Dual Track Family Case Management and Monitoring:

The Key to Recovery from Addiction and Other Behavioral Disorders

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Case Management (CM) is a new concept in the addiction and behavioral health field intended to improve recovery rates for persons suffering from chronic diseases such as alcoholism, drug dependence, depression, and other addictive and behavioral disorders. In our practices, implementing a comprehensive case management plan significantly increases chances for sustained recovery, particular for those persons leaving inpatient treatment or other supervised living environments.

Our purpose in writing this article is provide family members, advisors and professionals with information regarding this important concept so they can better serve their families facing these disorders. For the reader familiar with our advice on using leverage to encourage compliance with treatment recommendations, the recommendations referred to include case management plans.

This article will describe the concept and common elements in a family case management plan, and explain why a bi-furcated case management model is needed to support recovery. We will also discuss the dual-track concept, where one person coaches the family in the creation and implementation of the plan and another person offers services to the identified person (IP) and reports on compliance. Quality resources, combined with this two-track model and leverage, offer both families and individuals the best chances for success.

A. Case Management – An Overview

Case management refers to the coordination and implementation of services on behalf of the patient. The "case" being managed is actually the alcoholic/addict, so a more accurate term might be "Patient or Addict Management". Prior to leaving treatment, a patient is given a list of activities to engage in to support continued abstinence and stable recovery. These activities comprise a "post-treatment plan", "discharge", or "case plan".

- If addicts or alcoholics in early recovery would follow a suggested discharge plan and work to find productive activities in the community, the sustained abstinence rate for patients leaving treatment would be higher.

The problem – and it is a significant one – is that patients leaving treatment do not follow these plans, or attempt to engage productively in the world, and many of them relapse.

- This is called the **"Compliance Problem"**.

In order to improve recovery rates, some treatment centers are advocating case management – having a case manager encourage the addict to attend the activities specified in the post-treatment plan and otherwise support his/her recovery. The idea is to improve compliance on the part of the addict with post-treatment plans through case management.

Case management has existed for years in the public sector but is new to addiction treatment, a field historically focused on inpatient treatment. Upon leaving treatment, patients were given their post-treatment plan, a medallion, hearty hugs, and minimal support. Under criticism for high relapse rates, treatment centers began to look at the only two models of successful addiction treatment - those provided by airlines for pilots and medical boards for doctors.

- Both of these programs implement case management systems for several years, one reason why they are so successful.

To provide more continuity of care, treatment centers began adopting the concept of post treatment case management – either by providing services themselves or recommending outside case managers to patients (and sometimes their families).

Case management services range from simply overseeing and assuring attendance at specified activities in the post-treatment plan to far more intensive and personalized services, such as live-in sober companions and locating recreational or vocational activities for the patient.

The list of case management activities is long and comprehensive. If continued over several months– if not years – case management can, indeed, improve recovery rates. Before examining the types of services that can be offered, it is important to know the barriers to effective implementation of case management services, which will be discussed in the next section.

B. Barriers to Effective Implementation of Case Management

Case management makes theoretical sense, but in practice it has several serious limitations discussed in this section. Fortunately, there are ways to minimize or eliminate these barriers, but it is important to know what they are in order to respond as they arise.

1. The Addict Must Agree to Case Management

The addict has to agree to be managed. It is a voluntary activity on his/her part. Many people coming out of treatment want to decide on their own what they chose to do for recovery. They may agree to a case manager if the treatment center helps educate them on the service during treatment, but the patient may balk at certain elements such as drug testing or signing releases. The addict can decide to terminate or ignore the case manager with no consequence, a serious flaw in the effort to improve outcomes.

2. The Case Manager Primarily Works for the Person with Addiction

The case manager, in most instances, works for the addict yet also tries to manage family expectations. The family may have certain goals in regard to case management and the case manager is responsible for ensuring those are met, while aligning him or herself with the patient.

- Regardless of the source of payment for services, the case manager can often be vulnerable to the whims of a patient in early recovery, who may want to terminate releases, refuse drug tests, and remain non-compliant with particular parts of the case management plan.
- Alternatively, the family may pressure the case manager to implement their agenda, which causes the addict to become resentful and feel controlled.

One person assigned to work with a family system is torn between the interests of the addict and his or her family members. This makes it difficult for both the addict and family to receive crucial services.

3. The Scope of the Case Management Plan is Too Narrow or the Timeframe of Services is Too Short

Addiction is chronic disease that must be managed over the long-term with a Recovery Management Plan. Inpatient treatment is only one element of the plan and it must fit into the overall strategy for recovery.

- The plan begins with an intervention model that has the best chance to lead to long-term sobriety, patient appropriate treatment, a family systems approach and a post-treatment plan that reintegrate the addict into his/her family.

Case management plans tend to be focused only on short-term recovery and coordinating services specific to inpatient treatment for the addict – not on the more global connections to family and community or identifying asset based strengths (versus problem or deficit based weaknesses). While this is not the place for a lengthy discussion on the value of this holistic model, be aware of the difference between an overall Recovery Management Plan and an individually focused post-treatment case management plan.

Case Management Services

Examples of case management services that need to be continued for at least a year for many young adults"

- Assigned case manager to provide guidance, support and accountability
- In person and telephonic meetings
- Education on addiction and other behavioral health issues
- Location of and participation with patient in healthy recreational or physical activities (hiking, yoga, art classes, etc)
- Assistance with patient's development of educational and vocational interests
- Help with life skills activities (ex. budgeting, cooking, time management)
- Sober coaching
- Drug testing and other monitoring
- Crisis management, including after-hours support
- Supportive transitions to work, school and volunteer activities

Families will indicate interest in the above-listed services before a patient goes into treatment or when he or she first comes out of treatment. As the addict appears "better," families can be quick to reduce or end services (the mistaken misperception that the addict will be "fine). The highest success rates for case management come from pilots and physicians, where services are in place over the course of several years (more in Section D).

4. The Family System is Ignored

The addict's relationship to his/her family is a very important factor in recovery. These relationships need to be improved and strengthened so the family can be *positive enablers of recovery*. Families are traumatized by addiction, have a superficial understanding of what they are up against, and are provided inadequate services by treatment centers.

Examples of family services:

- Education on disease and effective coping strategies
- In-person and phone counseling
- Assistance managing crisis situations (relapse and other)

- Referrals to family-focused resources
- After-hours access to a clinical resource for emergency situations
- Advice on the use of "leverage" to encourage compliance by the addict
- Helping family members come to a common understanding as to how to best support the addict in his/her recovery

These services also apply to interactions with trustees, family offices, or other entities involved with the addict.

For families providing financial support for their addict's residential care, advice is needed regarding appropriate amounts, as well as how to use such support as one form of incentive to comply with treatment recommendations. This topic tends to be a leading source of conflict in early recovery and one where the family support professional can be very helpful to parents and other interested relatives.

5. Cost

There is no mechanism to pay for case management. Insurance companies do not pay for these services. Some treatment centers include it in their treatment fee or refer patients out to generic providers who provide minimal services. Because treatment is so expensive, many families are reluctant to spend more money on post-treatment services. However, because this phase – the post-treatment phase – is so important, more money will need to be invested in your loved one's recovery. Investing your money wisely is the key.

Two suggestions:

- First, you can scale services provided by the case manager in accordance with your budget. You may only be able to afford drug/alcohol testing, telephone reports regarding attendance at specified activities, and a once a week group for parents. Go with what you can afford – but select what is most helpful in supporting recovery.
- Second, understand the stages of recovery so you are solidly grounded in the clinical reasons for maintaining case management over many months and know why it is worth the cost. (See the next section for more on the recovery stages.)

In concluding this section, as you are likely aware, our approach is family systems oriented with emphasis on recovery plans to manage the disease of addiction over the long-term. And, in order to overcome the defects in case management as practiced by most providers, we follow the pilot/physician model in using leverage for compliance through a dual-track system. (See Section D)

C. The Stages of Recovery Take Much Longer Than 28 Days

This section discusses the stages of recovery and explains why 28 days in an inpatient treatment center does not provide addicts with a sufficient time period to achieve stable recovery. By understanding the stages of recovery, parents and advisors will know that treatment occurs over many months, and therefore, compliance with treatment recommendations by patients is similarly required. It also helps to know the recovery stages when talking with a treatment counselor about a loved one.

Recovery is a Process, Not an Event

In 1985, Stephanie Brown, PhD, a Stanford addiction researcher, wrote a book in which she

outlined the stages or recovery as a developmental process and identified the tasks of treatment for the patient and the therapist at each stage taking place over many months. **She found that alcoholism recovery is an ongoing process, *not an event*.** Her book on treating the alcoholic is based on her dissertation at Stanford.[i]

It is a fact that it takes much longer than 28 days to reach stable recovery, even for the highly motivated. Most people know nothing about treatment – what the goals are, how those goals relate to abstaining from use, and the ultimate goal of leading a sober life.

- Interestingly enough, even patients know little about underlying reasons for engaging in activities in treatment.

Family and friends need to be educated on this topic in order to understand whether or not their loved one is making progress in treatment, what the barriers are to recovery, and how to plan for what the next steps may be for treatment to be successful.

A recent article in a professional addiction journal discussed the developmental approach to recovery and the six stages to achieving stable remission[ii]:

- Transition — *Recognition of Addiction*
- Stabilization — *Recuperation*
- Early Recovery — *Changing Addictive Thoughts, Feelings and Behaviors*
- Middle Recovery — *Lifestyle Balance*
- Late Recovery — *Family of Origin Issues*
- Maintenance — *Growth and Development*

In our experience this is a <u>two to five-year process</u>, depending on the progression of the disease, severity of use, and co-occurring conditions (i.e. trauma, abuse, learning, mental illness).

Let's look at the first three stages – **Transition, Stabilization and Early Recovery** – in detail from a treatment perspective for a better understanding of how the addict progresses through the recovery process.

1. Transition: *Recognition of Addiction*

Inpatient treatment includes recognition of addiction, although partial or full recognition occurs prior to entering treatment for many. Recognition might be referred to in the context of Step One in the Twelve Steps:

We admitted we were powerless over alcohol – that our lives had become unmanageable.

Family members may hear about compliance with this process (he's completed Step Three), but they know little about their loved one's commitment to recovery (he wants to stop using cocaine, but wants to keep drinking beer and smoking weed).

- This is critical information that should be communicated to you by your loved one's treatment counselor because it affects the content of the post-treatment case management plan.

If you, as family members, do not know what the problem is, you will not know what is needed for on-going recovery after treatment. As the funder – the buyer of services for your

loved one – it is reasonable to be told this information.

2. Stabilization: Recuperation Stage – Five Tasks to Facilitate[iii]:

- Achieving Recovery From Withdrawal
- Interrupting Active Preoccupation
- Creating Short-Term Social Stabilization
- Learning Non-Chemical Stress Management
- Developing Hope and Motivation

Parents must get rid of the idea that addiction is episodic and resolvable in 28-day inpatient treatment programs. Just looking at Stage Two tasks should be sufficient to achieve this change in expectation as to what can be accomplished in treatment (information on brain alteration due to addiction reinforces this fact).

- Understand that your loved one leaves treatment *not stabilized*, with few internal resources to resist relapse.

Wouldn't it be nice to find out from the treatment center how your loved one was progressing in these five tasks? To reduce this risk, the patient leaving an inpatient setting needs the support and encouragement built into the Family Case Management system to navigate the five stabilization tasks.

3. Early Recovery: The Process of Changing Addictive Thoughts and Feelings

This early recovery activity is critical to the fundamental change necessary to both stabilize abstention from use and build a sober and more serene life. By this time in the recovery process, most of the physical cravings from detoxification are minimal or gone (except for marijuana or benzodiazepines, like Xanax).

- What we are talking about here is the mental and psychological desire to use drugs, alcohol, and engage in other addictive activities.

For family members, the process of *changing addictive thoughts, feelings and behaviors* is obviously a good idea, but how does that happen? In a recent article in Counselor Magazine, the writer noted that adhering to treatment goals and positive interactions with the therapist often set the stage for significant breakthroughs in attitudes and commitment to recovery.

The core principle of compliance is: *Bring the body and the mind will follow!* It is the commitment to participation in recovery activities – the case management plan - that leads to change. That commitment can come from outside pressure on the addict or from internal motivation developed over time while in recovery.

D. Understanding the Pilot/Physician Model

The only treatment programs with first-class success rates for continuous abstention over several years are the programs run by medical boards for doctors and by airlines for pilots. You, as a parent, advisor, or other concerned family member, need to be familiar with their outcomes and know why they are so successful.

While pilots do have high recovery rates, most of the literature now focuses on the success rates of the medical boards' physician health programs (PHP) for addicted doctors in each

state. These programs present reliable data because of the rigorous and continuous oversight by state regulators and systematic testing for drugs and alcohol use.

Outstanding Long-Term Recovery Rates for Physicians and Pilots

Let's start with this well-kept secret:

- ***Doctors have first time continuous abstinence rates of 78% at five years!***
- ***92% of airline pilots are continuously abstinent at two years!***

No other group approaches these recovery rates, and in fact, studies show one-year continuous abstinent rates at less than 25%.[iv]

Three elements of these programs relevant to effective implementation of a case management system for the family addict are:

- Using leverage or pressure to encourage adherence to the recovery/case plans by using the threat of license revocation for non-compliance.
- A "two track" case management system in which the airlines/medical boards dictate and oversee the addicted employee's treatment activities (the case).
- Requiring their employees to sign a contract in which they agree to engage in specific post-treatment recovery activities (again, the case), including drug testing, to assure both accountability and clarity regarding the agreed to activities.

(See the articles list in the appendix for more information on leverage. What follows is a brief overview.)

1. The Importance of Using Therapeutic Leverage (Pressure)

As mentioned, medical boards use the threat of license revocation as leverage, or pressure, to obtain compliance by physicians with their program requirements.

- Pressure is maintained for up to two years to assure that doctors are well on their way to recovery.

This type of leverage is very effective and we have been helping our clients – parents, family leaders, trustees, and business owners – find similar pressure points to encourage their addicts to enter treatment and comply with post-treatment recommendations, including case management plans.

We emphasize ***Leverage First*** because without leverage, any intervention strategy, including a post-treatment case management plan, has little chance of succeeding. We also want to stress that leverage needs to be used incrementally, case specific, and almost never as an abrupt and all-or-nothing tool. Employ leverage, or the implied threat of leverage, in a respectful and loving manner.

For more from professionals on the benefits of coercion in supporting recovery, I offer the following quotes from experts:

- Sally Satel, M.D. *For Addicts, Firm Hand Can Be the Best Medicine*. The New York Times, Aug.15, 2006.

  A myth is that the addict must be motivated to quit – that, as it is often put, "You have to do it yourself." Not so. ***Volumes of data attest to the power of coercion in shaping behavior.*** *With a threat hanging over their heads, patients often test clean.*

- Susan Merle Gordon. *Relapse & Recovery: Behavioral Strategies for Change*. Caron Foundation Report. 2003: p. 18.

  Internal motivation is a more powerful predictor of recovery than external motivation. Moving from external motivation to internal motivation is a long process. Therefore it is ***critical for external pressure to continue until this transition is fully underway, if not complete. The failure to follow this advice is a major cause of relapse.***
  (Paraphrased from report.)

This expert advice is a caution for all families who are waiting for their addicts to "want to recover on their own". Without the help of family and friends, the addict will continue to suffer as the disease progresses.

- Remember that one of hallmarks of addiction is the loss of control over addictive substances or behaviors, regardless of whether it occurs daily, weekly, or monthly.

For families, the options are not leverage or choice – *they are leverage or neglect.*
You need to take steps to help your addict sustain initial recovery and this requires using pressure to encourage compliance with case management plans.

Treatment Center: Duty of Loyalty to their Patients
Remember that you will rarely be told by a treatment center to use leverage to assure compliance by your addict's case management plan, as they represent the patient and what the patient wants – their loyalty is to patients, not to the family. So you will need to find your own professional help and advocate – your own family support – to help encourage your addict to comply with his/her case management plan through the use of leverage.

2. Family Recovery Management
While the focus of discussion in this article is on case management for the individual leaving treatment, our preference is to describe a recovery management plan that encompasses the entire process – from the intervention phase to stable recovery – and incorporates the family, as well as the addict. In doing so, we will discuss the importance of and process whereby the family (employer, trustee) uses pressure to assure compliance with all treatment recommendations, including the case management plan.

Physicians Treatment Programs Unique
Addiction treatment is the only field of medicine where physicians receive different treatment than other population groups.

- It is different because medical boards oversee and dictate the terms of the recovery program for doctors.
- Their program is also different in that it is both better in quality and longer in duration – much better treatment over many months!

The pilot/physician programs could be called the *medical boards and airline recovery programs*, because these organizations manage and direct the recovery programs for doctors and physicians.

Families, working with qualified addiction professionals providing their guidance and

expertise, must also find ways to manage and direct their addicts' recovery program over the long term, just as the medical boards and airlines do for their doctors and pilots.

- As this is a much different approach than current practice familiar to many, we will discuss in more detail how we apply the medical board program for doctors to other groups in what we call **The Dual Track Family Recovery Management Program for Addicts/Alcoholics**.

Our conceptual and service model is to view individual case management as a component of the larger management plan to address addiction as a chronic disease over the long-term:

Medical Board (PHP) Track – Patient Track

Without going into detail, the most important part of the PHP program is that it is a TWO-TRACK system:

- **Employer Track** USES LEVERAGE

-Medical boards dictate recovery activities and receive progress reports

- **Employee Track** COMPLIES WITH LEVERAGE

-Physicians have their own recovery; treatment, aftercare, 12-step meeting, therapy, 2-3 year process

Family Recovery Management Two-Track System

When adopted by families and their addicted loved ones, the system is:

- **Family Track** USES LEVERAGE

-Professionals working with families encourage recovery activities and receive progress reports from treatment centers – professionals oversee this process

- **Addict Track** COMPLIES WITH LEVERAGE

-Addict has his/her own recovery: treatment, aftercare, positive life development activities, 12-step meeting, therapy, 2-3 year process and assigned case manager to help guide him or her through the process

We call this **DUAL-TRACK FAMILY RECOVERY MANAGEMENT**.

3. Dual Track Family Recovery Management – What is it?

Family Track

- The family is helped by a professional to support their loved one's recovery ("positive enabling")
- Professional is independent of addict
- Seeks compliance by the addict
- Sophisticated and measured use of leverage to change behavior of addict

Addict Track

- Addicts have their own recovery resources
- They have an assigned case manager to help guide them through early states of sobriety and to participate in activities, from monitoring (ex. drug testing) to development-focused interests (ex. mountain biking)
- Compliance with the case management plan means continued emotional and financial support

To reiterate, this program is *professionally assisted support for families to improve treatment outcomes*.
Professional assistance for families includes working with families to:

- Discuss the problem family member
- Determine effective intervention strategies
- Identify sources of leverage to encourage treatment compliance, and
- Interact with family members to change the "system" from indirectly or directly supporting the addictive process to supporting recovery (learn *positive enabling* and healthy co-dependence)

Note that the family can't merely use leverage to get their addict into treatment and then ease off, thinking all will be okay (a common mistake). Leverage or pressure must continue to be applied over months, as treatment is only the beginning of the recovery process. Stabilization of urges and emotions occurs well after 28 days.

Common elements of the successful PHP/pilot programs, as applied to affluent family systems are:

- Emphasis on open communication between all parties (complete releases)
- Immediate response if relapse
- Leverage used to assist in implementing a structured recovery program
- Drug-testing
- Pro-active therapeutic "community" (counselors, sponsor, meetings, etc.)
- Contract – specified recovery activities and relapse plan

All of these elements are part of a recovery management strategy supported by the family and implemented collaboratively with their addiction counselor.

You may have heard the slogan, ***Recovery Begins After Treatment***. For both the pilot/physician and family recovery management programs, the emphasis is on recovery activities occurring *after* inpatient treatment.

- As highlighted throughout this article, one of the leading causes of relapse is non-compliance with treatment recommendations.

Therefore, the Family Recovery Management Program (FRMP) should first be thought of as a means to encourage the family addict to comply with post-treatment recommendations – the Case Management Plan.

E. The Contract Between the Addict and Oversight Entity – The Recovery Contract

The Recovery Contract sets out the activities the addict will engage in after treatment. Medical boards use it for addicted doctors. This agreement is another reason for the high PHP success rates because it leaves no room for debate as to what the physician's recovery activities are and what constitutes compliance. As Drs. Skipper and DuPont, two physicians overseeing PHP programs, state:

> *Regardless of referral source or condition, all physician participants were required to sign a contract specifying the nature and duration of their treatment and monitoring, as well as the consequences for failing to abide by the contract.*

This type of contract can be used prior to treatment as an intervention tool to provide feedback in the event of non-compliance or at any other stage of the recovery process. For the families, this written agreement takes different forms, is individualized for each family situation, and has a plan in the event of relapse. The contract creates its own "leverage" or "pressure" because there are consequences to the addict if he/she fails to comply (we call this "self-executing leverage").

For the post-treatment case management plan, the terms might include the following:

- 12-Step or self-help group meetings
- Biological fluid and breath testing
- Psychiatric and psychological monitoring
- Chemical dependency continuing care group
- Monthly evaluations
- Additional optional provisions case specific (sober companion, work, attend intensive outpatient groups, school, other positive recreational activities)
- Relapse plan

In exchange for agreeing to the above, the family usually puts in the agreement or otherwise separately states that financial support, access to family resources, and participation in family activities is contingent on adhering to the agreement.

Is this too much to ask of the addict to sign a contract? In our view, addiction has taken its toll through burned relationships, wasted money, and self-destruction. It is time for transparency and accountability if the addict wants financial support and to attend family gatherings. This is not a personal attack on the addict – it is "evidence-based", as stated in the following:

- *Some clinical people are uncomfortable with this idea**, but the research shows that some accountability in the environment is very good for people**. That includes, for example, drug testing with immediate, certain consequences such as you see in drug courts.*[v]

The contract is clinically driven and one important reason why doctors have such high recovery rates, so, no, the addict is not being punished; the family is following recommendations as to what works!

In closing this section, we have reviewed the importance of using leverage to encourage compliance with case management plans, our dual track process where the family track exercises influence on the addict track, and the recovery contract as a means to assure accountability and clarity by the addict. This is the way we help our client families to effectively implement case management.

Conclusion – Educated Family Members Make a Difference

One overriding theme in this discussion of case management is that addicts need educated and active family members to help them comply with recovery plans. Not only do families need to be educated, they must also find qualified professionals to assist them in using leverage, developing a post-treatment contract, and managing the recovery contract.

Implementing a comprehensive case management plan significantly increases chances for sustained recovery, as proven by the first class success rates for medical board programs for physicians. We hope this article provides families, advisors and professionals with key information regarding this important concept so they can better serve their loved ones/clients challenged by addiction and other behavioral disorders.

Footnotes

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[i] *Unraveling the Mystery of Personal & Family Recovery: An Interview with Stephanie Brown, PhD* Feature Articles - *Treatment Strategies or Protocols* Written by William White, MA Monday, 15 August 2011 14:22

[ii] *Recovery From Addiction, A Developmental Model, Part One, It's All in the Journey*, Sept. 2008, p 8.

[iii] Ibid, p 12

[iv] White, William on outcome rates, Counselor Magazine, 6/05, p. 5.

[v] White, Kurtz, & Sanders, 2006. Recovery Counselor Magazine, December 2011 *Addiction Treatment Circles of Recovery: An Interview with Keith Humphreys, PhD* By William L. White, MA Counselor Magazine, December 2011.