

DRAFT EXECUTIVE SUMMARY:

TOWARD RECOVERY MANAGEMENT AND RECOVERY-ORIENTED SYSTEMS OF CARE SCIENTIFIC RATIONALE AND PROMISING PRACTICES

William L. White, MA
Senior Research Consultant
Chestnut Health Systems

Northeast Addiction Technology Transfer Center
Great Lakes Addiction Technology Transfer Center
Philadelphia Department of Behavioral Health & Mental Retardation Services

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Draft Executive Summary:

**Toward Recovery Management and Recovery-Oriented Systems of Care:
Scientific Rationale and Promising Practices**

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Epilogue by Dr. Michael T. Flaherty and Lonnetta Albright

Introduction (Excerpt)

Many questions have yet to be answered, but today we can draw empirically grounded conclusions about the performance of addiction treatment as a system of care and the relationship between particular treatment approaches and long-term recovery. Based on a review of this growing body of data, a number of long-tenured observers of modern addiction treatment are setting forth a most provocative argument: Significantly improving long-term recovery outcomes will require a radical reengineering of addiction treatment as a system of care. Rather than system refinement, these observers are advocating a “fundamental shift in thinking” (Moos, 2003), a “fundamental redesign” (White, 2005), “a seismic shift rather than a mere tinkering” (Humphreys, 2006), and a “sea change in the culture of addiction service delivery” (Miller, 2007).

What is prompting such rhetoric? What changes in service philosophy and design are being proposed and tested? What scientific findings and systems-performance benchmark data underlie these calls for “systems transformation” and the push for “recovery-oriented systems of care?” The purpose of this monograph is to answer these and related questions.

The material presented here defines and distinguishes two quite different models of addiction treatment: an acute-care (AC) model that focuses on brief biopsychosocial stabilization and a recovery-management (RM) model that emphasizes sustained recovery support. The historical tension between these models is reaching a tipping point, and the stakes involved in the outcome are quite high (White, 1998). As a professional field, we have oversold what a single episode of acute care can achieve for the more than two million individuals who enter addiction treatment each year. As a result, we are vulnerable to a backlash of cultural pessimism that might threaten the future of addiction treatment in America. Disillusioned service consumers and their families, allied professionals, policy makers, public and private purchasers of care, and a public weary of celebrities repeatedly recycling through “rehab” might collectively revoke the probationary status under which modern addiction treatment has operated as a social institution for five decades. As we approach or surpass the point at which nearly everyone in the culture knows someone for whom addiction treatment did not “work,” the task we embark on in these pages could not be more important.

This monograph is written for those on the front lines of addiction treatment. It is written for the addiction service professionals, the clinical supervisors, and the clinical and administrative directors whose daily decisions widen or narrow the doorways of entry to long-term recovery for those they serve. You are being asked in this monograph to take a searching and fearless professional inventory of addiction treatment as currently practiced by yourself and others.

This monograph is also written to the policymakers, purchasers of care, monitors, and evaluators of addiction treatment. You are being asked to look at the scientific and system-performance data that support growing calls for “recovery-focused systems transformation” and to explore new approaches to funding and monitoring local addiction treatment programs.

This is the fifth of seven planned monographs related to recovery management.

- The first, co-authored by William White, Dr. Ernest Kurtz, and Mark Sanders and published by the Great Lakes Addiction Technology Transfer Center in 2006, described the field’s beginning shift toward a recovery paradigm, outlined the latest research on the varieties of recovery experience, and summarized the recovery-management model and its particular relevance to communities of color.
- The second monograph, an edited consensus statement authored by Dr. Michael Flaherty and published by the Northeast Addiction Technology Transfer Center in 2006, was the product of an “addiction as chronic illness” advisory group whose members included Victor Capoccia, Dr. Mady Chalk, Dr. Herman Diesenhaus, Dr. Eric Goplerud, Rick Harwood, Dr. David Lewis, Dr. Tom McLellan, Dr. Kevin Mulvey, Dr. Rick Rawson, Dr. Ed Wagner, William White, and Dr. Mark Willenbring.
- The third monograph, co-authored by William White and Dr. Ernest Kurtz and published by the Northeast Addiction Technology Transfer Center in 2007, was a primer on how addiction professionals and recovery coaches can effectively link clients from addiction treatment to indigenous communities of recovery.
- The fourth monograph, jointly published by Great Lakes ATTC and the Northeast ATTC in 2008, contained a series of interviews with persons on the forefront of developing “recovery-oriented systems of care,” including Dr. H. Westley Clark, Dr. Tom Kirk, Dr. Arthur Evans, Mike Boyle, Phil Valentine, and Lonnetta Albright.
- The two other planned monographs offer technical papers on the implementation of peer-based recovery support services and on treatment redesign within recovery-oriented systems of care.

The current monograph pauses to underscore the scientific rationale for addiction treatment systems transformation. This monograph:

- Defines and distinguishes acute-care and recovery-management models of addiction treatment
- Defines and distinguishes the terms recovery management and recovery-oriented systems of care
- Identifies recovery-focused performance measures (e.g., access, engagement, retention, service scope/duration, linkage to communities of recovery, and post-treatment monitoring and support) that can be used to evaluate addiction treatment as a system of care and evaluate the performance of local organizations specializing in the treatment of severe AOD problems
- Presents findings from studies of addiction treatment and from national and state addiction treatment data-collection systems related to the identified performance measures
- Highlights promising practices aimed at improving long-term recovery outcomes
- Suggests measures that can be used to evaluate addiction treatment at both macro (system of care) and micro (individual program/unit/worker) levels of performance

The remainder of this document presents the draft Executive Summary.

Executive Summary

This Executive Summary presents in brief the assertions made and supported in the chapters to follow. It is intended both as a preview of the full monograph and as an overview of what the scientific literature has to offer on this vitally important subject.

CHAPTER ONE

Modern Addiction Treatment:

Emergence and Evolution of an Acute-Care Model

- Addiction (severe alcohol and drug dependency) shares many of the defining characteristics of chronic primary illnesses, e.g., Type-2 diabetes mellitus, hypertension, and asthma.
- Characterizing addiction as a chronic illness does not mean that all AOD problems have a prolonged course requiring professional treatment, that full recovery is not possible, or that self-management responsibilities are diminished.
- Although long-characterized as a chronic disorder, addiction has been addressed in an essentially acute-care (AC) model of treatment.
- The AC model of addiction treatment is characterized by its crisis-linked timing, brief duration, singular focus on achievement of abstinence, professionally dominated decision-making processes, short service relationships, and expectation of full and permanent problem resolution following “graduation.”
- The development of the AC model of addiction treatment was shaped by the medicalization, professionalization, and commercialization of addiction treatment and the subsequent growth of managed behavioral health care in the United States.

CHAPTER TWO

The Momentum for Change

- The AC model of specialized addiction treatment has measurable positive effects when compared to alternative non-specialized interventions or an absence of intervention, but these effects vary widely by program, counselor, and population served.
- Based on the growing body of outcome data, marketing of the AC model has oversold the benefits that individuals, families, and referral sources can expect from a single episode of brief, specialized treatment of severe AOD problems.
- Challenges to the AC model and calls for a more sustained recovery management (RM) model have come from multiple sources: a new grassroots recovery advocacy movement, disillusioned purchasers of care, research data on limitations of the AC model, positive evaluations of RM model components (e.g., recovery checkups), and excitement generated by recent “recovery-oriented systems-transformation” pilots, e.g., the State of Connecticut and the City of Philadelphia.
- “Recovery-oriented systems of care” (ROSC) are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by severe substance use disorders. The system in ROSC is not a treatment agency but the macro-level organization of a community, a state, or a nation.
- “Recovery management” (RM) is a philosophical framework for organizing addiction treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality-of-life enhancement for individuals and families affected by severe substance use disorders.

CHAPTER THREE

Recovery-focused System-performance Measures

- Interest is rapidly growing in the development of formal, systems-level performance measures for addiction treatment.
- Recovery-focused performance measures include three dimensions of systems evaluation: 1) measures of infrastructure stability and adaptive capacity, 2) recovery-focused service process measures, and 3) long-term recovery outcome measures.

- Infrastructure stability and adaptive capacity reflect the capacity of an organization to undergo system-transformation processes (e.g., from an AC to a RM model of care) and the capacity of an organization to fulfill over time its commitment to continuity of contact and support for individuals and families entering long-term recovery processes.
- Recovery-oriented service process measures are intermediary outcomes (e.g., early identification, engagement, retention, etc.) that are linked to the final goal of long-term individual and family recovery.
- Long-term recovery outcome measures represent the major fruits of recovery, defined here as the resolution of alcohol and other drug problems, the progressive achievement of global (physical, emotional, relational) health, and citizenship (elimination of threats to public safety, life meaning and purpose, self-development, social stability, and social contribution).

SUMMARY: RECOVERY-FOCUSED SYSTEM-PERFORMANCE MEASURES

- I. Infrastructure Strength and Adaptive Capacity
 - A. Recovery Representation/Orientation
 - B. Health and Stability of Administrative/Clinical Leadership
 - C. Organizational Health and Stability
 - D. Capitalization and Funding Diversification
 - E. Financial Stewardship
 - F. Institutional Relationships
 - G. Workforce Composition and Stability
 - H. Technological Capabilities
 - I. Adaptive Capacity
- II. Recovery-focused Service Process Measures
 - A. Treatment attraction and access
 - B. Screening, assessment, and level-of-care placement
 - C. Composition of the service team
 - D. Service relationship (engagement, retention, and discharge status)
 - E. Service dose, scope, and quality
 - F. Locus of service delivery/influence on the post-treatment recovery environment
 - G. Assertive linkage to communities of recovery.
 - H. Post-treatment monitoring, support, and early re-intervention
- III. Recovery Outcome Measures
 - A. Pre-/post-treatment changes in:
 - AOD use/consequences
 - Living environment
 - Physical health and health care costs
 - Emotional health
 - Family relationships and family health
 - Citizenship (legal status, education, employment, community participation, community service)
 - Quality of life (spirituality, life meaning and purpose)
 - B. Post-treatment Service/Support Utilization Patterns
 - Utilization of professional services
 - Utilization of indigenous recovery support institutions
 - C. Changes in Family and Community Recovery Capital

CHAPTER FOUR

The Infrastructure of Addiction Treatment

- Measurable elements of addiction treatment infrastructure required to fully implement an RM model include recovery orientation and representation, leadership stability, an esteemed status of addiction treatment as a cultural or community institution, capitalization and funding diversification, organizational stability, workforce stability, and adaptive capacity.
- Recovery advocates perceive a historical weakening of the recovery orientation of addiction treatment programs—that addiction treatment has become detached from the larger and more enduring process of long-term recovery.
- The shift from an AC to a RM model of treatment will require repositioning addiction treatment as a cultural institution and re-educating the public and policy-makers about the nature of addiction and its treatment.
- The shrinking proportion of health care resources devoted to addiction treatment and the growing reliance on governmental funding for treatment will limit the resources and demand effective stewardship of the resources that can be mustered to support systems-transformation efforts.
- Challenges to systems-transformation efforts include the instability of addiction treatment organizations, the mass exodus of long-tenured leaders within the addiction treatment field, and the lack of system-wide programs of leadership development and succession planning.
- Ensuring continuity of contact in long-term recovery support relationships will require reversal of the currently high annual turnover rate within the addiction treatment workforce.
- The creation of ROSC and the shifting of local treatment agencies toward a RM orientation will require tandem efforts to strengthen both the national infrastructure of addiction treatment in the United States and the infrastructures of local addiction treatment service providers. Lacking such efforts, ROSC and RM will constitute only a new rhetoric and isolated pockets of innovation, rather than a true transformation of the system of care.

CHAPTER FIVE

Who Receives Addiction Treatment?

The Variability of AOD Problems and their Patterns of Resolution

- There are marked differences between alcohol and other drug (AOD) problems seen in the larger community and those seen in clinical settings.
- Those with AOD problems seen in clinical settings are marked by greater personal vulnerability; greater problem severity, complexity, and chronicity; and lesser degrees of recovery capital.
- Strategies of natural recovery, moderated resolution of AOD problems, and resolution of AOD problems through brief intervention that are quite viable in community populations have less utility with the clinical population now entering addiction treatment in the United States.
- The effective treatment of AOD problems requires a clear formalization and delineation of strategies distinguishing transient and less-severe AOD problems from AOD problems of great severity, complexity, and chronicity.
- The most fundamental issue facing the field of addiction treatment is whether the field claims ownership of all AOD-related problems (and changes its treatment philosophies and service practices to fulfill that claim) or claims only a portion of AOD-related problems (e.g., only substance use disorders or only substance dependence), leaving less-severe AOD problems to other social institutions.

CHAPTER SIX

Recovery-focused Service Process Measure One:

Treatment Attraction and Access

- Only 10% of persons needing addiction treatment receive such treatment in any year, and only 25% of persons meeting criteria for a substance use disorder will receive such specialized treatment in their lifetime.
- Multiple factors impede help-seeking for AOD problems: misperception of the severity of AOD problems, misjudgment regarding ability to resolve AOD problems without help, the cost of professional treatment, treatment-related social stigma, the lack of critical treatment supports such as transportation or day care, and resistance to complete abstinence as the only proffered treatment goal.
- The AC model of addiction treatment attracts only the small percentage of persons admitted voluntarily to addiction treatment, with most entering treatment under external coercion at a late stage of problem development.
- High pre-treatment drop-out rates (initial contact without service initiation—ranging from 25-50%) are linked to personal ambivalence, lack of geographical or financial access, waiting lists, and personal obstacles to participation.
- Promising practices related to increased attraction and access include social marketing of AOD problem-resolution options and successes, assertive outreach, lowered thresholds of engagement, interim services for those on waiting lists, short-term case management to enhance engagement, regular check-ups for those resisting immediate service entry, telephone prompts through the early engagement process, family mobilization strategies, extended clinical hours, and delivery of services in non-stigmatized sites.

CHAPTER SEVEN

Recovery-focused Service Process Measure Two:

Screening, Assessment, and Level-of-Care Placement

- Early screening and brief interventions for AOD problems are effective strategies for reaching persons with AOD problems who are involved in non-specialized community-based service settings, particularly primary health care settings.
- RM models of assessment differ from the AC models in key dimensions. Assessment processes: are global rather than categorical; define the individual, family, and community as the unit of assessment rather than just the individual; are asset-based rather than problem- or deficit-based; and constitute a continuing process rather than an event taking place at a particular point in time (intake).
- ■ Where level-of-care decisions in the AC model focus primarily on problem severity and complexity, such decisions in the RM model are heavily influenced by the assessment of personal, family, and community recovery capital.
- Promising practices related to screening, assessment, and placement include AOD problem screening in primary care settings, Internet-based screening services, the use of standardized global assessment instruments, family-focused assessment protocols, and regular recovery community resource mapping.

CHAPTER EIGHT

Recovery-focused Service Process Measure Three:

Composition of the Service Team

- The shift from AC models of addiction treatment to RM models requires increased involvement of medical, psychiatric, and other allied professionals and the development and mobilization of peer-based recovery support services.
- There are a growing number of individuals and families with long, complex service careers within multiple systems who, despite the massive investment of dollars in crisis stabilization, exhibit minimal progress toward long-term recovery.
- RM models of care emphasize multi-agency models of intervention and embrace a larger goal of breaking intergenerational cycles of problem transmission, thus providing a framework for the integration of primary prevention, early intervention, treatment, and long-term recovery support strategies.
- Promising practices in enhancing service team composition include providing primary medical/psychiatric care in tandem with addiction treatment; the use of recovery coaches to provide continuity across levels of care; increased use of volunteers; and the creation of multi-agency, multi-disciplinary service teams.

CHAPTER NINE

Recovery-focused Service Process Measure Four:

Service Relationship (Engagement and Retention)

- Pre-treatment drop-out rates in addiction treatment exceed 50% of those who initially seek services.
- Less than half of persons admitted to addiction treatment successfully complete treatment.
- In recent years, the percentage of clients administratively discharged from addiction treatment-most for confirming their diagnosis by using alcohol or other drugs while in treatment-has ranged from 10-16%, or 200,000-320,000 individuals per year.
- Those persons who do not complete addiction treatment, both those who drop out and those who are extruded, constitute the population in greatest need of such treatment.
- Promising practices in enhancing engagement and retention include using motivational interviewing from the earliest stages of treatment or pre-treatment, using the most senior staff to induct new enrollees in treatment, using participation incentives, altering administrative discharge policies and practices, using a choice philosophy to expand the range of client decision making, increasing the focus on therapeutic alliance in training and supervision, and monitoring engagement indicators by service unit and by individual counselor.

CHAPTER TEN

Recovery-focused Service Process Measure Five:

Service Dose, Scope, and Quality

- Length of service contact is the best single predictor of post-treatment addiction recovery status.
- Length of time in treatment has decreased through the modern evolution of addiction treatment, rendering ever briefer the service relationship within the AC model of treatment
- The majority of clients discharged from addiction treatment in the United States receive less than the 90 days of service contact recommended by the National Institute on Drug Abuse.
- Expanding the scope of ancillary medical, psychiatric, and recovery support services in addiction treatment can elevate long-term recovery outcomes, but such service comprehensiveness is not the norm within the addiction treatment service sector.
- Progress is being made in the integration of evidence-based practices within mainstream addiction treatment, but treatment methods continue that are ineffective or potentially harmful.
- Promising practices related to the dose, scope, and quality of addiction treatment services include greater use of stepped care, more assertive linkage to recovery support groups and post-treatment recovery support institutions (e.g., recovery homes, recovery schools, and recovery ministries), co-location of medical/psychiatric/social services, increased emphasis on evidence-based treatments, increased monitoring of fidelity to preferred service methods via clinical supervision, and increased communication between clinicians and researchers.

CHAPTER ELEVEN

Recovery-focused Service Process Measure Six:

Locus of Service Delivery/Influence on the Post-treatment Recovery Environment

- Most addiction treatment services are institution-based; service providers have little contact with the natural environments of the individuals and families who consume their services.
- Post-treatment family and social environments play significant roles in the long-term recovery process.
- Recovery has the potential to destabilize intimate and family relationships that have survived the trials of addiction.
- Families can benefit from extended post-treatment monitoring and support.
- Clients deeply enmeshed in drug cultures face special challenges in transitioning from recovery initiation in institutional settings to recovery maintenance in their natural environments.
- Greater attention must be focused on the ecology of long-term recovery.
- Promising practices related to locus of service delivery and shaping the post-treatment recovery environment include assertive linkage to communities of recovery, home- and neighborhood-based services, abstinence-based social clubs, recovery support centers, the development and/or use of recovery homes and recovery schools, the use of indigenous healers and institutions (e.g., folk healers, recovery ministries), and the use of consumer council and alumni association members to conduct street outreach and recovery coaching.

CHAPTER TWELVE

Recovery-focused Service Process Measure Seven:

Assertive Linkage to Communities of Recovery

- Participation in recovery mutual-aid groups can elevate long-term recovery outcomes for diverse populations
- The effects of recovery mutual-aid involvement reflect multiple mechanisms of change and vary by the number of meetings in early recovery, duration of participation, and intensity of participation.
- Combining addiction treatment and recovery mutual aid is more effective than either alone.
- The positive effects of recovery mutual-aid groups are offset by weak linkage and a progressive attrition in participation over time.
- Assertive linkage to a recovery support group is more effective than passive referral (verbal encouragement to attend), but the linkage process in most treatment programs is of the passive variety.
- Half of all clients completing treatment do not participate in recovery support groups after discharge, and of those who do, 40-60% discontinue participation within a year of treatment discharge.
- Participation in other recovery community institutions (e.g., recovery homes, recovery schools, recovery industries, recovery support centers, recovery ministries/churches) may enhance long-term recovery, but evaluation of this potential is at an early stage.
- Promising practices related to linkage to communities of recovery include the enhanced institutional linkage between treatment institutions and communities of recovery; use of assertive linkage procedures; orientation and linkage to Internet-based recovery support groups; and expanding treatment philosophies to embrace diverse religious, spiritual, and secular pathways of recovery.

CHAPTER THIRTEEN

Recovery-focused Service Process Measure Eight:

Post-treatment Monitoring, Support, and Early Re-intervention

- Post-treatment monitoring and support can significantly elevate long-term recovery outcomes.
- Only a small percentage (20-36%) of adolescents and adults completing addiction treatment receive post-treatment continuing care.
- RM models of continuing care are distinguished from AC models by several critical factors: 1) post-treatment monitoring and support is provided to all clients, not just those discharged; 2) responsibility for continued contact lies with the service staff rather than the client; 3) support is provided at saturation levels in the first 90 days following discharge from treatment; and 4) “recovery checkups” are provided for an extended period of time (up to 5 years).
- The telephone and the Internet constitute two underutilized media for post-treatment monitoring, support, and early re-intervention.
- Promising practices related to post-treatment monitoring and support include enhancements aimed at participation (behavioral contracts, prompts, escorts, financial incentives); removing barriers to participation; extending time-span of support via recovery checkups; telephone- and Internet-based systems of continuing care; and expanding the range of environments in which continuing care occurs, e.g., home- and work-based follow-up.

CHAPTER FOURTEEN

Post-treatment Recovery Outcomes

- Reported treatment outcomes vary by definitions of key measures, e.g., abstinence, sobriety, recovery, lapse, relapse, success.
- Post-treatment evaluations consistently report improved odds of sustained abstinence, reduced AOD consumption by those who use, a reduction in AOD-related problems, and reductions in crime and risk of HIV infection.
- The majority (more than half) of people completing specialized addiction treatment in the United States resume some AOD use in the year following treatment.
- Post-treatment relapse rates are higher for men, adolescents, persons dependent on opiates, and persons with co-occurring substance use and psychiatric disorders.
- Between one-fourth and one-third of all clients discharged from addiction treatment will be readmitted to treatment within one year, and 50% will be readmitted within 2-5 years.
- The majority (64%) of those entering publicly funded treatment in the United States already have one or more prior admission, including 22% with 3-4 prior admissions and 19% with 5 or more prior admissions.
- Clients discharged from addiction treatment have high post-treatment mortality rates-1.6 to 4.7 times greater than age-matched populations without substance use disorders.
- Stable recovery can be preceded by years of cycling in and out of sobriety experiments.
- Evaluations of specialized addiction treatment also reveal the potential for harmful effects of such intervention.
- The potential for long-term recovery from substance use disorders is affirmed by population studies noting recovery rates of 50% or higher.

CHAPTER FIFTEEN

A Closing Reflection: Recovery, Science, and Systems Transformation

- Findings from scientific studies and systems-performance data support expanding the acute-care model of intervention into severe AOD problems to a model of sustained recovery management.
- The findings support addiction treatment system redesign efforts focused on: infrastructure enhancement; early intervention and improvements in service access and therapeutic engagement; improved systems of individual, family, and community assessment; broadening institutional and professional resources involved in service delivery; a shift in the service relationship to a partnership model; elevating the scope, quality, and duration of service delivery; assertively linking individuals and families to communities of recovery; providing post-treatment monitoring, support, and early re-intervention services to all clients/families for up to five years following completion of primary treatment; and the systematic collection of long-term, post-treatment recovery outcome data for all clients/families admitted to addiction treatment programs.
- Selected states, local communities, and addiction treatment institutions have already begun this recovery-focused systems-transformation process.
- Model components of the recovery-management model (e.g., models of assertive outreach, strategies for enhanced service access, evidence-based proactive initiatives, recovery check-up pilots) are already in operation and can be refined for system-wide implementation.
- An existing model of intervention and long-term support that incorporates many dimensions of the recovery-management model is the network of Physician Health Programs in the United States, whose evaluations have revealed the highest long-term recovery rates reported in the scientific literature.
- It is time we proactively managed the prolonged course of addiction and recovery careers rather than focusing on self-encapsulated episodes of biopsychosocial stabilization.

REFERENCES

(50+ pages of peer-reviewed literature citations)