BSAS PRACTICE GUIDANCE: RESPONDING TO RELAPSE

Prevent • Treat • Recover • For Life

I. RATIONALE:

BSAS endorses responses to relapse which aim to keep the individual engaged in treatment while the individual works to achieve and maintain abstinence. The prevalence of relapse is well known, and effective relapse prevention principles and techniques have been integrated into a range of programs and treatment models.[1] Nevertheless, research[2] finds that more than half of all individuals entering substance abuse treatment can be expected to use substances during or after treatment, and nearly two-thirds of that number will do so more than once. NIDA recently estimated that most people need at least three months in treatment to reduce substance use and achieve abstinence. [3] These rates attest to the challenges of behavior and lifestyle change involved in recovery. And they underscore the fact that continued engagement in treatment cannot be contingent upon uninterrupted abstinence.

BSAS Principles of Care call for treatment that is guided by the individual's needs and recognizes that needs change as the individual develops and progresses in treatment and recovery. Relapse[4] is a key point of re-assessment of these needs. The individual and treatment staff consider first, whether the relapse has caused harm to the individual or others, and what action needs to be taken to reduce and prevent further harm. Together they reflect on whether the current level of care is the right one for this individual; and whether the treatment plan adequately addresses the individual's vulnerabilities and incorporates the individual's strengths and resources. Factors known to be major contributors to relapse must also be considered. These include co-occurring disorders, especially depression; trauma; physical conditions and injuries; social isolation; poor nutrition and overall poor health; and smoking and tobacco use. [i] Throughout these reflections, the chief aim of the treatment provider is to keep the individual engaged in treatment and invested in pursuing recovery, so that even if the individual decides to leave treatment, he or she can return without fear or shame.

II. GUIDANCE:

A. Organization:

Policy:

- Agency policy:
  - States that continued participation in treatment is not contingent on uninterrupted abstinence;

[1] The National Registry of Evidence-Based Practices lists 17 different programs which offer evidence of effectiveness in relapse prevention.
[2] National Institute on Drug Abuse, (Website updated 2010) *Drugs, Brain, Behavior: The Science of Addiction*
[3] National Institute on Drug Abuse, *Seeking Drug Abuse Treatment: Know What to Ask*. NIH publication 12-7764.
[4] In this paper the word 'relapse' includes single incidents as well as sporadic or intermittent episodes of substance use.

- States that responses to relapse focus on keeping individuals engaged in treatment.

Operations:

- Agency establishes process for response to relapse, which includes participation by the individual, staff (e.g. counselor) and supervisory personnel.
- Agency develops cooperative agreements (QSOA's) with entities offering services, which can support keeping individuals engaged in treatment after relapse. These include:
  - Detox, CSS and TSS programs;
  - Mental health providers;
  - Opioid Treatment Programs;
  - Medical care providers;
  - Wellness service providers.
- In relationships with other systems (e.g. criminal justice, child welfare) agency personnel promote understanding that relapse occurs in the context of treatment and does not mean failure of treatment.

Supervision, Training and Staff Development:

- Individual and group supervision focus on:
  - Staff beliefs about what relapse means;
  - Staff own values about treatment, abstinence and recovery;
- Training and workforce development build understanding of
  - Developmental process of recovery;
  - Co-occurring disorders and trauma;
  - Health and nutrition needs of individuals in treatment.

B. Service Delivery and Treatment:

Assessment and Re-assessment:

- Assessments and re-assessments address:
  - Risk or symptoms of co-occurring disorders;
  - History of trauma (including injuries and combat experience);
  - Health conditions;
  - Indications of need for medication assisted treatment;
  - Discussion of challenges of behavior change;

- Recognition of skills and abilities which individual brings to work of treatment and recovery;
- Tobacco use and smoking.

Treatment Planning:

- Treatment plans:
  - Address the individual's known vulnerabilities to relapse, e.g. co-occurring disorders, tobacco use and smoking;
  - Identify interventions needed when the individual faces increased risk of relapse, e.g. counseling session or telephone check-in before a weekend or family visit.
- As a component of a treatment plan, the individual and staff develop and agree upon a plan for disclosing and discussing substance use should it occur.

Service Provision:

- Relapse prevention and support services are provided in groups.
- Staff reinforce use of resources available through self-help groups and Recovery Support Centers to build relationships supporting recovery and reduce social isolation.
- Services include (either directly or through QSOA):
  - Tobacco and smoking cessation;
  - Assessment and re-assessments for co-occurring disorders;
  - Nutrition support;
  - Opportunities for physical activities/exercise;
  - Mindfulness practices such as meditation or journaling.

Response to Relapse During Treatment:

- Staff assist individuals to develop individualized action plans aimed at:
  - Preventing and reducing harm to the individual and others affected;
  - Identifying changes needed to forestall repeat substance use, including need for medication assisted treatment or additional mental or physical health assessment and/or treatment.
- Staff and individual assess the 'fit' between the level of care and the individual's needs.

Education:

- Individuals are provided information about risks of relapse and factors which undermine abstinence:
    - Co-occurring disorders, especially depression;
    - Poor nutrition and health;
    - Lack of ties to a supportive recovery community;
    - Smoking and tobacco use.

III. MEASURES:

- Staff and consumer surveys and focus groups;
- Referrals for services such as mental health assessments and treatment, health and nutrition;
- Tracking data on individuals who stay in and complete treatment, despite episodes of substance use;
- Use of 'success stories' as learning opportunities for staff to explore effectiveness of responses to relapse.

IV. RESOURCES:

BSAS Resources:

Massachusetts Department of Public Health, Bureau of Substance Abuse Services
Practice Guidance: Integrating Medication Assisted Treatment in Behavioral Treatment,
http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html

Massachusetts Recovery Support Centers listing: http://www.helpline-online.com/helplinesearch.aspx?pageid=providerlist&txtService=Peer%20Recovery%20Support%20Centers%20(DPH)&svcid=237&catortmt=tmt&pl=helpline

Effective Relapse Prevention Programs: Listed on the National Registry of Evidence-based Practices and Programs:
http://www.nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=relapse%20prevention

It's Time to Stop Kicking People Out of Treatment: A thoughtful and thought provoking article by William White, et al. Available from: White W, Scott C, Dennis M, Boyle M. It's time to stop kicking people out of addiction treatment. *Counselor*. 2005; 6(2): 12-25.

Seeking Drug Treatment: Know What to Ask: A brief, clear description of treatment for individuals, this booklet addresses relapse in realistic and encouraging terms. Available at: http://www.drugabuse.gov/publications/seeking-drug-abuse-treatment

NIATx: Promising Practices: Describe specific and concrete strategies which support individual's in building their foundation for recovery.
http://www.niatx.net/promisingpractices/Search.aspx?SPNID=19

Ask Clients to Participate in Treatment Planning
http://www.niatx.net/promisingpractices/Show.aspx?ID=81&SPNID=32

Encourage Clients to Use PDSA Cycles to Test Their Own Change
http://www.niatx.net/promisingpractices/Show.aspx?ID=82&SPNID=32

Identify Clients at Risk for Leaving and Intervene
http://www.niatx.net/promisingpractices/Show.aspx?ID=86&SPNID=32

Assign peer buddies
http://www.niatx.net/promisingpractices/Show.aspx?ID=89&SPNID=32

Build Community Among Clients
http://www.niatx.net/promisingpractices/Show.aspx?ID=90&SPNID=3

BSAS welcomes comments and suggestions. Contact: BSAS.Feedback@state.ma.us

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[i] Curran, G.M., et al. (2007) Recognition and management of depression in a substance use disorder treatment population. *American Journal of Drug and Alcohol Abuse*, 33: 563-569.
Suter, M., et al. (2011) Depressive symptoms as a predictor of alcohol relapse after residential treatment programs for alcohol use disorder. *Journal of Substance Abuse Treatment*, 41:225-233.
Shiffman, S., & Balabanis, M. (1996). Do drinking and smoking go together? *Alcohol Health & Research World,* 20:107-110.
Stuyt, E. (1997). Recovery rates after treatment for alcohol/drug dependence: Tobacco users vs. non-tobacco users. *The American Journal on Addictions*, *6*, 159-167.