

Issue Date: March-April 2006, Posted On: 3/1/2006

A Direct Contact After Discharge

Connecticut agencies test telephone recovery support conducted by peers

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The Connecticut Department of Mental Health and Addiction Services (DMHAS) has embraced the concept of recovery as the guiding framework for the services it provides. This has become part of a major initiative to transform adult behavioral health services in Connecticut. A variety of factors, including new research on treatment effectiveness and the expectations of people in recovery, have influenced this transformation. The DMHAS commissioner in a 2002 policy statement on recovery defined the concept as “a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite, or within the limitations imposed by that condition.”

The state's initiative includes aligning fiscal and administrative policies, developing a philosophical and conceptual approach, and seeking to build competencies and service structures to support the recovery orientation. One aspect of this initiative is the development of Centers of Excellence in Recovery-Oriented Programs and Practices. DMHAS's systems of care agencies have the opportunity to apply to become a Center of Excellence. These centers are learning laboratories in the development of new practices and programs.

Project overview

The Telephone Recovery Support Project is one initiative in a Center of Excellence focusing on ways to move toward “Recovery Management”¹ services, particularly in the provision of peer-to-peer recovery support services. While it is widely agreed that addiction is a chronic disease, it often is treated as an acute disease. Recovery Management shifts from brief episodes of treatment intervention to support over a longer period through monitoring, recovery coaching, linking people to communities of self-help and recovery, and engaging in early reintervention.² The idea of telephone recovery support coordinates well with William White's recovery model:

1. Addiction recovery is a reality.
2. There are many paths to recovery.
3. Recovery flourishes in supportive communities.
4. Recovery is a voluntary process.
5. Recovering and recovered people are part of the solution; recovery gives back what addiction has taken.¹

Mark Godley and colleagues at Chestnut Health Systems in Illinois, in an unpublished study embracing the values of Recovery Management, developed a Telephone Continuing Care program for patients with substance abuse problems. The program used Chestnut Health Systems staff and student interns. While telephone-based continuing care has been used increasingly in the management of chronic medical illnesses, it had not been used in recovery settings. In Godley's pilot investigation,³ participants had completed residential care and were linked to continuing care. The program's research goals were to maintain contact with patients after residential treatment for three months, and to prevent relapse or to shorten the duration of relapse.

DMHAS sought to replicate the Telephone Continuing Care program in Connecticut, with several significant adaptations. One community substance abuse treatment agency, Community Prevention and Addiction Services, Inc. (CPAS), would make client referrals to Connecticut Community for Addiction Recovery (CCAR), a recovery community organization. Both agencies agreed with this simple concept: A person recently released from a treatment setting would benefit from receiving a weekly phone call from another person in recovery. With that premise, CCAR would recruit volunteers who would be trained to call clients recently discharged from CPAS. DMHAS would provide technical assistance for implementation and monitoring of the program for the first 90 days.

The project was implemented initially as a collaboration between CPAS and CCAR to support individuals being discharged from residential treatment or in active outpatient treatment. A new term, "recoveree," was developed to designate appropriately those persons who would receive the calls. The goal was to maintain contact with recoverees and offer support for their recovery. Tracking data and personal responses from the phone logs was designed to evaluate the effectiveness of telephone support. After the first 90 days, CCAR was exploring the expansion of recoveree participation by opening up the service to other agencies and programs in the community.

CPAS engaged the services of counseling staff at its programs to approach current enrollees about using the telephone support program. To begin implementation, CPAS management instructed staff on the purpose and design of the new service. Critical to successful implementation was agreement from management and staff that this was a valuable service. Through early, proactive discussion with CPAS staff and the ongoing development of a treatment and recovery culture focused on continuing care, staff was amenable to the new process.

During the 90-day pilot, a continuous flow of recoverees entering CPAS were offered the service. Representatives from CPAS and CCAR and other stakeholders formed a steering committee to monitor the project's progress.

Telephone support implementation

Prior to discharge, CPAS staff offered recoverees the opportunity to enroll in the Telephone Recovery Support Project. In an effort to ensure that all recoverees were receiving the same clear message from all staff making the offer for telephonic support, staff read to recoverees from a script. Any recoverees who accepted the offer were asked to complete a consent form. A release of information form allowing CPAS to communicate confidential information was also collected.

Staff was instructed not to coerce recoverees to use the service, nor to imply that participation was a

requirement of their treatment. After discharge, CPAS staff faxed the signed consent forms to CCAR, which would initiate the telephone support calls to recoverees.

The initial phase focused on recruitment and training of CCAR volunteers. A four-hour training course used extensive role-plays of various call scenarios, with an emphasis on boundary issues. A call protocol offered a standardized script for all calls. CCAR developed a resource manual for volunteers that identified community resources such as sober socialization activities (e.g., sober dances, concerts, retreats, and walks), an often overlooked facet of early recovery.

All calls were made from the CCAR Windham Recovery Community Center, with a supervisor on the premises. An attempt was made to contact each recoveree weekly. The steering committee agreed that ten attempts would be made per recoveree—if no contact was made after ten attempts, the file would be closed. A limited number of referrals occurred during the first 30 days of the pilot, as CPAS clients were opting to go from one level of care to another (such as from detox to rehab).

During the next 30 days, program eligibility was expanded to include ten residents of a recovery house. All ten residents opted to participate. Again, during the final 30 days, program eligibility was expanded to include clients from two outpatient programs. Call volume increased significantly, and a second group of CCAR volunteers was recruited and trained.

Results

Most of the recoverees contacted were white males with primary addiction problems. CCAR volunteers placing the calls included one Latina female, two African-American males, and three white males. A total of 227 calls were attempted, with 55 successful calls (24%).

In reviewing the first 90 days of the project, we found that phone supports can be effective in maintaining recovery and assisting those who experience relapse. For the calls that were unanswered, messages were left and some individuals called the volunteer back. One recoveree received the message upon returning from a residential treatment setting and called to express his appreciation.

The volunteers provided the phone service two evenings per week; this schedule might have been too limiting to reach a number of the recoverees. CCAR is scheduling another volunteer training to bring on additional volunteers. This may provide an opportunity to expand the hours of availability to make calls to recoverees.

As the months progressed, referrals increased because of a number of factors. First, criteria for eligibility expanded to include more individuals than originally planned. Second, awareness of the service increased as more people were contacted. Word of mouth is the best referral for any service. Also, other providers wanted to offer this valuable support service to their clients, as well.

At present, the recruiting, training, and scheduling of the volunteers are facilitated by various steering committee members. Hiring a volunteer coordinator to take on these tasks, as well as to support volunteers in recovery themselves, should be explored.

The various parties' commitment to the project's development and implementation was integral to the

project's success. Philosophically, they were concerned first and foremost with what works best for the recoveree. This illustrates community organizations collaborating to the benefit of those in recovery.

Implications for recovery

The Telephone Recovery Support Project provided additional supports to recoverees discharged from treatment programs or in active outpatient treatment. The volunteers, as well as the recoverees, reported satisfaction with the service. The service was available to all recoverees, regardless of status of recovery. The implication was that all recoverees were valued, and the role of the volunteers was to assist in their recovery. The volunteers were able to make recommendations to the recoverees for other community supports or treatments.

This level of support is noninvasive, makes no demands of the recoveree except that he/she has a telephone, and is conducted at the recoveree's request. If the person no longer wants the calls, he/she simply tells the volunteer to remove him/her from the list. To date, no one has asked to be removed.

Plans for the service in the coming months include making attempts to match recoverees with volunteers based on preferred language and ethnicity, in an effort to maintain a commitment to culturally competent services.

Research indicates that supports are an integral part of recovery. The Telephone Recovery Support Project provides one more level of support for those in recovery. This promising service will continue and expand in the area it currently serves and, with the same level of commitment, will be replicated in other parts of Connecticut.

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