOUSE OF REPRESENTATIVES

APPROVED
MAR 2-3 2010

MAY 2010
Compared to CBT-treated patients, 12-step treated patients more likely to be abstinent, at a $8,000 lower cost per pt over 2 yrs ($10M total savings).

Also, higher remission rates, means decreased disease and deaths, increased quality of life for sufferers and their families.
Peer-based Recovery Support Services

- Mutual help organizations
- Peer-based recovery support services
- Recovery community centers
- Recovery supports in educational settings
- Sober living environments
- Clinical models of long-term recovery management
Formal Peer Support: Recovery Coaching

• Interacting with peers who have the lived experience of addiction and successful long-term recovery and how are supportive of recovery may help reduce relapse risk. They can facilitate...
  – Acquisition of coping skills
  – Increases in abstinence self-efficacy
  – Maintenance of recovery motivation
  – Serve as a healthy recovery role model and social contact
  – Provide community service
  – Linkages and emotional support
Recovery Case Management

• Homeless individuals randomized to receive intensive case management experienced better outcomes for monthly income and employment, housing stability, and substance use at 2 year follow-up (Cox et al., 1998)

• In a cohort of people who inject drugs seeking treatment, individuals randomized to receive a case manager were more likely to:
  – Be admitted to a treatment program (98% vs. 57%)
  – Be admitted sooner (17 days on average versus 188 days)
  – Remain in treatment longer (27 months versus 14 months) (Mejta, Bokos, Mickenberg, Maslar, & Senay, 1997)
Sober Living Environments Peer Run/Self-Governing

- Mutual help organizations
- Peer-based recovery support services
- Sober living environments
- Clinical models of long-term recovery management
- Recovery community centers
- Recovery supports in educational settings
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- Recovery community centers
Sober Living Homes

Outcomes for residents in free standing SLHs

Polcin et al., 2010

SLHs associated with tripling of abstinence rates and halving of arrest rates
Societal Benefits of Oxford Houses

- **Sample:** 150 individual completing treatment in the Chicago metropolitan area
- **Design:** Randomized controlled trial
- **Intervention:** Oxford House vs. community-based aftercare services (usual care)
- **Follow-up:** 2 years
- **Outcome:** Substance use, monthly income, incarceration rates

Oxford Houses are democratic, mutual help–oriented recovery homes for individuals with substance abuse histories. There are more than 1200 of these houses in the United States, and each home is operated independently by its residents, without help from professional staff.

In a recent experiment, 150 individuals in Illinois were randomly assigned to either an Oxford House or usual-care condition (i.e., outpatient treatment or self-help groups) after substance abuse treatment discharge. At the 24-month follow-up, those in the Oxford House condition compared with the usual-care condition had significantly lower substance use, significantly higher monthly income, and significantly lower incarceration rates. *(Am J Public Health. 2006;96:1727–1729. doi:10.2105/AJPH.2005.070839)*
Oxford House vs. Usual Care

Sober living had –

- half as many individuals using substances across 2 yr follow up as usual care
- 50% more likely to be employed
- 1/3 re-incarceration rate
Cost-benefit analysis of the Oxford House Model

- **Sample**: 129 adults leaving substance use treatment between 2002 and 2005
- **Design**: Cost-benefit analysis using RCT data
- **Intervention**: Oxford House vs. usual continuing care
- **Follow-up**: 2 years
- **Outcome**: Substance use, monthly income, incarceration rates
Mean per-person societal benefits and costs

<table>
<thead>
<tr>
<th></th>
<th>Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-month total costs</td>
<td>$20,000</td>
</tr>
<tr>
<td>24-month total benefits</td>
<td>$30,000</td>
</tr>
<tr>
<td>Difference (benefits - costs)</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

Net benefit for Oxford House: $29,022.00
Bottom Line

• The costs associated with Oxford House treatment are returned nearly tenfold in the form of:
  ↓ Reduced criminal activity
  ↓ Reduced incarceration
  ↓ Reduced drug and alcohol use
  ↑ Increased earnings from employment
Clinical Models of Long-term Recovery Management

- Mutual help organizations
- Peer-based recovery support services
- Recovery supports in educational settings
- Recovery community centers
- Sober living environments
- Clinical models of long-term recovery management
Recovery Management Check-ups
4-year outcomes from the Early Re-Intervention experiment using Recovery Management Checkups

- N=446 adults with SUD, mean age = 38, 54% male, 85% African-American
- randomly assigned to
  - quarterly assessment only
  - quarterly assessment plus RMC
- Recovery Management Checkups
  - Linkage manager who used motivational interviewing to review the participant’s substance use, discuss treatment barrier/solutions, schedule an appointment for treatment re-entry, and accompany participant through the intake
  - If participants reported no substance use in the previous quarter, the linkage manager reviewed how abstinence has changed their lives and what methods have worked to maintain abstinence

Source: Dennis & Scott (2012). Drug and Alcohol Dependence, 121, 10-17
Recovery Management Checkups

- Participants randomized to RMC were significantly more likely than control participants to:
  - Return to treatment at all (70 vs. 51%)
  - Return to treatment sooner (by 13 months vs. 45 months)
  - Receive more treatment (1.9 vs. 1.0 admissions and 112 vs. 79 total days of treatment)

- RMC participants also:
  - Needed treatment for significantly fewer quarters (7.6 versus 8.9 quarters)
  - Had more total days of abstinence (1026 versus 932 of 1350 days)

- Outcome Monitoring plus RMC generates less in societal costs than OM alone

Dennis & Scott, 2012
McCollister et al., 2013
Results 1
Return to treatment

• Participants in RMC condition sig. more likely to return to treatment sooner

Source: Dennis & Scott (2012). Drug and Alcohol Dependence, 121, 10-17
Results 4
Days abstinent (0-1350)

Of 18 vars tested, the only variables that predicted return to treatment was the intervention.
Cost-effectiveness analysis of Recovery Management Checkups (RMC)

- **Sample**: 446 patients with substance use disorders residing in Illinois

- **Design**: Cost-effectiveness analysis using RCT data

- **Intervention**: Outcome monitoring (OM) plus RMC vs. OM-only

- **Follow-up**: 4 years

- **Outcome**: Cost per participant, number of days of abstinence, number of substance use-related problems

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**Abstract**

**Aims**  This study performs the first cost-effectiveness analysis (CEA) of Recovery Management Checkups (RMC) for adults with chronic substance use disorders. **Design**  Cost-effectiveness analysis of a randomized clinical trial of RMC. Participants were assigned randomly to a control condition of outcome monitoring (OM-only) or the experimental condition OM-plus-RMC, with quarterly follow-up for 4 years. **Setting**  Participants were recruited from the largest central intake unit for substance abuse treatment in Chicago, Illinois, USA. **Participants**  A total of 446 participants who were 38 years old on average, 54% male, and predominantly African American (85%). **Measurements**  Data on the quarterly cost per participant come from a previous study of OM and RMC intervention costs. Effectiveness is measured as the number of days of abstinence and number of substance use-related problems. **Findings**  Over the 4-year trial, OM-plus-RMC cost on average $2184 more than OM-only ($P < 0.01). Participants in OM-plus-RMC averaged 1026 days abstinent and had 89 substance use-related problems. OM-only averaged 932 days abstinent and reported 126 substance use-related problems. Mean differences for both effectiveness measures were statistically significant ($P < 0.01$). The incremental cost-effectiveness ratio for OM-plus-RMC was $23.38 per day abstinent and $59.51 per reduced substance-related problem. When additional costs to society were factored into the analysis, OM-plus-RMC was less costly and more effective than OM-only. **Conclusions**  Recovery Management Checkups are a cost-effective and potentially cost-saving strategy for promoting abstinence and reducing substance use-related problems among chronic substance users.

**Keywords**  Chronic substance use disorder, cost-effectiveness analysis, economic evaluation, Recovery Management Checkups.
Costs and Effectiveness Estimates

- Cost on average (per participant) to deliver:
  - OM-plus-RMC: $4,889
  - OM-only: $2,705

- Incremental effectiveness of OM-plus-RMC:
  - 94 additional days abstinent
  - 37 fewer substance use-related problems
Telephone-based Continuing Care

In an RCT of extended case monitoring:

• Time to first drink and time to first three heavy consecutive drinking days was significantly longer for patients receiving case monitoring compared to the usual continuing care

• Case monitoring produced a cumulative cost savings for outpatient chemical dependence costs of $240.00 per person relative to usual continuing care

Hilton et al., 2001
Recovery Community Centers

- Recovery community centers
- Mutual help organizations
- Peer-based recovery support services
- Sober living environments
- Clinical models of long-term recovery management
- Recovery supports in educational settings
There are currently more than 80 centers operating nationally.
RCCs in New York and New England
Recovery Community Centers

• Expected outcomes for individuals utilizing these services include:
  – Measured accomplishments, increased coping skills, continued recovery and turnaround time following relapse, and increased recovery capital (SAMHSA, 2011)

• Data from 11 Vermont RCCs found:
  – Participants attending recovery centers for longer periods of time reported longer periods of sobriety
  – 46% of individuals reported past criminal justice involvement prior to coming to the centers and no incidents since (Vermont Recovery Network, 2014).
Recovery Supports In Educational Settings

- Recovery supports in educational settings
- Mutual help organizations
- Peer-based recovery support services
- Sober living environments
- Clinical models of long-term recovery management
- Recovery community centers
Recovery High Schools

• There are approximately 35 recovery high schools operating in 15 states

• A study of 17 recovery schools found that:
  – Students reported 266 days of abstinence since enrollment with continuous abstinence increasing from 20% during the 90 days before enrolling to 56% currently
  – Students’ opinions of the schools were high with 87% reporting overall satisfaction (Moberg & Finch, 2008)

• A study of graduates of recovery schools found that 39% reported no drug or alcohol use in the last 30 days and over 90% had enrolled in college (Lanham & Tirado, 2011)
Collegiate Recovery Programs

• There are almost 50 CRPs recognized by the Association of Recovery in Higher Education (ARHE)

• Data in two model programs suggests relapse rates are very low at approximately 4% to 13% in any given semester

Laudet et al., 2014
Texas Tech University: Single group Pre-Post Design

- To enter the CRC, students need to have 1 year of recovery, attend at least 1 12-step on campus meeting per week, and succeed in their classes

- evaluation of the program: 2004-2005, N=82, (18-53 yrs old)

- relapse rate within a semester was 4.4%; most maintained high GPA

Source: Cleveland et al. (2007)
Augsburg College
StepUp program

- Support groups and sobriety-specific houses
- Outcomes...

Annual avg relapse rate across 13 yrs = 13%, Down to about 7% in recent yrs
Rutgers Recovery House data
2008-2011

<table>
<thead>
<tr>
<th>School yr, divided by semesters</th>
<th>Students Living in</th>
<th>Relapse Numb</th>
<th>Avg. Yearly Abs</th>
<th>Avg. Relapse</th>
<th>GPA</th>
<th>Graduated or Returned</th>
<th>Graduated or Return %</th>
<th>Alumni Participation</th>
<th>Graduated</th>
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</thead>
<tbody>
<tr>
<td>2008, Fall</td>
<td>12</td>
<td>1.0</td>
<td>91.60%</td>
<td>8.40%</td>
<td>2.61</td>
<td>11</td>
<td>91.66%</td>
<td>N/A</td>
<td>7</td>
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<tr>
<td>2009, Spring &amp; Summer</td>
<td>13</td>
<td>1.0</td>
<td>92.30%</td>
<td>7.70%</td>
<td>2.79</td>
<td>13</td>
<td>100.00%</td>
<td>6</td>
<td>8</td>
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<tr>
<td>2009, Fall</td>
<td>21</td>
<td>0.0</td>
<td>100.00%</td>
<td>0.00%</td>
<td>3.09</td>
<td>20</td>
<td>95.24%</td>
<td>23</td>
<td>10</td>
</tr>
<tr>
<td>2010, Spring &amp; Summer</td>
<td>21</td>
<td>0.0</td>
<td>100.00%</td>
<td>0.00%</td>
<td>3.08</td>
<td>20</td>
<td>95.24%</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td>2010, Fall</td>
<td>23</td>
<td>0.0</td>
<td>100.00%</td>
<td>0.00%</td>
<td>3.08</td>
<td>22</td>
<td>95.65%</td>
<td>29</td>
<td>4</td>
</tr>
<tr>
<td>2011, Spring</td>
<td>24</td>
<td>4.0</td>
<td>83.33%</td>
<td>16.67%</td>
<td>3.05</td>
<td>21 (as of 6/10/1)</td>
<td>87.50%</td>
<td>33</td>
<td>4</td>
</tr>
</tbody>
</table>

Avg., Fall 08 to Spr 11          | 19                | 0.5         | 94.54%         | 5.45%       | 2.95| 17.83                 | 94.22%                | 21.6                 | 16 total |

Annual avg relapse rate across 13 yrs = 6%

Source: Laitman & McLaughlin (2011)
THE PHOENIX MULTISPORT MISSION

Phoenix Multisport fosters a supportive, physically active community for individuals who are recovering from alcohol and substance abuse and those who choose to live a sober life. Through pursuits such as climbing, hiking, running, strength training, yoga, road/mountain biking, socials and other activities, we seek to help our members develop and maintain the emotional strength they need to stay sober.

Explore The Photo Gallery

MIRZA PELJTO

"Phoenix has helped me redefine my identity in sobriety."

Join a Circle Of Support!

Please join our Circles of Support campaign to help keep our programs FREE to those in recovery from drug and alcohol addiction. Pledge Your Monthly Support to Phoenix Multisport!

Local Chapters

Denver

Colorado Springs

Boulder

Special Events

04.03  2233 Champa Street
Denver

Kettle Bell Bootcamp

Kettle bell training is a safe and effective system that offers a three in one workout that targets cardio, strength...

04.05  318 W. Colorado
Suite 102
Colorado Springs

VIEW CALENDAR
Whether you're in recovery, seeking help from any addiction, family or friend, register for IN THE ROOMS® now. You'll get exclusive free access to Daily Meditations, Speaker Tapes and Daily Online Video AA / NA meetings. There are over 294,349 members who are willing to share their experience, strength and hope with YOU.

Join Now!

InTheRooms is Fun, and FREE to Join!
Start having fun in Recovery now!
Don't worry, your anonymity will always be protected.

User Name
Email Address
Password

By clicking below I agree with the Terms of Use

register

Community Statistics
Comments: 9,602,385
Messages: 3,317,040
Photos: 728,906
Status Updates: 1,673,188
Discussions: 75,580
Speaker Tapes: 1,675

Do You Need Immediate Detox or Treatment Now?
We can HELP 24 Hours a Day

Click HERE to Get Help Now!

INHEROOMS is the world's largest Recovery Social Network.
Whether you're sober, clean, or seeking help with your drug addiction or alcoholism, we welcome you, and will connect you with other people who share YOUR addiction, in YOUR local area, and all across the world!
There is hope... You are not alone

Learn to Cope is a support group for parents and family members dealing with a loved one addicted to heroin, Oxycontin and other drugs. It began in 2004 when I needed a place to go to get support for our family and today our son is alive and well, so there is hope. Currently there is a crisis, an epidemic of OC and Heroin use in Massachusetts. Most of the kids are between 17-25 years old, some are in high school others have...
How do you know if you have been affected by someone's problem drinking?

How can I find a meeting?

What do healthcare professionals say about Al-Anon?

Friends and families of problem drinkers find understanding and support at Al-Anon meetings
Summary
Recovery Process and Rationale for RSSs

• RSSs open up new pathways to recovery and can enhance and extend the effects of professionally-delivered care by...

  – Helping change social networks towards those that model and support recovery in the communities in which people live

  – Helping build resilience, buffer stress, and increase recovery coping, confidence and motivation over the long-term

  – Help individuals build further “recovery capital” by providing supports in high risk educational environments like colleges/high schools, providing linkages to employment opportunities, and health/social services

  – Providing ongoing recovery-specific support at little cost reducing burden on professional health services while enhancing remission rates, thereby reducing health care costs, and appear cost-effective and worthy of investment
The ASAM Criteria
Achieving Lasting Change

June 3, 2016 – NADCP 22nd Annual Training Conference
Anaheim, CA

David Mee-Lee, MD
Chief Editor of The ASAM Criteria
Senior Fellow, Justice Programs Office, American University
Senior Vice President, The Change Companies®
Recovery in Addiction

“Recovery is the process through which severe alcohol and other drug problems (here defined as those problems meeting DSM-5 criteria for substance use disorder) are resolved in tandem with the development of physical, emotional, ontological (spirituality, life meaning), relational and occupational health.”

“The immediate goal of reducing alcohol and drug use is necessary but rarely sufficient for the achievement of the longer-term goals of improved personal health and social function and reduced threats to public health and safety.”

Dopamine Levels

Frontal Cortex

Nucleus Accumbens

VTA/SN

Healthy Brain

Meth Brain
Addiction is a *Brain Disease*

Prolonged Use Changes the Brain in Fundamental and Lasting Ways
ASAM Definition of Addiction

• “Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry.” (August 15, 2011)

• Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations.

• Pathologically pursuing reward and/or relief by substance use and other behaviors.

• Addiction is about brains – not just about behaviors.
The ASAM Criteria
Complications-driven Treatment

NO DIAGNOSIS → TREATMENT OF COMPLICATIONS → NO CONTINUING CARE → RELAPSE

Diagnosis-driven Treatment

Individualized, Clinically and Outcomes-driven Treatment

Patient/Participant Assessment
BIOPSYCHOSOCIAL Dimensions

Plan
INTENSITY OF SERVICE
Modalities and Levels of Service

Progress
Severity of Illness/Level of Function

Problems/Priorities
Severity of Illness/Level of Function

ASAM Principles of Addiction Medicine. 5th Ed. 2014.
The ASAM Criteria: Multidimensional Assessment

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional/Behavioral/ Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse/Continued Use/ Continued Problem Potential
6. Recovery Environment

The ASAM Criteria pp. 43-53
Criminogenic Factors and ASAM Criteria Dimensions

Criminogenic Factors
- Antisocial values, attitudes, behavior, personality
- Criminal/deviant peer association
- Substance Abuse
- Dysfunctional family relations

ASAM Criteria Dimensions
- Dimensions 3, 4, and 6
- Dimension 6
- Dimensions 1, 4, 5, 6
- Dimension 6
Biopsychosocial Treatment

*Treatment Matching: Modalities*

- Motivate: Dimension 4
- Manage: All six Dimensions
- Medication: Dimensions 1, 2, 3, 5 – MAT
- Meetings: Dimensions 2, 3, 4, 5, 6
- Monitor: All six Dimensions
**The ASAM Criteria**

**Treatment Levels of Service**

### Note:
Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.
Level 0.5: Early Intervention Services

• Individuals with problems or risk factors related to substance use, but for whom an immediate Substance-related Disorder cannot be confirmed

Opioid Treatment Services (OTS)

• Criteria for Opioid Treatment Program (OTP) (methadone); antagonist meds (naltrexone) and Office-Based Opioid Treatment (buprenorphine)
Withdrawal Management Services

Level 1-WM
• Ambulatory Withdrawal Management without Extended On-site Monitoring

Level 2-WM
• Ambulatory Withdrawal Management with Extended On-site Monitoring

Level 3.2-WM
• Clinically Managed Residential Withdrawal Management

Level 3.7-WM
• Medically Monitored Inpatient Withdrawal Management

Level 4-WM
• Medically Managed Inpatient Withdrawal Management

The ASAM Criteria, pp. 132-143
Level 1 and 2 Services

• Level 1  Outpatient Treatment
• Level 2.1  Intensive Outpatient Treatment
• Level 2.5  Partial Hospitalization

The ASAM Criteria, pp. 184-218.
Level 3 Residential/Inpatient

- Level 3.1 Clinically Managed, Low-Intensity Residential Treatment

- Level 3.3 Clinically Managed *Population-Specific High Intensity* Residential Treatment (Adult Level *Only*)

*The ASAM Criteria, pp. 222-243.*
Level 3 Residential/Inpatient

• Level 3.5 Clinically Managed, Medium/High-Intensity Residential Treatment

• Level 3.7 Medically Monitored Intensive Inpatient Treatment

The ASAM Criteria, pp. 244-279.
Level 4 Services

- Level 4 Medically Managed Intensive Inpatient

*The ASAM Criteria, pp. 280-290.*
Focus Assessment and Treatment

WHAT DOES THE PATIENT WANT? WHY NOW?

DOES THE PATIENT HAVE IMMEDIATE NEEDS DUE TO IMMINENT RISK IN ANY OF THE SIX ASSESSMENT DIMENSIONS?

CONDUCT MULTIDIMENSIONAL ASSESSMENT

WHAT ARE THE DSM DIAGNOSES?
Focus Assessment and Treatment

1. Multidimensional Severity/Level of Function Profile
2. Identify which assessment dimensions are currently most important to determine treatment priorities
3. Choose a specific focus and target for each priority dimension
4. What specific services are needed for each dimension?
Focus Assessment and Treatment

WHAT “DOSE” OR INTENSITY OF THESE SERVICES IS NEEDED FOR EACH DIMENSION?

WHERE CAN THESE SERVICES BE PROVIDED, IN THE LEAST INTENSIVE BUT SAFE LEVEL OF CARE OR SITE OF CARE?

WHAT IS THE PROGRESS OF THE TREATMENT PLAN AND PLACEMENT DECISION; OUTCOMES MEASUREMENT?
From Punishment to Lasting Change

*Implications for *Sanctions* and *Incentives*

1. Judges to mandate assessment and treatment adherence.
2. Treatment provider responsible to keep court apprised of any risk to public safety, not just passive compliance with attendance and positive or negative drug screens.
3. Sanction for lack of good faith effort and adherence in treatment, not for signs and symptoms of their addiction and/or mental illness.
From Punishment to Lasting Change

Implications for Sanctions and Incentives

4. If client is not changing their treatment plan in a positive direction, client is “doing time” and not “doing treatment and change.”

5. Incentives for clients can be explored/matched to what is most meaningful to them.

6. A close working relationship between client, judge, court team and treatment providers needed to actualize this approach.
Bibliography

- “A Technical Assistance Guide For Drug Court Judges on Drug Court Treatment Services” - Bureau of Justice Assistance Drug Court Technical Assistance Project. American University, School of Public Affairs, Justice Programs Office. Lead Authors: Jeffrey N. Kushner, MHRA, State Drug Court Coordinator, Montana Supreme Court; Roger H. Peters, Ph.D., University of South Florida; Caroline S. Cooper BJA Drug Court Technical Assistance Project. School of Public Affairs, American University. May 1, 2014.


