

RECOVERY MANAGEMENT: WHAT IF WE REALLY BELIEVED THAT ADDICTION WAS A CHRONIC DISORDER?

INTRODUCTION

A quiet revolution is unfolding within the worlds of addiction treatment and recovery support. This revolution is founded on new understandings of the nature of substance use disorders and their management. It calls for shifting the treatment of severe and persistent alcohol and other drug (AOD) problems from an emergency room model of acute care (AC) to a model of sustained recovery management (RM). The RM model wraps traditional interventions in a continuum of recovery support services spanning the pre-recovery (recovery priming), recovery initiation and stabilization, and recovery maintenance stages of problem resolution. Particularly distinctive is the model's emphasis on post-treatment monitoring and support; long-term, stage-appropriate recovery education; peer-based recovery coaching; assertive linkage to communities of recovery; and, when needed, early re-intervention.

SECTION I: PROMOTIONAL FORCES

There are several forces pushing the addiction field toward a redesign of its treatment processes. Frontline addiction professionals are articulating (and a growing number of scientific studies are confirming) the limitations of addiction treatment as currently practiced. Grassroots recovery advocacy organizations are calling upon the treatment industry to reconnect professional treatment to the larger and more sustained process of addiction recovery. Pioneer states (e.g., Connecticut) are building research, clinical, and recovery advocacy coalitions to infuse the recovery management model into new "recovery-oriented systems of care." And finally, technological advances in the management of primary chronic health care problems (e.g., diabetes, heart disease, asthma, arthritis, cancer, chronic lung disease, glaucoma, irritable bowel syndrome) are suggesting alternative approaches through which severe and complex behavioral health disorders might be managed more effectively.

PREMISES

The shift from acute care to sustained recovery management models rests upon six propositions.

1. *Alcohol and other drug problems present in transient and chronic forms.* The transient forms vary in intensity, from the clinical (*substance abuse* and *substance dependence*) to the subclinical (problems not meeting DSM-IV criteria for abuse or dependence). Transient forms share a short duration (a single episode or period of problematic use) and a propensity for natural resolution or resolution through brief professional intervention. Transient

BIOGRAPHICAL SUMMARY



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AOD problems are common in community populations, but are more rarely represented among populations entering addiction treatment. Compared to community populations, clients entering addiction treatment are distinguished by:

- greater personal vulnerability (e.g., family history of substance use disorders, early age of onset of AOD use, developmental trauma)
- greater severity and intensity of use and related consequences
- high concurrence of medical/psychiatric illnesses
- greater personal and environmental obstacles to recovery
- less “recovery capital” (the internal and external resources required to initiate and sustain recovery)

2. *The evidence is overwhelming that the course of severe substance use disorders and their successful resolution (addiction, treatment, and recovery careers) can span years, if not decades.*

Alcohol and other drug dependencies resemble chronic disorders (e.g., type 2 diabetes mellitus, hypertension, and asthma) in their etiological complexity (interaction of genetic, biological, psychological, and physical/social environmental factors), onset (gradual), course (prolonged waxing and waning of symptoms), treatment (management rather than cure), and clinical outcomes. To characterize addiction as a chronic disorder is not to suggest that recovery is not a possibility. There are millions of people in stable, long-term recovery from addiction. The notion of addiction as a chronic disorder does, however, underscore the often-long course of such disorders and the sustained “treatment careers” that can precede stable recovery. Recent studies have confirmed that the majority of people with severe and persistent substance use disorders (i.e., substance dependence) who achieve a year of stable recovery do so following 3-4 treatment episodes over a span of eight years.

3. *Severe and persistent AOD problems have been collectively depicted as a “chronic, progressive disease” for more than 200 years, but their historical treatment more closely resembles interventions into acute health conditions (e.g., traumatic injuries, bacterial infections).* If we (the practitioners of addiction treatment) really believed addiction was a chronic disorder, we would not:

- view prior treatment as predictor of poor prognosis (and grounds for denial of treatment admission)
- convey the expectation that all clients should achieve complete and enduring sobriety following a single, brief episode of treatment
- punitively discharge clients for becoming symptomatic
- relegate post-treatment continuing care services to an afterthought
- terminate the service relationship following brief intervention
- treat serious and persistent AOD problems in serial episodes of self-contained, unlinked interventions

4. *Acute models of treatment are not the best frameworks for*

treating severe and persistent AOD problems. The limitations of the acute model of addiction treatment as currently practiced include:

- **Failure to Attract:** Less than 10% of U.S. citizens who meet DSM-IV criteria for substance abuse or dependence currently seek treatment, and most of those admitted to treatment arrive under coercive influences.
- **Failure to Engage/Retain:** More than half of the people admitted to addiction treatment in the U.S. do not successfully complete treatment, and 18% of people admitted to addiction treatment are administratively discharged from treatment.
- **Inadequate Service Dose:** A significant percentage of individuals completing treatment receive less than the optimum dose of treatment recommended by the National Institute on Drug Abuse.
- **Lack of Continuing Care:** Post-discharge continuing care can enhance recovery outcomes, but only one in five clients actually receives such care.
- **Recovery Outcomes:** The majority of people completing addiction treatment in the U.S. resume AOD use in the year following treatment, most within 90 days of discharge from treatment.
- **Revolving Door:** Of those admitted to publicly funded addiction treatment, 60% already have one or more prior treatment admissions, and 24% have three or more prior admissions. Between 25% and 35% of clients who complete addiction treatment will be re-admitted to treatment within one year, and 50% will be re-admitted within 2-5 years.

A large number of people are undergoing repeated episodes of brief interventions whose designs have little ability to fundamentally alter the trajectory of substance dependence and its related consequences. This failure does not result from client foibles or the inadequate execution of clinical protocol by service professionals. It flows instead from a fundamental flaw in the design of the intervention - an acute-care model of treating addiction that is analogous to treating diabetes or asthma through a single, self-contained episode of inpatient stabilization. In the AC model, brief symptom stabilization is misinterpreted as evidence of sustainable recovery.

5. *Most people discharged from addiction treatment are precariously balanced between recovery and re-addiction in the weeks, months, and years following treatment.*

Recent studies have confirmed the fluidity of post-treatment adjustment. One such study conducted quarterly monitoring interviews of 1,326 clients over three years following an index episode of addiction treatment. Each client was categorized each quarter as 1) in the community using, 2) incarcerated, 3) in treatment, or 4) in the community not using. More than 80% of the clients changed status one or more times over the course of the three years. Beyond the groups of clients who categorically succeed or do not succeed stands a larger body of clients who vacillate between periods of recovery and periods of re-addiction. The precarious nature of early recovery is further confirmed by longer-term studies finding

that stable recovery from alcoholism (the point at which the future risk of lifetime relapse drops below 15%) is not achieved until 4-5 years of continuous recovery, and that stable recovery from opiate addiction takes even longer. Such findings beg for models of sustained post-treatment monitoring and support.

PROMISES AND PROSPECTS

Recovery management models hold great promise in treating severe and complex substance use disorders. Chronic disorders are disorders that resist cure via brief intervention but can often be successfully managed (the achievement of full or partial recovery). Such management entails care and sustained support aimed at enhancing the strength, quality, and durability of remission periods and shortening the frequency, duration, and intensity of relapse episodes. This longer-term vision of the treatment and recovery process is based on several critical assumptions:

1. A single brief episode of treatment rarely has sufficient effect for those with the most severe substance use disorders (i.e., substance dependence) to sustain recovery following the intervention.
2. Multiple episodes of treatment, if they are integrated within a recovery management plan, can constitute incremental steps in the developmental process of recovery.
3. Treatment episodes over time may generate cumulative effects.
4. Particular combinations and sequences of professional treatment interventions and peer-based recovery support services may generate synergistic effects (dramatically elevated long-term recovery outcomes).

RM models are focusing initially on the power of post-treatment monitoring and recovery support services. Early studies are confirming the potential utility of such approaches. One study of recovery management checkups (RMC) and early re-intervention over 24 months following treatment found that members of the RMC group had significantly fewer post-treatment days of substance use, were more likely to return to treatment, were more likely to return to treatment sooner, received treatment on a greater number of days following discharge from the index episode, and experienced fewer quarters during follow-up in which they were in need of treatment.

Treating alcohol and other drug dependence solely through repeated episodes of detoxification and brief stabilization is clinically ineffective and constitutes a poor stewardship of personal and community resources. It contributes to the pessimism of clients, service providers, policy makers, and the public regarding the prospects for permanent resolution of alcohol and other drug problems. It is time we acted as if we really believed addiction was a chronic disorder. Today millions of people are reaping the fruits of recovery while others continue to suffer. It is time we widened the doorway of entry into recovery for those with the most severe and persistent substance use disorders. To achieve that will require changes in our thinking, changes in our clinical technologies, and changes in systems of service reimbursement.

SECTION II: MODEL DEFINITION

The recovery management model of addiction treatment shifts the focus of care from professional-centered episodes of acute symptom stabilization toward the client-directed management of long-term recovery. It wraps traditional interventions within a more sustained continuum of:

1. pre-recovery support services to enhance recovery readiness
2. in-treatment recovery support services to enhance the strength and stability of recovery initiation, and
3. post-treatment recovery support services to enhance the durability and quality of recovery maintenance.

The influence of this emerging model is evident in many quarters. It is evident in the research community's exploration of addiction as a chronic disease (O'Brien & McLellan, 1996; McLellan, Lewis, O'Brien & Kleber, 2000). It is reflected in the work of the Behavioral Health Recovery Management project in Illinois (White, Boyle & Loveland, 2003a/b) and other pioneer state efforts to reshape addiction treatment into a "recovery oriented system of care" (e.g., see <http://www.dhhas.state.ct.us/recovery.htm>). Interest in recovery management at the federal level is revealed in the move toward a more recovery-oriented research agenda at NIAAA and NIDA, in SAMHSA and CSAT's growing interest in peer-based models of recovery support services (particularly within CSAT's Recovery Community Support Program), and in the White House-initiated Access to Recovery program. Private sector interest in recovery-focused treatment system enhancements is reflected in the Robert Wood Johnson's Paths to Recovery Initiative (<http://www.pathstorecovery.org>). The shift from acute intervention models to models of sustained recovery support are further reflected in the policy agendas of new grassroots recovery advocacy organizations across the country (see <http://www.facesandvoiceofrecovery.org>).

Describing the emerging "model" of recovery management is a bit like describing a painting while it is being created, but there are broad principles and early changes in clinical practices that are becoming visible. There may be no single program in the country that reflects all the changes described below, but these changes do collectively represent what is increasingly being characterized as a model of *recovery management*.

MODEL PRINCIPLES

There are several cornerstone beliefs that distinguish the recovery management model from acute models of addiction treatment. These principles and values include:

1. emphasis on resilience and recovery processes (as opposed to pathology and disease processes)
2. recognition of multiple long-term pathways and styles of recovery
3. empowerment of individuals and families in recovery to direct their own healing
4. development of highly individualized and culturally nuanced services
5. heightened collaboration with diverse communities of recovery, and

6. commitment to best practices as identified in the scientific literature and through the collective experience of people in recovery. (<http://www.bhrm.org/papers/principles/BHRMprinciples.htm> and <http://www.dmhas.state.ct.us/corevalues.htm>)

MODEL PRACTICES

White, Boyle and Loveland's (2003a/b) review of recovery management (RM) pilot programs reveals several critical differences between the RM models and traditional acute care (AC) models of intervention. These differences span seven broad areas of clinical practice.

Engagement and Motivational Enhancement: RM models place great emphasis on engagement and motivational enhancement. This emphasis is reflected in low thresholds of engagement (inclusive recruitment and admission processes), an investment in outreach and pre-treatment support services, and high retention and low post-admission extrusion (administrative discharge) rates. Within the RM model, motivation is viewed as an important factor in long-term recovery, but is viewed as something that emerges within the service relationship rather than a precondition for service initiation. This emphasis is based on two premises: 1) chronic disorders increase in complexity and severity over time, and 2) recovery outcomes are enhanced by the earliest possible point of recovery initiation and stabilization. AC models of addiction treatment are essentially reactive in their wait for individuals to enter states of crisis that bring them to treatment. RM models reach out to people prior to such crises and sustain contact with them to re-nurture motivation for recovery following such crises.

Assessment and Service Planning: In traditional treatment, the clinical assessment is categorical (focused on substance use and its consequences), is pathology-based (focused on the identification and elucidation of problems), and is an intake activity. Problem severity dictates level of care, and the problems list drives the development of the treatment plan. In recovery management models, assessment is global (focused on the whole life of the recovering person), asset-based (focused on recovery capital - internal and external assets that can help initiate and sustain recovery), and is continual over the span of the service relationship. This altered view of the assessment process is based on three propositions:

1. Chronic disorders beget other acute and chronic problems, therefore all aspects of the life of the recovering person must be assessed and incorporated into an integrated recovery process.
2. Service intensity and duration is dictated by the interaction of problem severity and recovery capital, therefore problem severity alone is an inadequate and disempowering framework for service planning,
3. There are developmental stages of long-term recovery and service and support needs can shift dramatically in the transition from one stage to another, therefore stage-dependent service needs must be continually reevaluated.

The traditional professionally-directed, short-term treatment plan of the acute care model is replaced in the RM model by long-term and short-term recovery plans prepared by the person seeking recovery. The former focuses primarily on reducing pathology; the latter focuses on building recovery capital and a meaningful life.

Service Duration and Emphasis: Acute care models do an excellent job of biopsychosocial stabilization, but often fail to facilitate the transition between recovery initiation and recovery maintenance. The evidence of such failure can be found in post-treatment relapse and treatment re-admission rates (see Section 1). Recovery management models rest on the assumption that the factors required to sustain recovery over a lifetime are different than those factors that spark brief sobriety experiments. The recovery management model emphasizes four post-treatment service activities: sustained post-stabilization monitoring, stage-appropriate recovery education and coaching, assertive linkage to local communities of recovery, and, when needed, early re-intervention. Detoxification and traditional treatment exist within RM models, but the focus of service shifts from crisis intervention to post-treatment recovery support services.

Locus of Services: The institutional focus of the acute care model ("How do we get the addicted person into treatment?") shifts within the RM model to the larger community ("How do we nest the process of recovery within the client's natural environment?"). With this shift, there is a greater emphasis on home- and neighborhood-based services and in direct monitoring technology (e.g., telephone, mail, Internet), as well as an emphasis on organizing indigenous recovery support services within the client's physical and social environment. The RM model also pushes treatment agencies toward greater advocacy responsibilities related to stigma and discrimination, the removal of environmental obstacles to recovery and the development of needed recovery support resources within local communities.

Role of the Client: In acute care models of intervention, the person entering treatment is viewed as the major obstacle to his or her own recovery, and thus is dependent upon an expert who assumes fiduciary responsibility for diagnosis and treatment. RM models champion the necessity and right of the person who is seeking recovery to self-manage his or her own recovery process. Each client must become an expert on his or her condition and its management. This emphasis is reflected in the client's role in service planning and evaluation as well as in the RM model's inclusion of recovering people and family members in policy-making positions and as volunteers and paid service providers.

Service Relationship: The service relationship within the RM model shifts from one that is hierarchical, time-limited, and highly commercialized (the AC model) to one that is less hierarchical, more time-sustained and more natural. In the RM model, the service provider role is more that of a teacher and ally within a long-term health care partnership. RM models are also pioneering new approaches to peer-based recovery support services that utilize new service roles, e.g., peer counselors, recovery coaches, recovery support specialists (White, 2004). The RM model

emphasizes the importance of sustained continuity of contact in a primary recovery support relationship. This relationship would be analogous to the long-term alliance between a primary care physician and his or her diabetic patient or the long-term support that exist within addiction recovery mutual aid societies.

Model Evaluation: The evaluation of acute care models of addiction treatment focuses on measuring the short-term effects of a single, brief episode of intervention. Evaluation within the RM model focuses on measuring the long-term effects of multiple service interventions. The goal is to identify particular combinations or sequences of clinical and recovery support services that generate dramatically elevated (cumulative or synergistic) effects upon recovery outcomes within particular populations of people. The RM model also balances science-based evaluations of service outcomes with consumer and community/tribal evaluations of service processes and recovery outcomes.

Today, elements of the RM model exist within many traditional treatment programs that have evolved toward more client-responsive clinical policies and practices. Elements of the model exist within CSAT's Recovery Community Support Program and RWJ's Paths to Recovery grantee sites. The model is being tested within research studies that are evaluating elements of the RM model. It exists within the growing network of recovery homes and recovery support centers. The recovery management model of intervening with severe substance use disorders marks a dramatic change in the design of addiction treatment in the United States. Time will tell whether this model will struggle as a loosely attached appendage to the existing system of addiction treatment or whether it will transform addiction treatment in the United States into a truly recovery-oriented system of care and long-term support.

SECTION III: IMPLEMENTATION CHALLENGES

The scientific evidence documenting the need to shift addiction treatment from an acute model of intervention to a model of sustained recovery management is so overwhelming it leaves one wondering why this model is not yet fully implemented. The roots of this failure are historical, conceptual, financial, organizational and technical.

The first barriers to treating addiction as a chronic disorder are the forces of [historical and conceptual momentum](#). The modern field of addiction treatment is rooted in an acute biopsychological model of intervention. Addiction treatment programs were created in the image of the acute care hospital (via the profound influence of hospital-derived accreditation standards). The central service role in addiction treatment was similarly modeled after the therapy disciplines of psychiatry, psychology and social work (via addiction counselor certification and licensure standards). For those of us steeped in the modern world of addiction treatment, it is almost impossible to think of treatment in terms other than number of days or number of sessions, and hard to think about continuing care as anything beyond the availability of a short regimen of "aftercare" sessions. We have viewed addiction treatment in terms of multiple levels of

care and theory-based modalities, but have failed to recognize that all of these approaches are nested within an acute care model of assess, admit, treat and discharge. To escape this closed conceptual world, programs exploring the RM model are re-educating their service workers and are conducting a rigorously honest, recovery-focused inventory of their current service practices.

All of the [reimbursement and regulatory systems](#) that govern addiction treatment are based on the acute care model. These structures, originally designed to elevate the consistency and quality of addiction treatment, now constitute a major barrier to shifting to more recovery-oriented systems of care. When programs embracing the RM philosophy seek to admit families rather than individuals, create multi-agency service teams that include indigenous institutions and cultural healers, utilize long-term recovery plans rather than short-term treatment plans, incorporate peer-based recovery support roles/teams, develop non-clinical recovery support systems in local communities, and provide long-term monitoring and early re-intervention services, they find themselves facing almost insurmountable fiscal and regulatory barriers. It is tragic and ironic that the major challenges of recovery management are posed, not by the complex needs of individuals and families seeking recovery, but by the systems originally set up to help facilitate that recovery. The mainstream implementation of recovery management will require a major overhaul of the reimbursement and regulatory systems governing addiction treatment. States like Connecticut that have begun this overhaul process are making a significant contribution to the future of addiction treatment and recovery in America (<http://www.dmhas.state.ct.us/recovery.htm>).

Slowing the development and implementation of RM models are the [weak organizational infrastructures](#) and [high staff turnover rates](#) that pervade the world of addiction treatment (McLellan, Carise, & Kleber, 2003). RM is founded on the continuity of relationship between an organization and the communities it serves and the capacity for sustained continuity of contact between each organization's front line service professionals and the individuals and families within those communities who suffer from severe and persistent AOD problems. If there is an Achilles heel of the RM model, it is in the combined effects of organizational instability and staff turnover within the addictions field (Roman, Blum, Johnson, & Neal, 2002). If the process of RM is to parallel that of the long-term relationship between a primary care physician and a patient/family impacted by a chronic disease, that instability and turnover must be reversed.

The lack of a [science-based understanding of long-term recovery](#) constitutes a significant obstacle to the design of RM programs. As a field, our scientific knowledge about addiction and brief models of treatment has grown exponentially in recent decades, but our science has yet to connect the problem and the intervention to the process of long-term recovery. We know comparatively little from the standpoint of science about the prevalence, pathways and styles of long-term recovery. The ability to find potent combinations and sequences of professionally-directed treatment interventions and peer-based recovery support services rests on the emergence of a recovery

research agenda at the federal level. Without scientific data, RM pioneers will lack a reliable compass to navigate the recovery frontier.

A fifth obstacle in implementing RM models of care involves the [integration of professional-directed treatment services and peer-based recovery support services](#) (particularly within the newly emerging role of recovery coach). Questions abound related to such integration. Are recovery support services best provided by addiction treatment organizations or by free-standing recovery support and recovery advocacy organizations? Should recovery support services be added to the role of addiction counselor or segregated within a new specialized role? What are the best ways to recruit, train and supervise recovery support specialists? What are the boundaries of competence of these new recovery support specialist roles, and how do they fit into larger multidisciplinary teams? Which models of integrating or coordinating professional and peer-based recovery support services are associated with the best long-term recovery outcomes? Answers to such questions are crucial to the future evolution of the RM model, and their absence constitutes a major implementation obstacle.

The [service capacity](#) of an organization or service professional within the RM model has yet to be clearly defined. If, for example, an addiction counselor is responsible for providing on-going monitoring and support, stage-appropriate recovery education, assertive linkage to communities of recovery, and early re-intervention services for those leaving traditional inpatient or outpatient treatment, what is a reasonable caseload for such a counselor? The answer is that we don't know. RM will require a significant reallocation of resources - a shift that will de-emphasize expensive, high intensity acute care and emphasize lower-intensity, lower cost and more enduring recovery support services. Service capacities for organizations and individual workers will have to be redefined in that transition.

The [ethical guidelines](#) that have guided addiction treatment agencies and addiction counselors for the past three decades grew out of the acute care service relationship and were closely modeled after the ethical guidelines for psychologists and social workers (e.g., discouragement or prohibition of self-disclosure, prohibition of all dual relationships, prohibition of gifts, etc.). These guidelines, which presupposed a short-term, expert-based fiduciary service relationship, do not easily fit the less hierarchical and more enduring service relationships that characterize the RM model. It is crucial that ethical standards evolve to guide the provision of professionally-delivered and peer-based recovery support services. The lack of current ethical guidelines for recovery support services raises the ethical vulnerability of service organizations and service professionals.

POTENTIAL PITFALLS

This three-part series on the recovery management model of addiction treatment and recovery support would be incomplete without an exploration of some of the potential pitfalls of the RM model. Experience to date suggests three potential pitfalls beyond the implementation challenges noted above.

Not everyone with an AOD-related problem needs RM services.

Many individuals with such problems will resolve these problems on their own or will do so through mutual aid or brief professional intervention. Misapplying an RM model to persons with low problem severity and high recovery capital could generate [iatrogenic effects](#) within the RM model. Such misapplication could injure persons with transient AOD problems by inappropriately attaching a stigma-laden diagnosis and delivering services that are ineffective, a financial burden and potentially harmful.

The emphasis on addiction as a chronic disorder within the RM model could inadvertently contribute to [cultural pessimism](#) about the resolution of AOD problems and heighten the stigma and discrimination attached to those problems (Brown, 1998). To counter such effects, RM models must constantly emphasize the reality of full recovery in the lives of millions of people who have suffered from severe and prolonged AOD problems.

The 1980s witnessed a period of [institutional profiteering](#) in which persons with alcohol and other drug problems were viewed as a crop to be harvested for financial profit. A too rapid shift to RM models of reimbursement could unleash the same forces. Profiteers could garner large, capitulated contracts for recovery support services, but then minimize the services delivered through such contracts to maximize institutional and personal profit. These profiteers could escape accountability for recovery outcomes behind the rhetoric that addiction is a chronic disease. To avoid this, RM models of reimbursement must include a high level of accountability for recovery outcomes. This will require clinical information systems that can track clinical outcomes and other performance indicators across multiple episodes of care.

Attempts to shift addiction treatment from a revolving emergency room door (via unending cycles of brief intervention) to a model of sustained recovery management face many implementation obstacles and potential pitfalls. These obstacles and pitfalls are offset by the potential of the RM model to align the design of addiction treatment with the growing body of scientific evidence documenting the chronicity of severe AOD problems and the complexity of long-term recovery. That potential and what it means for millions of people suffering from addiction will inspire many addiction professionals and addiction treatment organizations to experiment with this fundamental redesign of addiction treatment.

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RECOMMENDED WEB SITES

<http://www.bhrm.org>

http://www.behavioral.net/2003_05-06/featurearticle.ht

<http://www.bhrm.org/bhrmpsummary.pdf>

ABOUT THE BEHAVIORAL HEALTH RECOVERY MANAGEMENT (BHRM) PROJECT

The Behavioral Health Recovery Management (BHRM) project seeks to apply the principles of disease management to assist individuals with chemical dependency and/or serious mental illness to engage in a process of recovery from these illnesses.

The major components include the application of evidence based treatments coupled with longitudinal recovery support as an alternative to the acute interventions that characterize traditional behavioral health approaches. In addition, the project emphasizes a consumer-centered, strengths-based service delivery model.

The project is a partnership of Fayette Companies located in Peoria, Illinois and Chestnut Health Systems headquartered in Bloomington, Illinois and the University of Chicago, Center for Psychiatric Rehabilitation in Chicago, Illinois. Funding is provided by the Illinois Department of Human Service's Office of Alcoholism and Substance Abuse.

A full description of the project is can be obtained at:

<http://www.bhrm.org/bhrmpsummary.pdf>.

BHRM Mission Statement

"Applying the principles of disease management to assist in the treatment of chemical dependency and/or serious mental illness."



The Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration
Unifying science, education, and services to transform lives



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