



Relapse Policy
San Mateo County
Alcohol and Other Drug Services

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The Policy

- Continued alcohol and/or illicit drug use or relapse during treatment “is viewed as part of a chronic condition that can be treated”
- Efforts must be made to retain people in treatment despite continued AOD use “in order to enhance relapse prevention interventions and use relapse as an opportunity for consumer reassessment and reengagement”

Relapse Policy (cont)

- 1) “Consumers will not be automatically discharged for relapsing from current treatment level of care”
- 2) Consumers may be discharged if they engage in illegal activities, or activities listed under Title 9 that compromise their safety or the safety of others (e.g., possessing, selling, or sharing **on-site** at a provider facility, residential and non-residential).

Relapse Policy (cont)

- 3) Upon relapse, “a reassessment of the consumer’s current status must be initiated to determine if the consumer needs a modification to his/her treatment plan, including a different level of care”.
- 4) “Should a change in level of care be required, the provider shall orient the consumer to the change, provide all pertinent information to the receiving provider and facilitate the transition to the appropriate level of care”.

What is your agency's relapse policy? (discussion)

- Is it in writing?
- Are there clear lines of authority?
- Are the same factors considered for each person?
- Do clients with more sophisticated negotiating skills get treated differently?

The Rocky Road of Recovery



- George Vaillant tracked patients in an A.A.-based hospital program for 8 years and compared their outcomes with alcoholics who received no treatment. He was disappointed:
- “It seemed perfectly clear that. . . I was working for the most exciting alcohol program in the world. But then came the rub. Fueled by our enthusiasm, (we) tried to prove our efficacy (or effectiveness). Our clinic followed up our first 100 ...patients. . . [and found] evidence that the results of our treatment were no better than the *natural history of the disease*.”

G.E. Vaillant, *The Natural History of Alcoholism*, Harvard University Press, Cambridge, MA, 1983.

(Thus...) **Success is the Exception**

- **60% do not complete their treatment episode**

Percentage who complete...

- Hospital residential highest (69%) (complete)
- Detoxification (62%) (complete)
- Short-term residential treatment (61%)
- Long-term residential treatment (43%)
- Intensive outpatient treatment (38%)
- Outpatient treatment (36%)
- Methadone lowest
- Completion rates were lower in longer-term and less structured settings

- **Who completes:** no prior treatment history (15% more likely), over 30 years of age (10% more likely), Caucasians, alcoholics (rather than users of illicit drugs), high school graduates (18% more likely), men (5%).

2004 Treatment Discharges: Treatment Episode Data Set (TEDS)

Relapse and the Literature

- The relapse literature is focused on *post-treatment* (not *in treatment*)
- Experts cannot agree on
 - Whether there is a difference between a minor slip and a major resumption;
 - Whether resumption or continuation of *any* substance constitutes a relapse;
 - Whether one has to be in recovery to relapse;

Administrative Discharge by the numbers

- 18% (288,000) of 1.6 million people admitted to publicly funded treatment were thrown out/administratively discharged (49% complete, 24% leave AMA, 9% transferred)
- Highest modality of administrative discharges were methadone programs (30%), followed by long term residential (25%), and intensive outpatient (23%).

SAMHSA, 2002, Treatment Episode Data Set (TEDS)

What we call it (all in a name)

- Discharge for cause
- Discharge upon staff request
- Administrative Discharge
- Disciplinary Discharge
- Throw out



Why we discharge for relapse ...

- To protect the integrity of the treatment environment (the therapeutic milieu thought to be critical---but fragile, and must be protected... sacrifice one for all)
- Make best use of limited resources (clients who act out/use are wasting limited resources)

Slides 11, 12, 14 and 15 adapted from White, W., Scott, C., Dennis M., & Boyle, M.

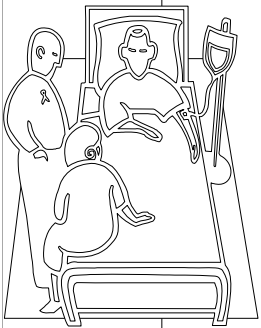
"Its Time to Stop Kicking People Out of Addiction Treatment, *Counselor*, April 2005.



Why we discharge for use (cont)

- Protect program reputation (programs that tolerate using will lose the respect of larger community and more compliant clients)
- So programs don't enable clients (protecting clients from the repercussions of their behavior protects and enables clients and encourages further use)
- Protect other clients from becoming vulnerable to relapse if relapse is tolerated in the community
- To protect recovering staff (relapse, triggers, etc.)

Why re-think discharge of clients for AOD use?



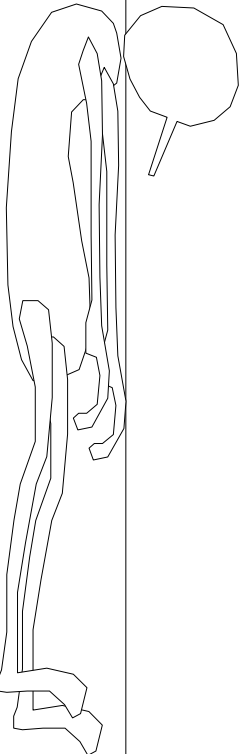
- It is unprecedented in the health care system (refuse to treat or abandon clients with a chronic condition for exhibiting behaviors for which one was admitted to treatment)*
- Long term recovery is best supported by *patience* and *support* rather than *punishment* and *abandonment*

*Drug Dependence, A Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation. Journal of American Medicine Association October 4, 2000 Vol 284, No. 13 (1693).



Re-thinking (cont)

- Administrative Discharge links treatment provider with CJ sanctions, punitive actions, and more loss (family rejection, re-incarceration, homelessness).
- Despair is increased, hope/optimism is decreased (and a core element of successful treatment is hope)
- Clients with a history of trauma are vulnerable to re-traumatization



Re-thinking (cont)



- Staff may act out feelings of powerlessness, disappointment, frustration via a discharge disposition
- Thus, recovering staff may need to process own vulnerability in working with people in relapse (facilitate an environment open to discussion of counter transference)

Learning from Nicotine Addiction: A Parallel Process

- Eventual success in quitting smoking is associated with *multiple treatment attempts* (15% - 20% 1 year quit rates)
- Smokers *most often relapse*, but increase length of abstinence with each quit attempt
- Re-treatments can be short and inexpensive (patch, helpful hints)
- Keeping smokers engaged or re-engaged in treatment creates a new habit: not smoking
- *Of course*, persons who return to ETOH, cocaine, and heroin addiction have more severe short term consequences than smokers



Keep 'Em In Treatment

- Length of stay in treatment is the single strongest predictor of post-program success



Keep 'Em in Treatment (continued)

- Treatment retention is associated with more favorable post-treatment outcomes: lower drug and alcohol use, reduced criminal behavior, and increased employment

Condelli & Hubbard, 1994; Gossop, Marsden, Stewart, & Rolfe, 1999; Grella, Hser, Joshi, & Anglin, 1999; Hubbard et al., 1989; Joshi, Grella, Hser, & Anglin, 1999; Simpson, Joe, & Brown, 1997; Simpson, Joe, Fletcher, Hubbard, & Anglin, 1999).

Remaining in treatment for an adequate period of time is critical

- The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment
- *Strategies to keep people engaged in treatment are critical*

NIDA, *Principles of Drug Addiction Treatment: A Research Based Guide* (Principle #5)

Continuity of Care

- The optimal *continuity of care plan* is to keep people maintained in a single and consistent treatment program
- When addicted persons are discharged for exhibiting the behavior they are seeking treatment for, continuity of care is compromised
- However, when discharge is inevitable: a client at a single program is part of and entitled access to the system-wide continuum of care

Strategies: Making the culture shift

- *Work to re-conceptualize and re-define* the role and meaning of relapse in the treatment process
- *Work to re-view* addiction (in many clients) from an acute to a chronic condition (which may include relapse)
- *Work to re-train* so that more strategies to deal with relapse are part of the clinical tool box

Acknowledge the influences on treatment culture

- Drug Courts, parole and probation officials, CPS, SACPA/Prop 36 have all impacted treatment philosophy, treatment policy and procedures, and treatment dispositions
- A re-focus on how to best serve the client in relapse may help reframe *the agency's treatment mission* in regards to other stakeholder's priorities

Strategies to consider

- Pre-treatment orientation (Tx Readiness)
- Re-focus time/energy on motivation and engagement strategies
- Review discharges (wrong level of care, poor assessment, lack of client support or supervision)
- ASAM Treatment Matching or consider alternative milieu



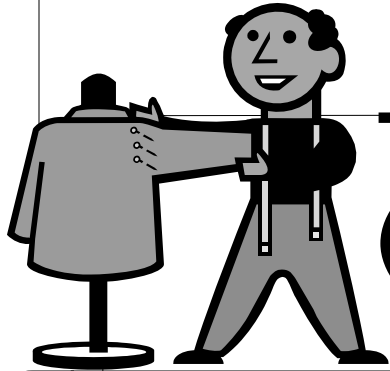
"Off hand, I'd say you're suffering from an arrow through your head, but just to play it safe, I'm ordering a bunch of tests."

Strategies to Consider (cont)

- Develop alternatives to residential placement/other treatment milieus
- Develop improved clinical supervision of counselor staff
- Medication (addressing symptoms that prevent clients from being engaged)
- “Hate the condition, Love the person”
- Develop a contingency relapse plan (consider including client in plan)

Maintaining the Treatment Milieu

- People not in treatment are not working on their recovery (persistence pays)
- Balance between not exiting clients and maintaining treatment milieu is key
- Process by which relapsers work back into the community and its graces is critical---for both community and individual success



Tailored Community Response (walking the fine line).....

- Develop consequences that are...
 - A) (publicly) onerous enough so that others are not given unspoken permission to relapse, while
 - B) not so onerous so as to drive relapsers out of treatment
- Tailor public/peer consequences to promote individual growth

Vigilance and Relapse Prevention During the Treatment Episode:

- **Possible drug use during treatment must be monitored continuously.** The objective monitoring of a patient's drug and alcohol use during treatment, through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.

NIDA, *Principles of Drug Addiction Treatment: A Research Based Guide*
(Principle #11)

Drug Testing: From 'gotcha' to clinical tool

- Reframe drug testing
 - Celebrate clean tests with the community
 - Employ as carrot rather than stick
 - Opportunity to reinforce positive recovery
 - Positive drug tests viewed as opportunity for change/growth/re-commitment to program



Learning from Relapse is Critical

- Immediately cease all *illicit* drug/alcohol consumption. Remove self from situation. Seek supportive help
- Analyze preceding events to avoid future relapses
- Re-commit to program of complete abstinence

Dejong, W. **1994**. Relapse Prevention: **An Emerging Technology** for Promoting Long Term Abstinence. *The International Journal of the Addictions* (29)6.

When discharge occurs

- ***Always Refer.*** Transfer level of care (service modalities, programs, systems)
- Utilize supervision to understand and process the event



When discharge occurs (continued)

- Use clinical process (root cause analysis or other method) to consider *program improvement* (rather than *individual failure*)



"AND HERE'S OUR NEW AND IMPROVED VERSION."

A referral is part of each and every discharge.....

- Provider must share all necessary and permitted (release) documentation and communicate clearly with the receiving clinician/agency;
- Bed can be held (and paid for by county if requested)
- Referrals are not only facilitated, but a follow-up is critical

Immediately after discharge

- The most vulnerable time for clients, whether in relapse or not*
- An early relapse does not necessarily foretell disaster or a failed recovery*
- Clients need more attention, time, and structure following relapse (not less)

*Br Med J (Clin Res Ed) > v.294(6584); May 30, 1987

Staff in Recovery, Staff Familiar with Recovery Process and 12- Step...

- Most often have a wisely developed therapeutic stance: compassion, understanding, and firm commitment to the importance of total abstinence
- Recognize and understand destructive impact of dwelling on shame and failure
- Will work to integrate flexible relapse policy with an established welcoming policy

Relapse Prevention Models

- CENAPS/Gorski and RP/Marlatt
 - Two systemic interventions to prevent relapse and support recovery. Both.....
 - based on cognitive-behavioral interventions
 - focus on importance of life-style changes to maintain long-term recovery
 - break the cycle of “recovery to relapse”

Gorski and Relapse (and) Prevention

CENAPS-Center for Applied Sciences

- Developed as clinical initiative
- Based on a disease model of addiction
- Adheres to a 12-step philosophy
- Developed for motivated but relapse-prone individuals

Gorski (continued)

- Addict's brain dysfunction interferes with ability to think clearly, manage emotions, and regulate behavior
- Thus, process of relapse begins prior to a return to drug/alcohol use (hallmark of his work)

Gorski (continued)

The client's mistaken view:

- Relapse prone patients are unable to access treatment because of three mistaken beliefs:
- 1. Relapse is self-inflicted (not the model most experts now adhere to)
- 2. Relapse is an indication of treatment failure: (1/2 to 2/3 of treated people relapse)
- 3. Once relapse occurs recovery will never really happen (relapses handled appropriately help reduce the risk of future relapses)

Marlatt and Relapse (and) Prevention

RP-Relapse Prevention

- A cognitive-behavioral/social learning approach
- Developed in a research setting
- Addiction is learned habits, consisting of maladaptive thoughts and behaviors
- The goal is to prevent relapse or prevent a slip from becoming a full-blown relapse

Marlatt (continued)

- Self-control treatment method
- Replace negative thoughts with positive functional thoughts (cognitive restructuring)
- Focus on events or factors that can precipitate a relapse



End of Presentation