

## **Telephone Recovery Support & the Recovery Model**

By Tom Broffman, PhD, Rick Fisher, LCSW, Bill Gilbert, LCSW & Phillip Valentine

### **The Recovery Model and the CT Dept. of Mental Health & Addiction Services**

The Connecticut Department of Mental Health and Addiction Services (DMHAS) have embraced the concept of Recovery as the guiding framework for the services that it provides. This has become part of a major initiative to transform adult behavioral health services in Connecticut. This transformation has been influenced by both the expectations set forth in the President's New Freedom Commission Report on Behavioral Health, growing bodies of research of treatment effectiveness and the expectations of consumers and people in recovery. The Commissioner of DMHAS in his policy statement on Recovery has defined it 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" (Kirk, 2002). This initiative includes aligning fiscal and administrative policies, the development of a philosophical and conceptual approach and an effort to build competencies, skills 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 been given the opportunity to apply to become a Center of Excellence. These centers are learning laboratories in the development of new practices and programs.

### **Background and Overview of the Telephone Recovery Support Project**

The Telephone Recovery Support project was one initiative of a series of Centers of Excellence focusing on innovative ways to move towards "Recovery Management" (White, 2004) services, particularly in the provision of peer-to-peer recovery support services. While it is widely agreed upon that addiction is a chronic disease, it is often treated like an acute disease. "Recovery Management" shifts from brief episodes of treatment intervention to supporting people over a longer period of time through monitoring, recovery coaching, linking people to communities of self-help and recovery,

and early re-intervention (White, et al, 2003). Telephone Recovery Support is simpatico with William White's Recovery Movement 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 (White, 2004).

Dr. Mark Godley and his colleagues at Chestnut Health Systems, in an unpublished study, embracing the values of Recovery Management, developed a Telephone Continuing Care program for patients with substance abuse problems utilizing staff and student interns. While Telephone Continuing Care has been used increasingly in the management of chronic, medical illnesses, it has not been used in recovery settings. In Dr. Godley's pilot investigation (Godley et al., 2004) participants had completed residential care and were linked to continuing care. The programs research goals were to maintain contact with patients after residential treatment for three months to prevent or shorten relapse time .

DMHAS was desirous of replicating the Telephone Continuing Care Program in CT with several significant adaptations. One community substance abuse treatment agency, Community Prevention and Addiction Services, Inc. (hereafter CPAS) would make client referrals to Connecticut Community for Addiction Recovery (hereafter CCAR), a recovery community organization. Both agencies agreed wholeheartedly 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 in mind, CCAR would recruit volunteers who would be trained to call clients recently discharged from CPAS. Technical assistance would be provided by DMHAS to aid in implementation and monitoring the program for the initial 90 days.

CPAS was the applicant for the Telephone Recovery Support Project. The project was implemented in the first 90 days as a collaboration between CPAS and CCAR to support individuals who were being discharged from residential treatment programs or

who were clients 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 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 recoverees enrolled at CPAS programs about using the telephone recovery support program. To begin implementation, CPAS staff was instructed by management on the purpose and the design of the new service. Critical to the implementation and success of the telephonic support service was agreement from management and staff that this was a valuable and desirable service to provide. 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. Calls were made by CPAS management to remind staff to continue offering the telephone service to the recoverees. Over the 90 days of the pilot, then, a continual flow of recoverees entering CPAS were offered the service. Representatives from CCAR and CPAS, and other stakeholders formed a steering committee to monitor the progress of the project. Crucial to the effectiveness of the steering committee meetings was the participation of a DMHAS funded consultant who provided meeting facilitation and expert consultation.

### **Telephone Recovery Support Project Process**

Prior to discharge, staff offered recoverees the opportunity to enroll in the telephone recovery support program. In an effort to assure that all recoverees were receiving the same clear message from all staff making the offer for telephonic support, a script was developed that staff read to the recoverees. Any recoverees who accepted the offer were asked to complete a consent form agreeing to participate in the service. The form also collected the name and the address of the recoveree who was to be called. In addition, a release of information form allowing CPAS to communicate

confidential information was also collected. Staff was instructed to in no way coerce recoverees to use the service, nor imply that participation was a requirement of their treatment. After the recoveree discharged from the program, CPAS staff faxed the signed consent forms to CCAR, which would initiate the telephone support calls to the recoverees.

### **Telephone Recovery Support Implementation Phases**

The initial phase focused on recruitment and training of CCAR volunteers. A four hour training was provided utilizing extensive use of role plays of various call scenarios with emphasis on boundary issues. A call protocol was developed providing a standardized script for all calls. During the training a key issue arose – what were the persons receiving calls to be called – and that is when the new term, “recoveree”, was suggested. A resource manual was developed by CCAR for the volunteers identifying community resources including sober socialization activities (e.g., sober dances, concerts, retreats, walks), an often overlooked facet of early recovery. All calls were made from the CCAR Windham Recovery Community Center with availability of an on-site supervisor. An attempt was made to contact every recoveree weekly. The steering committee agreed that 10 attempts would be made per each recoveree and after 10 attempts if no contact was made the file would be closed. During the first 30 days there were a limited number of referrals as CPAS clients were opting to go from one level of care to another (e.g., detox. to rehab.).

During the next 30 days the eligibility for the program was expanded to include 10 residents of a Recovery House. All 10 residents opted to participate, which in turn increased the call volume for the recovery volunteers.

Given the program’s success, during the final 30 days the program eligibility was expanded to included clients from two outpatient programs. The call volume increased significantly and a second group of CCAR volunteers were recruited and trained.

### **Results**

The majority of the recoverees contacted were, white, males with primary addiction problems. The CCAR volunteers placing the calls were diverse with 1 Latina

female, 2 African American and 3 white males. A total of 227 calls were attempted with a success rate of 55 (24%) [insert Chart 1].

### **Conclusions**

In review of the first 90 days of the project, the early findings indicate phone supports can be effective in maintaining recovery and assisting those who experience relapse. A total of 227 attempted calls were made with 55 contacts during the 90-day period, averaging approximately four calls per contact. The remaining 172 calls were unanswered, but messages were left and some individuals called the volunteer back. [insert Chart 2] One recoveree received the messages upon his return from a residential treatment setting and called to express his appreciation. The volunteers provided the phone support service two evenings per week; this schedule may have been too limiting for a number of the recoverees, whose schedules may not have allowed for contacts during those times and dates. CCAR is scheduling another volunteer training to recruit and train additional volunteers; this may provide an opportunity to expand the hours of availability to make the calls to recoverees.

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

The availability of the volunteers' times and days to attempt contact with recoverees may have limited the numbers of actual contacts. As the program expands, the flexibility of volunteers' schedules may expand, as well, to include other days, times. 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 provide continuous support to the volunteers, who are also in recovery, should be explored.

The commitment of the various parties involved in the development and implementation of the project was an integral part of its success. Philosophically, they were concerned first and foremost with "what works best for the recoveree". This was

an example of collaboration with community organizations that worked to the benefit of those in recovery.

### **Implications for Recovery**

The Telephone Recovery Support Project provided additional supports to recoverees who were discharged from treatment programs or those in active outpatient treatment. The volunteers, as well as the recoverees, reported satisfaction with the service. The project validated White's Recovery Model as "recovering and recovered people are part of the solution; recovery gives back what addiction has taken" (White, 2004). The service was available to all recoverees, regardless of status of recovery. Thus, the implication was that all the recoverees were valued and that the role of the volunteer 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 non-invasive, makes no demands of the recoveree except that they have a telephone where they can be reached, and is at the request of the recoveree. If they no longer want the calls, they simply tell the volunteer to take them off the list. To date, no one has asked to be removed from the call list.

The plans for the service in the coming months include recruiting more volunteers, expanding the times and days for calls, and making attempts to match recoverees with volunteers based on preferred language and ethnicity in an effort to maintain their commitment to cultural competency.

Research indicates that supports are an integral part of recovery. The Telephone Recovery Support Service provides one more level of support for those who are in recovery. This promising recovery support service will continue and expand in the Willimantic area and, with the same level of commitment, will be replicated in other areas of Connecticut by CCAR.

## References

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