



# Selected Papers of William L. White

[www.williamwhitepapers.com](http://www.williamwhitepapers.com)

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

**Citation:** The Behavioral Health Recovery Management Project Project summary and concept Posted at [www.williamwhitepapers.com](http://www.williamwhitepapers.com)

## The Behavioral Health Recovery Management Project Project Summary and Concept June 28, 2000<sup>1</sup>

Michael G. Boyle, William L. White, David Loveland,  
Mark D. Godley, & Russell J. Hagen

### Facing the Challenge of Severe Behavioral Health Disorders: The Behavioral Health Recovery Management Project

Chronic conditions of mental illness, alcoholism, and drug addiction often resemble the course and pattern of chronic physical disorders, such as diabetes, coronary heart disease or arthritis. Such disorders are often characterized by alternating episodes of stabilization and symptom activation that require long-term strategies of disease management. Despite recognition of this fact in the behavioral health field, treatment approaches continue to follow an acute care model as reflected in our language of “admitting” and “discharging” to and from clients’ episodes of care within treatment agencies. By comparison, a primary care physician treating a diabetic patient would not discharge the patient after stabilization of a diabetic coma.

Although there is a growing recognition in primary health care for the application of disease management procedures in the treatment of chronic physical disorders, behavioral health treatment of chronic conditions of mental illness and addiction continue to be influenced by an acute medical model paradigm that has been exemplified by short-term community hospitalizations for mental illness and the 28-Day inpatient addiction rehabilitation facilities for substance abuse disorders (Hasenfeld, 1985; Price & Smith, 1983; Institute of Medicine, 1990). Nearly 54% (\$42.7 of \$79.3 billion) of national expenditures for behavioral health in 1996 in the United States was for either short-term inpatient treatment, residential treatment, medical treatment (physician other than psychiatrist), or nursing home care (Mark, McKusick, King, Harwood, & Genuardi, 1998). Complicating the development of effective models of care in the behavioral health field is the ascent of managed care. Some

<sup>1</sup> The Behavioral Health Recovery Management project is a joint venture of Fayette Companies, Peoria, IL and Chestnut Health Systems, Bloomington, IL. Sponsored by: The Illinois Department of Human Services Office of Alcoholism and Substance Abuse

providers and researchers are concerned that state level managed care models will place more emphasis on cost reduction and acute intervention strategies that are influenced primarily by the bottom line rather than on treatment efficacy (Goldman & Morrissey, 1997; Mechanic, Schlesinger, & McAlpine, 1995; Newman & Tejada, 1996; Schlesinger & Gray, 1999). The growth of behavioral health managed care with an emphasis on cost reduction over treatment efficacy may lead to the elimination of progressive, community-based models of care that are considered costly in the short term.

Concurrent with the pervasive application of managed care and the perpetuation of the acute care model, there is a growing number of individuals with multiple treatment needs (e.g. comorbid conditions of mental illness and a substance abuse disorder) (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998; Regier et al. 1990), that cannot be met in the current fragmented and segregated treatment system (Minkoff, 1987). Individuals with comorbid conditions, such as mental illness and an addiction, find themselves facing an increasingly complex and categorically segregated service system in which no agency has the capacity to meet their complex and often long-term needs (Krauss, 1989; Morrissey, 1999; NASADAD; 1998; Ridgely, Goldman, & Willenbring, 1990). The result of this fragmented treatment system is a perpetual pattern of exclusions, extrusions (“administrative discharges”), revolving admissions and discharges, inappropriate and potentially harmful treatment interventions such as unneeded institutionalization (e.g. incarceration) and “dumping” of individuals with complex treatment needs (Drake, Mueser, Clark, & Wallach, 1996; Ridgely, Goldman, Willenbring, 1990; Torrey, Erdman, Wolfe, & Flynn, 1990).

Finally, there is a well-documented gap between the known effectiveness of treatment approaches and the application of these practices in applied settings. While research has shown treatment for mental health and chemical dependency to be as

effective as treatments for other chronic disorders, such as forms of heart disease, diabetes and some mental illness (Leshner, 1999), there is a wide breach between research and practice (Fichtner, Luchins, Malan, & Hanrahan, 1999; Francis, Docherty, & Kahn, 1996; Norquist, Lebowitz, & Hyman, 1999). There are also wide variations in treatment practices among similar populations with similar needs (Gilbert et al. 1998). In addition, many factors (e.g., funding constraints) prevent the dissemination and widespread application of numerous innovative programs in both mental health and substance abuse treatment (Torrey, 1990). The gap between clinical research and clinical practice has become a growing concern at the national level (Institute of Medicine, 1990; Institute of Medicine, 1998).

A possible solution to these compounding issues is a reconceptualization of the current behavioral health system in terms of integration across disciplines and the adoption of a service model that transcends the limitations of the traditional acute medical model (Krauss, 1989; Lebowitz & Harris, 2000; Minkoff, 1989; Norquist, Lebowitz, & Hyman, 1999; Osher, 1996). Additionally, the rise of the consumer/survivor movement in the United States is consistent with a shift from the deficit-focused professionally-driven medical model toward a strength-based approach. The latter supports the tenants of recovery over maintenance and self-determination over institutional dependency (Anthony, 1993; Chamberlin, 1990; Kaufmann, 1999).

The need to re-conceptualize the behavioral health service delivery model has provided the impetus for the development of the Behavioral Health Recovery Management Project (BHRMP), a multidisciplinary project established through the Illinois Department of Human Service's Office of Alcoholism and Substance Abuse to develop comprehensive disease management guidelines for the treatment of chronic conditions of mental illness and substance abuse disorders. The purpose of BHRMP is to develop evidence-based practice guidelines for behavioral health,

apply research to investigate the validity, cost, and utility of these guidelines, and disseminate these models with references for additional resources and training for implementation.

The guiding principles of the BHRMP are that:

- Individuals can engage in a process of recovery from chronic conditions of mental illness and drug and alcohol addictions.
- Treatment services should be ongoing and matched in type, duration, and intensity to the needs of individuals.
- Treatment is guided by a strength-based paradigm of service delivery (Rapp, 1998; Saleebey, 1997).
- Primary health, mental health, and substance abuse treatment should be integrated within providers and systems (Osher, 1996).
- A biopsychosocial approach to treatment interventions (Engel, 1977; Smith & Nicassio, 1995).
- Treatment is guided by evidence-based protocols (Rush, Rago, & Crimson, 1999; Vega, 1999).
- The community is an oasis of natural resources such as self-help/mutual-help organizations, religious organizations, housing supports, consumer-driven services, and social networks (Kisthardt, 1997) that should be incorporated into the treatment protocol (McKnight, 1995).

Pharmaceutical companies and a few progressive staff model HMOs have pioneered disease management in general healthcare to address chronic illness. This approach frequently utilizes case management to coordinate the efforts of multi-disciplinary providers and employs evidence-based practice guidelines. A key component of a disease management program is the involvement of the client, his or her family and significant others as

partners in the management of the illness. Educational programs, skills training and various audio/visual supports are used to empower the consumer to manage their condition. Empowerment of the consumer and the crucial theme of recovery in both the substance abuse and mental health fields have led this project to utilize the term "recovery management" rather than disease management. Recovery management is the mobilization and integration of personal, family, professional and indigenous community resources toward the goal of enhancing the duration and quality of life of those experiencing severe and persistent behavioral health disorders.

Recovery management offers promise for improving outcomes in the treatment of chronic behavioral health conditions and long-term cost effectiveness. The BHRM project will establish the basis of treating serious mental illness and chemical dependency as chronic diseases, establish principles in developing a recovery management approach, identify the best clinical guidelines that are evidence-based and/or consensus derived, test the guidelines in community settings, modify as necessary, and convert the guidelines to clinical algorithms where practical. Particular emphasis will be placed on identifying or developing longitudinal systems to assist individuals to manage their recovery from both substance abuse and mental illness. New approaches that will guide behavioral health organizations in service delivery are also anticipated. A web site will be used to communicate progress and issues to the field.

## References

Anthony, W.A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. Psychosocial Rehabilitation Journal, 16, 11-23.

Chamberlin, J. (1990). The ex-patients' movement: Where we've been and where we're going. The Journal of Mind and Behavior, 11, 323-336.

Drake, R.E., Mercer-McFadden, C., Muesser, K.T., McHugo, G.J., & Bond, G.R. (1998). A review of integrated mental health and substance abuse treatment for patients with dual disorders. Schizophrenia Bulletin, 24, 589-608.

Drake, R.E., Mueser, K.T., Clark, R.E., & Wallach, M.A. (1996). The course, treatment, and outcome of substance disorder in persons with severe mental illness. American Journal of Orthopsychiatry, 66(1), 42-51.

Engel, G.L. (1977). The need for a new medical model: A challenge to biomedicine. Science, 196, 129-136.

Fichtner, C.G., Luchins, D.J., Malan, R.D., & Hanrahan, P. (1999). Real-world pharmacotherapy with novel antipsychotics. Journal of Practicing Psychiatry and Behavioral Health, 5, 37-43.

Frances, A., Docherty, J.P., & Kahn, D.A. (1996). The expert consensus guideline series: Treatment of schizophrenia. The Journal of Clinical Psychiatry, 57, Supplement 12B.

Gilbert, D.A., Altshuler, K.Z., Rago, W.V., Shon, S.P., Drismon, M.L., Toprac, M.G., & Rush, A.J. (1998). Texas medication algorithm project: Definitions, rationale, and methods to develop medication algorithms. Journal of Clinical Psychiatry, 59, 345-351.

Goldman, H.H., & Morrissey, J.P. (1997). A conceptual framework for evaluating the intersystem impacts of managed behavioral health care: Report on a roundtable discussion. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Hasenfeld, Y. (1985). Community mental health centers as human service organizations. American Behavioral Scientist, 28, 655-668.

Institute of Medicine. (1990). Broadening the base of treatment for alcohol problems. Washington, DC: National Academy Press.

Institute of Medicine. (1998). Bridging the Gap Between Practice and Research, Washington, DC: National Academy Press.

Kaufmann, C. L. (1999). An introduction to the mental health consumer movement. In A. Horwitz & T. Scheid (Eds.),

A handbook for the study of mental health: Social contexts, theories, and systems (pp. 493-507). Cambridge: Cambridge University Press,

Kisthardt, W. (1997). The strengths model of case management: Principles and helping functions. In D. Saleeby (Ed.), The strengths perspective in social work practice (2<sup>nd</sup> ed.) (pp. 97-114). New York: Longman.

Krauss, J.B. (1989). New conceptions of care, community, and chronic mental illness. Archives of Psychiatric Nursing, 3, 281-287.

Lebowitz, B.D., Harris, H.W. (2000). Efficacy and effectiveness: From regulatory to public health models. In I. Katz & D. Oslin (Eds.), Annual review of gerontology and geriatrics: Focus on psychopharmacologic interventions in late life (vol. 19). (pp. 3-12). New York: Springer

Leshner, A.I., (1999, June 11). Why shouldn't society treat substance abusers? [Letter to the editor]. Los Angeles Times.

Mark, T., McKusick, D., King, E., Harwood, H., & Genuardi, J., (1998). National Expenditures for Mental Health, Alcohol and other Drug Abuse Treatment (DHHS publication No. SMA 98-3255). Rockville, MD: Substance Abuse and Mental Health Services Administration.

McNight, J. (1995) The careless society: Community and its counterfeits. New York: Basic Books.

Mechanic, D., Schlesinger, M., & McAlpine, D.D. (1995). Management of mental health and substance abuse services: State of the art and early results. The Milbank Quarterly, 73, 19-55.

Minkoff, K. (1987). Beyond deinstitutionalization: A new ideology for the postinstitutional era. Hospital and Community Psychiatry, 38, 945-950.

Minkoff, K. (1989). An integrated treatment model of dual diagnosis of psychosis and addiction.

Morrissey, J.P. (1999). Integrating service delivery systems for persons with a severe mental illness: Definitions and perspectives. In A. Horwitz & T. Scheid (Eds.), A handbook for the study of mental health: Social contexts, theories, and

systems (pp. 449-466). Cambridge: Cambridge University Press.

National Association of State Alcohol and Drug Abuse Directors (NASADAD) (1998). SAMHSA/NASADAD release report on preliminary information on services to individuals with co-existing substance abuse and mental health disorders [On line], Available: <http://www.NASADAD.org>.

Newman, F. L., & Tejada, J.T. (1996). The need for research that is designed to support decisions in the delivery of mental health services. American Psychologist, 51, 1040-1049.

Norquist, G., Lebowitz, B., & Hyman, S. (1999). Expanding the frontier of treatment research. Prevention and Treatment, 2 [On line], Available: <http://journals.apa.org/prevention/volume2/pre0020001a.html>

Osher, F. (1996). A vision for the future: Toward a service system responsive to those with co-occurring addictive and mental disorders. American Journal of Orthopsychiatry, 66, 71-76.

Price, R.H., & Smith, S.S. (1983). Two decades of reform in the mental health system (1963-1983). In E. Seidman (Ed.), Handbook of Social Intervention (pp 408-437). Beverly Hills: Sage Publications.

Rapp, C.A. (1998). The strengths model: Case management with people suffering from severe and persistent mental illness. New York: Oxford University Press.

Regier, D.A., Farmer, M.E., Rae, D.S., Locke, B.Z., Keith, S.J., Judd, L.L., & Goodwin, F.K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse. Journal of the American Medical Association, 264, 2511-2518.

Ridgely, M.S., Goldman, H.H., & Willenbring, M. (1990). Barriers to the care of persons with dual diagnoses: Organizational and financing issues. Schizophrenia Bulletin, 16, 123-132.

Rush, A.J., Rago, W.V., & Crimson, M.L. (1999). Medication treatment for the severely and persistently mentally ill: The Texas medication algorithm project. Journal of Clinical Psychiatry, 60, 284-291.

Saleebey, D. (1997). Introduction: Power in the people. In D. Saleebey (Ed.),

The strengths perspective in social work practice (pp. 3-20). White Plains, NY: Longman.

Schlesinger, M., & Gray, B. (1999). Institutional change and its consequences for the delivery of mental health services: Definitions and perspectives. In A. Horwitz & T. Scheid (Eds.), A handbook for the study of mental health: Social contexts, theories, and systems (pp. 427-448). Cambridge: Cambridge University Press.

Smith, T.W. & Nicassio, P.M. (1995). Psychological practice: clinical application of the biopsychosocial model. In P.M. Nicassio & T.W. Smith (Eds.), Managing chronic illness: A biopsychosocial perspective (pp 1-32). Washington, DC: American Psychological Association.

Torrey, E., Erdman, K., Wolfe, S., & Flynn, L., (1990). Care of the seriously mentally ill: A rating of state programs (3<sup>rd</sup> ed.). Washington, DC: National Alliance for the Mentally Ill.

Torrey, E.F. (1990). Economic barriers to widespread implementation of model programs for the seriously mentally ill. Hospital and Community Psychiatry, 41, 526-531.

Vega, P. (1999). An introduction to behavioral health and disease management. In P. Vega (Ed.), Behavioral disease management (pp. 1-8). Providence, RI: Manisses Communications Group, Inc.