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Introduction
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The previous issue of The Bridge provided a “Recovery Movement 101” for readers desiring a quick introduction to this emerging phenomenon.

The issue, accessible at http://www.attcnetwork.org/find/news/attcnews/epubs/bridge_v5i1.html, followed an interview format with four experts: Mr. Greg Williams, and Drs. Michael Flaherty, Alexandre Laudet and Lee Kaskutas. Greg is a leader in the movement, producer of “The Anonymous People,” Mike is a research-informed clinician deeply involved with the movement through his work at the Institute of Research, Education and Training in the Addictions (IRETA), and Alexandre (National Development Research Institute) and Lee (Public Health Institute) have been completed NIH-funded research on the topic of recovery.

The issue comprises a substantial and valuable overview. Notable in the issue is the contrast between the enthusiasm of the activists and the “studied caution” of the researchers, with the former having much more to say than the latter. In this issue, I join members of our Editorial Board in offering responses and observations stemming from the material presented from the interviews.
The Recovery Movement and Moments in Time
Dennis McCarty, PhD
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In the exploration of the Recovery Movement in the previous issue of The Bridge, the experts were asked about the Movement's similarities to and the influence of the National Council on Alcoholism (NCA), now the National Council on Alcohol and Drug Dependence (NCADD). To newcomers in the field, the centrality and significance of this organization at an earlier time is easily overlooked, particularly because there is yet no published analytic history of the NCA.

In my career (which is only a bit briefer than Dr. Roman’s), I watched the evolution of the NCA's affiliated local Councils on Alcoholism. Their maturation and demise may foreshadow challenges for the Recovery Movement and its future. A brief history outlining the impacts of advocacy on court decisions, state legislation and federal legislation may help place the roles of the NCA and the Recovery Movement in context.

Judicial Action

In the 1950s and 1960s, women and men in recovery provided inspirational examples of recovery, formed local Councils on Alcoholism affiliated with NCA and based on NCA's guidelines, and advocated for humane care for alcoholics. Arrests for public intoxication clogged urban courts; drunkenness offenders were detoxified in drunk tanks and sentenced to county farms and workhouses for drying out (The President’s Commission, 1967).

Legal advocates seeking enlightened public policies appealed convictions for public intoxication. Decisions in U.S. circuit courts in 1966 (Easter v District of Columbia; Driver v Hinnant) and the U.S. Supreme Court (Powell v Texas) in 1968 effectively invalidated the use of arrest and incarceration to control chronic drunkenness. The courts determined that homeless alcoholics were ill and unable to restrict alcohol consumption to private settings. Public intoxication, therefore, was involuntary and, based on precedents in common-law, not punishable (Hutt, 1967; Kurtz & Reiger, 1975; NIAAA, 1971; Room, 1976).

After these decisions, an alternative to court management of homeless alcoholics ("public inebriates") was needed. The court decisions drew attention to the lack of treatment services and the inadequate scope of most state legislation to deal with the problems of alcoholism (Grad, 1978; Kurtz & Reiger, 1975; NIAAA, 1971; Room, 1976). Councils on Alcoholism helped move conversation about these needs from the courts to the executive and legislative branches of government.
State Legislation

The court rulings and subsequent legislation required states to change criminal laws and develop comprehensive treatment systems. The Uniform Alcoholism and Intoxication Treatment Act (Uniform Act) guided reform efforts in many states. The model act prohibited prosecution of alcoholics solely because of alcohol consumption and detailed a continuum of treatment services to promote recovery from alcoholism (NIAAA, 1971). To implement this vision, the Uniform Act included provisions to build and support a network of community services for the treatment and prevention of alcohol abuse and dependence. For each state and U. S. Territory, the Act required a single office designated as the “authority” for alcoholism prevention and treatment with explicit powers to fund, regulate, and coordinate prevention and treatment services. Within the states, regional treatment facilities and licensing standards were required. Finally, the Act affirmed the confidentiality of treatment records, authorized access to the records for purposes of research, and provided public funding for treatment services for indigent patients.

The Uniform Act promoted a public health model for the control and treatment of public intoxication and alcoholism and (although modified slightly in each state) was implemented in 37 states (Finn, 1985). Services improved and more humane care was provided for public inebriates where state appropriations increased to support the care (Scrimgeour & Palmer, 1976). Overall, the impact of public intoxication on criminal justice resources declined dramatically and health care delivery systems were altered (Scrimgeour and Palmer, 1976).

The Uniform Act created and empowered state authorities for the treatment and prevention of alcoholism, fostered publicly funded alcoholism treatment systems, and increased access to care. The Act showed how legislation can promote systemic change in interventions for alcohol abuse and dependence. Federal legislation also stimulated system development.

Federal Legislation

The Highway Safety Act of 1966 (PL 89-564), required a report to Congress on alcohol use and traffic safety. The report “Alcohol and Highway Safety” estimated 25,000 alcohol-related highway fatalities each year, encouraged intervention and diagnostic services and noted the lack of data on the effectiveness of countermeasures (U.S. Department of Transportation, 1968). As a result, The National Highway Traffic Safety Administration supported Alcohol Safety Action Programs to screen offenders arrested for driving while intoxicated and treat alcoholism when it was identified.

The first federal funds for community-based alcoholism treatment and prevention services were authorized in 1967 and 1969 (NIAAA, 1971). The Alcoholic Rehabilitation Act of 1968 (P.L. 90-574) noted that alcoholism was a major health problem, encouraged community-based services, and authorized federal funds for con-
structure and staffing of services in community mental health centers (NIAAA, 1971). This early legislation reflected a growing awareness of alcohol-related problems but did not catalyze the development of services – funding was limited.

Senator Hughes, a recovering alcoholic and newly arrived in the Senate, was incensed that budget reductions eliminated the $4 million in federal funds for community assistance grants for alcoholism treatment, formed and chaired the first congressional committee to examine alcoholism and drug addiction from a health perspective – the Special Subcommittee on Alcoholism and Narcotics (Hughes, 1979). In mid-1969, committee members heard testimony from dignitaries willing to publicly identify themselves as alcoholics – Mercedes McCambridge (Academy Award-winning actress), Marty Mann (founder of the NCA) and Bill Wilson (co-founder of Alcoholics Anonymous). Physicians, researchers, clergy, and community leaders spoke on the extent and effects of alcoholism and alcohol-related problems and urged support for a national program to address alcoholism and alcohol abuse (Hewitt, 1995; Pike, 1988). Senator Hughes also noted that “Treatment for drug abuse is virtually nonexistent because addiction is not recognized as an illness … Under our laws it is a crime” (p. 288; Hughes, 1979).

The hearings led to the Comprehensive Alcoholism Prevention, Treatment and Rehabilitation Act. After intensive lobbying by “friends of Bill W.” who had access to President Nixon, the Comprehensive Act was signed on New Year’s Eve 1970 (Hewitt, 1995; Lewis, 1988; Pike, 1988; Smithers, 1988). Sometimes referred to as the “Alcoholic’s Bill of Rights,” the Hughes Act created a national program to support the development and funding of alcoholism treatment and prevention services and encouraged programs of research on alcoholism and its treatment (Hewitt, 1995; Lewis, 1988). The Act created federal formula grants for states to support treatment and prevention services, and authorized the National Institute on Alcohol Abuse and Alcoholism. The legislation also encouraged hospitals to admit alcoholics and protected the confidentiality of alcoholism treatment records.

**Impact**

In less than a decade from the mid-1960s to early 1970s, the NCA and its local chapters supported and added vigor to a national tsunami of change that focused attention on alcohol-related problems and alcoholism, dismantled criminal prosecution of public inebriates, and advocated for the state and federal legislation that authorized and funded treatment and prevention services for alcohol use disorders.

But the mission of the local NCA councils also changed. In their earliest days, they had pressed for humane care for alcoholics, and local councils became involved as ad hoc treatment providers, first operating volunteer care services and offering counseling, often in their homes. As the new legislation was implemented in the 1970s, the local councils developed licensed treatment facilities as state infrastructure developed and resources to support formal treatment increased.
Through these commitments of energies, the councils became less effective in their advocacy roles, and networks that had been vital in supporting advocacy weakened as the focus of attention became more local. The clinical enterprise became the dominant feature of their mission and local chapters morphed from volunteer advocacy into clinical enterprises with full-time employees. Names changed from the “XYZ Community Council on Alcoholism” to the “XYZ Community Addiction Treatment Center.” They were now care providers advocating for more resources to support their clinical enterprises. The advocacy became self-serving for these local operations rather than selfless for policy change on the national level.

The Recovery Movement faces similar challenges that current systems of treatment for alcohol and drug use disorders must address. Chronic models of care for addiction need to be integrated with primary medical care. How will advocacy efforts interface with primary care? Will recovery coaches have a role in primary care medical teams? Treatment services must embrace evidence-based practices. Will the Recovery Movement advocate for enhanced access to medication-assisted treatment for alcohol and opioid use disorders? Will the movement be open to research and having basic assumptions challenged and tested?

Finally, when the movement works to attack stigma and promote the value of recovery, it can be an effective voice. If the movement seeks to promote specific services that benefit specific individuals and programs, it will be a less effective mechanism. Advocacy by its nature is most effective when it is perceived as selfless.

References


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What is the Recovery Movement? Addiction is Not One Thing
Elizabeth Wells, PhD
University of Washington

The insightful responses to the interview questions about the Recovery Movement covered a lot of ground and left little that needs to be said. Stumped for a while about what I could add, I reflected upon the entire discussion and the fact that we now apparently have a new Recovery Movement that overlaps with both formal treatment and the 12-Step movement that has been around for many decades. In the 30 years that I have been involved in addiction-related research, I have seen the sands shift many times in how addiction is viewed and what are seen as the best ways to address it. And, there are often competing views that coexist about these two topics.

Although The Bridge issue was about recovery, it led me to think more about how we view addiction. Mike Flaherty stated, “NIDA has always said addiction is a biopsychosocial illness. I might add spiritual.” I have also always operated from this biopsychosocial/spiritual viewpoint, which both helps to define addiction but also makes it clear that addiction is not any one thing. There are clearly multiple routes by which a person develops an addiction to alcohol or other drugs, such that two people who have the potential to be “in recovery” might (and do) present very differently. The biological aspect includes many possible factors related to initiating or maintaining one’s addiction, such as genetic predisposition (alcoholism in the family), an insult to the brain in utero, or changes to the body and brain as a person becomes a chronic user. Similarly the psychological aspect might include such risk factors as a family history of bipolar disorder, a predisposition to high levels of anxiety, or early or recent traumatic experience. Social factors range from early failures in parent-child attachment to lack of role models for coping with stress or lack of current social support due to alienating friends or family. And the spiritual aspect relates perhaps to how and whether one has had the opportunity to develop a sense of coherence or meaning in life.

There are multiple ways in which these different factors can combine to create a person whose life has been negatively affected by substance use and who is seeking some sort of change. Although it may be helpful to group people with substance abuse problems in order to develop a limited set of effective treatments or recovery aids, no one treatment or recovery system is going to work for all. As Dr. Kaskutas pointed out, people define recovery in various ways, and they get to the point of what some call recovery through various routes. For this reason, as the sands shift across various forms of treatment and grassroots movements, it is important not to hold up one or another as the be-all and end-all. Will the “brain disease” or “chronic relapsing condition” definitions and the corresponding approaches work for every person? Probably not. This was
well-stated by Greg Williams in the previous issue, “Again the challenge here rests in us not placing internal or external value judgments on the “best” way for someone to enter in recovery. It must be self-defined. We must stop searching for the one way that is going to work for everyone and start searching for the path that works for the individual.” Greg also pointed out that there are some difficulties in implementing systems that respond the notion of multiple pathways to both addiction and recovery, when he said, “Until people in recovery get to know one another, and the validity of other pathways than own recovery experience (without attempting to universalize their experience as a higher quality of recovery than others) we will have some bumps along the way.” Although Greg was speaking of people involved in recovery, this might also be said of scientists and addiction professionals. Informed openness to multiple pathways and some resistance to simply going with the “flavor of the day” may be beneficial.

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Some Concerns About What is Not Included in the Recovery Movement

Dennis Daley, PhD
University of Pittsburgh

The previous issue of The Bridge was a very informative set of interviews with tremendous details, but I have a few concerns. Let me first offer two personal disclosures that likely shape my responses. First, Mike Flaherty is a friend and deeply respected colleague, and we go back 30 years in our extensive interactions with each other. Second, I myself am the author of several recovery guides for individuals with substance use disorders and their families.

1. I think a major “missing” component of the discussion of recovery-oriented systems of care is very little mention of the family. The term comes up several times, but without any details. Generally there is inadequate emphasis on how recovery relates to the family. For example, Dr. Flaherty mentions 120 people die daily from prescription drug overdoses. This has a tremendous adverse impact on families in many ways—dealing with grief; dealing with other burdens associated with a family member’s death (e.g., parents having to care for grandchildren because the parent died from an overdose or was incarcerated). Perhaps this minimization of family focus reflects the state of the field of addiction care in that families appear to be less involved in treatment, research studies seldom address family issues, major textbooks on addiction include few pages on family related topics (less than 4 percent of total pages).

2. In its support of a recovery movement, the mental health field has NAMI (National Association on Mental
Illness) and MHA (Mental Health America). Both organizations provide education and advocacy, and aim to affect public policy. In the addiction field, I am not aware of any similar national organization that does the same for families affected by an addiction or substance use disorder.

3. There is no mention of the importance of recovery literature used with individuals in treatment (and/or recovery). I cannot think of any treatment program that does not utilize supplement professional treatment with educational/recovery literature from mutual support programs like AA or NA (Big Book, Basic Text, educational brochures on many topics), or Al-Anon or Nar-Anon. Also, there are many of us in the field who have published recovery materials that reach a large number of individuals (e.g., Terry Gorski has written many books and workbooks on recovery that are used in many treatment programs; my colleagues and I have a large portfolio of recovery literature that reaches large numbers of individuals; for a controversial choice, Bill Miller has a book on moderate drinking for those with alcohol problems who are not alcoholic or dependent on alcohol.

I mention this because education and bibliotherapy are commonly used in both treatment and relapse prevention, and are valued by clinicians, clients in recovery, and family members. Mike Flaherty mentions the writings and resources on William White’s website on recovery (which offers many excellent written resources for anyone interested in recovery), but it should be recognized that many others have contributed significantly to recovery literature. Our surveys of more than 300 patients show that they rate recovery materials as very informative and helpful in learning coping skills to manage the challenges of recovery.

4. Mike Flaherty mentions the importance of “qualitative” science to supplement “quantitative” science, which I believe is an important area of knowledge. More qualitative research is needed to convey what we learn from in-depth descriptions of experiences of individuals with addiction or SUDs as well as such detail about the experiences of families in recovery. Narratives of recovery are invaluable. I once had a slide in one of my talks related to addiction and the family titled “beyond data” to convey that real people are affected by addiction, treatment and recovery, and data cannot convey the personal perspective. In our supervision and mentoring of medical students, psychiatric residents and other behavioral health professionals, we try to convey “understanding addiction (and recovery) from the inside out.” In other words, what is it like to have an addiction? What was your reaction when you created havoc in your family? What was it like to have lived with a family member who created an immense emotional and/or financial burden as a result of behaviors associated with an addiction?

5. Lee Kaskutas states that “we need to take seriously the idea of aftercare and of long-term recovery supports.” I believe the current clinical systems of care for addiction or SUDs rather narrowly rely on mutual support programs as the main form of long-term recovery. And, as Mike Flaherty states, most of the focus in treatment is on the “acute care” phase of treatment with recovery occurring outside of treatment. I think the mental
health field can teach us a lesson here when it comes to treatment of recurrent major depression. Treatment of recurrent major depression has three phases since 50 percent of individuals with major depression have at least one short-term recurrence: a) acute treatment, b) continuation treatment, and c) maintenance treatment. In the latter phase, the person recovering from depression can see a psychiatrist and/or other types of clinicians for years after the initial diagnosis. Each treatment episode may only last a few months, but this kind of structure keeps the person connected to providers.

This is the same fundamental model that some of us use to keep connected to our primary care physicians or specialists by having regular visits, and ACA advocates such a model for everyone. This model supports long-term recovery, and puts the person and the treatment team in a position to intervene early if a person may be headed to a recurrence of depression, or quick intervention if such a new episode has occurred. Unfortunately, many studies of addiction or SUDs are short-term, and only follow individuals with several months (and up to a year if they are lucky). And, many treatment programs put most of their resources in the early phases of addiction treatment/recovery (detox, rehab, partial hospital, intensive outpatient) rather than focusing on the long-term demands of successful recovery.

6. The responders talk about many paths to recovery, which it important, but are weak on distinguishing varying severities of SUD. Given that DSM-5 has changed “abuse” and “dependence” to “substance use disorders” that can be mild, moderate, or severe, the Recovery Movement does not address differing needs of individuals with more mild forms of a SUD. Not everyone needs long-term treatment or long-term recovery. Not everyone with a SUD has a “brain disease.” One of the problems in the field of SUD treatment is lumping all individuals into the same category of having an “addictive disease” without differentiating between those severely addicted to those with “mild” forms of a substance use disorder. It is risky and potentially a damaging exclusion to assume that those with less severe disorders do not experience stigma and do not require re-integration into social institutions following life crises and decisions to change behavior.

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Genuine Inclusion of the Whole Range of Routes to Recovery

Ron Jackson , University of Washington

I'm writing my reaction to this very interesting “conversation” piece on the recovery movement from the perspective of a person working almost exclusively in medication-assisted treatment (MAT) since 1972. I wish I could say that bias against individuals in recovery through MAT has been overcome through the avalanche of evidence of its effectiveness but, sadly, my experience is that it has not. Bias and stigma remain as strong as ever. Just read the recent Huffington Post article “Dying to be Free” (http://projects.huffingtonpost.com/dying-to-be-free-heroine-treatment/) and the readers’ comments about that article if you need proof of my assertion.

Those interviewed in The Bridge didn’t even mention the National Alliance of Medication Assisted Recovery (NAMA Recovery: http://methadone.org/) much less its MARS Project, which provides peer recovery support services to patients at Albert Einstein College of Medicine’s Methadone Maintenance Treatment Programs, in their recitation of recovery movement groups. Nonetheless, I was heartened to read the following quote from Greg Williams, described as “an established activist in the Recovery Movement, a leader of The Anonymous People:"

GREG WILLIAMS: “The biggest challenge rests in that we self-segregate in the wider recovery idea (no different than any other social affinity group). However, the beauty in some of the walks and community centers now emerging, and I am paraphrasing Bill White here, is that you have AA members, next to NA members, next to SMART recovery members, next to people on medication to support their recovery, next to people who found their recovery through faith. Until people in recovery get to know one another, and the validity of other pathways than own recovery experience (without attempting to universalize their experience as a higher quality of recovery than others) we will have some bumps along the way. When we can overcome the “in” fighting, perhaps then and only then will we be able to really and truly overcome the true enemies and barriers holding back the recovery experience for so many people today."

I certainly would echo the need for the Recovery Movement to embrace all individuals who are working on their recovery, regardless of method, but I think there is still a long way to go. As long as people receiving buprenorphine or methadone for the treatment of their opioid use disorders feel unwelcome at fellowship support group meetings, there is no solidarity in the movement. And when I see the Recovery Movement mobilize to take action when funding for MAT is threatened (as is the case currently in Maine), or when individuals in MAT are denied access to drug courts, then I'll know that there is solidarity and a movement that is truly inclusive. And I believe that there is a need for such a movement if the stigma of addiction is ever to be overcome successfully. I agree with Lee Kaskutas when she states, “Addiction is still stigmatized in American culture, and thus recovery also is still stigmatized.”
Resilience and Recovery
Holly Hagle, PhD
Director, National SBIRT ATTC

The previous issue of The Bridge focused on multiple aspects of the Recovery Movement that have emerged during recent decades. As I reflect on the issue and my past 12 plus years of experience with the ATTC Network, I have been able to witness the social movement referenced throughout the document.

One of the concepts that have always resonated with me is the focus on resiliency and community supports. The theme of community resiliency to grow recovery capital for individuals and their families was evident throughout all of the interviews. The Recovery Movement not only touches on intervention but also prevention. As these concepts come forward to the public at large through entities such as the Substance Abuse and Mental Health Service Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP) Strategic Prevention Framework, we can simultaneously focus on people’s recovery and prevention of substance use disorders.

Efforts to bring people’s recovery stories out to the public increase our knowledge and understanding of substance use. This moves us towards dismantling stigma and towards preventing future occurrences of the disease. For example, the Philadelphia Department of Behavioral Health and Intellectual disAbility Services has put the concept of resiliency at the forefront of their systems transformation. They are centering efforts to deliver services that create resiliency-building conditions. They offer this definition of resilience:

Resilience is a protective process which enables individuals to reach good outcomes even though they have endured significant adversities. Resilience is a common phenomenon arising from ordinary human adaptation and strength. It is a dynamic process that can change across time, developmental stage, and life domain.

Communities are forming online through social media outlets such as Twitter and Facebook that engage people in positive discussions on alcohol and other substances. Hello Sunday Morning (HSM) is one such group that uses social media (#HELLOSUNDAYMORNING). Another community-oriented organization is Shatterproof; their mission is to protect children from addiction to alcohol or other drugs by engaging in community building activities and an open dialogue about addiction.

Through these efforts I believe that over time substance use disorders will be seen for what they are: disorders that can be managed, that people do and can enter into Recovery, and do so with the support of their loved ones and the community.
This focus on the positive attributes of people, families and communities creates a pathway that builds on the strengths and assets of individuals, creating hope as people move through the process of recovery.

SAMHSA has increased the focus on recovery and the understanding that individuals with mental and/or substance use conditions are “met with the knowledge and belief that anyone can recover and/or manage their conditions successfully.” Health, home, purpose, and community are at the core of these recovery efforts. Dr. Mike Flaherty addressed the notion of prevention and intervention as enhancing the recovery movement, emphasizing that “community resiliency grows in each individual and family,” a wonderful notion and worthy of pursuit.

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Prospects and Promise of the Recovery Movement
Michael Boyle
University of Wisconsin

All of the interviewees in the previous issue of The Bridge identified stigma as being a major problem, acting as a barrier for people to self identify as being in recovery. Of course, this stigma has existed for generations. While most people have contact with someone in recovery—a neighbor, co-worker or member of an organization to which they belong—they may not know that the person is in recovery. From at least one perspective, a great potential for others' learning is lost by fear or shame blocking the revelation of a recovery identity.

To an unknown but likely large degree, the public's view of addiction is framed by the media with stories of entry and re-entry into rehab followed by repeated cycles of return to alcohol and drug use. They do not have a concept of the millions of people who have recovered and are leading satisfying and productive lives.

I think the greatest promise of the recovery movement is its potential to finally overcome stigma. Organizations like Faces and Voices of Recovery are taking on this challenge on a national basis and forming regional chapters. As the name suggests, they work to put forth the faces and voices of persons in recovery and work to fight stigma. The spread of Greg Williams' documentary film, The Anonymous People, takes another major step forward.

Despite the good efforts of the interviewees in the previous issue, I believe the “Recovery Movement” is difficult to define. Most often it involves some type of advocacy to support recovery targeted at policy makers, the media, general public and/or treatment providers.

Some years back, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) funded the creation of local recovery advocacy organizations. This effort was later changed to focus on recovery support efforts rather than advocacy. These organizations often have drop-in facilities and activities to support persons in recovery. Many of these local recovery organizations host annual recovery celebrations for people in recovery and their families to celebrate the joy of being in recovery. As these events become more widespread and receive more media coverage, public views are likely to change. One of the largest and most active is the statewide network known as the Connecticut Community for Addiction Recovery led by Phil Valentine. Hopefully, we will see a time when people feel free to speak about their recovery with well-deserved pride.

In addressing a part of the overall system within which there is some direct possibility of impacting change, SAMHSA developed Recovery Oriented Systems of Care (ROSC) that encompass a broader view than the traditional focus on treatment. An innovative component of this approach is recovery coaching. Success has
many parents but I will claim to be a papa along with David Loveland and Bill White for the birth of recovery coaching.

Fifteen years ago, when I was CEO of the treatment programs known as Fayette Companies, I was able to get legislation passed in Illinois to develop a disease management approach for behavioral health. My organization was funded for the project and I recruited Bill and David to be assistant directors of what became the Behavioral Health Recovery Management project.

One of our pilot efforts was recovery coaching: hiring a couple women in recovery to assist women after their completion of residential treatment. It was very positively received and expanded. Based on our experiences, David and I wrote a guideline to personal recovery planning and recovery coaching that is on our project web site under clinical guidelines at www.bhrm.org. The coaches helped women implement their personal recovery plans. A key point is that it was their own plan, not the aftercare plan dictated by a treatment program, one that is usually "one size fits all."

In his discussion about recovery coaching, Michael Flaherty states that he believes most recovery coaching is paid privately. That has not been my experience in recent years. Many treatment organizations are hiring recovery coaches or peer support specialists. States are covering the costs of these recovery supports through billable codes such as case management. Regional ATTCs in addition to SAMHSA are promoting the use of peer supports. Recovery coaches are not affiliated with any mutual aid groups such as AA. It is important that recovery coaches embrace the concept that there are many pathways to recovery and respect the approaches chosen by an individual.

In closing, my questions regarding the future of the Recovery Movement are these:

1. How can the impact of the recovery movement be measured? How will we know it is making a difference relative to other changes that may be underway?

2. Dr. Tom McLellan has said that his treatment outcome studies have reveal a large group of people who have moderated their use of alcohol at follow-up and no longer demonstrate negative symptoms of use. Could such persons be considered in recovery? Or, should recovery be defined as a minimum period of total abstinence such as the definition of being cancer free for five years? This is a hard question that taps fundamental and cherished beliefs, but it needs to be addressed

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What is Old or New in the Recovery Movement?
Paul Roman, PhD
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There is a clear tendency to regard the Recovery Movement as something new and separate from the larger activity of delivering treatment services to persons with substance use disorders (SUD). This is understandable in light of how the recent form of the Recovery Movement has emerged and gained support. My argument is that we can make a conceptual error by keeping recovery and the recovery movement apart from our basic enterprise because it is our basic enterprise. The discussion of the Recovery Movement in the prior issue of The Bridge helps clarify my belief that “recovery” is the core concept and the core issue for the SUD treatment community. Let me offer the first of three “twosomes” in this essay to explain why.

First, the social enterprise that played an immense role in the emergence and shaping of the $35 billion enterprise of SUD treatment in the U.S. is definitely Alcoholics Anonymous (AA). As is repeatedly observed, AA was not developed as a treatment but as a social mechanism for recovery. From a medical viewpoint, Bill W. was a modest treatment success on that monumental Saturday in Akron in 1935 when he made the critical phone calls that linked him to Dr. Bob. That day found a man who had been abstinent for about 6 months, following the last of multiple treatments at Towns Hospital in New York. The “White Light” or “Hot Flash” experienced in the hospital lends itself to cynicism about the Towns treatment enterprise if viewed through the lenses of today’s sophisticated addiction medicine. But Bill was both afraid and frustrated on that Sunday six months later, afraid of relapse but apparently frustrated that his abstinence had apparently not led to what he expected, particularly his failure to talk any other alcoholics into abstinence during this 6 month period. It is clear that he was seeking what we now call recovery.

The emerging AA articulated a plan that embedded a deep intuitive understanding about how lives might be transformed. Within the early AA paradigm, treatment and medical attention were described as vital, but were centered on detox and physical stabilization, followed by entry into the AA program for what we today call the “psychosocial” treatments. But the target was recovery, and the essence of the treatment movement was the targeting of recovery for patients and clients. As I outline below, this “Step” put what was to be the SUD treatment community at odds with the paradigm of medical care.

Second, using a single bit of empirical evidence, nearly the entire community of researchers, providers, practitioners, and policy makers subscribe to recovery as the True Index of what is desired and necessary in addressing SUD. This evidence is our unequivocally defining “treatment success” or “success rates” by locating patients and measuring their use of psychoactive substances at some distant point following the completion of
treatment. As I have stated in many other venues, this is unique in medical practice and healthcare, the larger world that the SUD community so much wants to join. Other measures of treatment outcome in medical look at patient symptoms and behavior during and immediately following treatment, a standard which a good many of our patients meet.

By these measures however, SUD treatment has a different problem, namely its common failure to fully engage admitted patients and to have them leave before the prescribed treatment is completed. But when so much of SUD treatment practice is in outpatient settings, this is a tough expectation, even for what might otherwise be regarded as top-quality treatment.

It should be evident that the “recovery expectation” as the index of effectiveness for treatment borders on the ludicrous from any kind of research design perspective. Evaluative designs are said to measure treatment impact but in reality it measures treatment impact + X forces + Y events in the external environment that have occurred since the patient left treatment. It assumes that somehow “treatment” should have turned patients into little Iron Women and Men who can take anything that the external environment is able to throw at them. And if SUD treatment has not given them enough resilience, then SUD treatment needs to “reach out” and construct and maintain structures in the post-treatment world which will adequately insulate the former patients from the forces that will undermine their developing or emerging recovery.

It is equally ludicrous to assume the SUD treatment community, and its constituencies that determine the policies that in turn pay the bills, will abandon this mode of measurement because they are indeed committed to recovery as the primary outcome of a successful treatment (and recovery) experience. It should be evident that these differences with other areas of medicine present major challenges as the efforts to integrate and practice alongside other medical care remain prominent. Continuing care cannot be dismissed in any area of medicine, but in other areas of medicine continuing care is provided as long as it is paid for, and it is up to the motivated patient to seek out this care rather than expecting the treatment program to track her down or send her text messages. Paying for recovery in the SUD field is the 800 pound gorilla swinging in the hammock. The pioneers in AA/NA did not have this problem because of the very early received wisdom that no money would ever be part of the work of these fellowships.

My second twosome are the big issues challenging the SUD treatment enterprise today, and what I see as some major “misses” in ignoring these matters and instead focusing on others, such as persuading the public that we are dealing with “brain disease” and that relapse is to be expected. This only enhances the stigma of recovery.

First, the impact of the SUD treatments that are currently being delivered is not the problem. This is despite
the commonly frantic statements that we need to discover what “works” in treatment, legitimizing the research resources that continue to pour into the pursuit for new medications and vaccines, and related studies to identify factors that “cause” addictive behaviors, which in turn will be controllable by biochemical interventions. Treatment does indeed work. A remarkable proportion of patients stay for the duration of treatment. At the end of those various treatments, a large number demonstrate abstinence and are tuned into the beginnings of relapse-sensitive coping and sobriety.

When such treatment effects are demonstrated in other branches of medicine, they are labeled as successful and worthy of eventually being described as “evidence-based.” Yet the popular press is increasingly loaded with criticism that the content of substance abuse treatment does not work (Hint: they read our own published evaluations based on the recovery paradigm). There is a convergence of explanations in the mass media and tomes by non-researchers that treatment does not work because it is largely based on obsolete principles and failure to recognize individual differences in treatment needs. But if a substantial proportion of patients leave SUD treatment clean and sober, what is the problem?

Unlike most other branches of medical care, this specialty has its biggest problems lodged in what happens prior to treatment and what happens after treatment. Many people who need treatment do not receive treatment and many people who receive treatment “relapse” (do not recover?) during the 12 months following treatment. In other specialties, problems such as symptom re-occurrence are not “blamed” on the treatment that the patient received, but on patient motivation and the environment.

Looking first at pre-treatment, the overall low rate of treatment is repeatedly explained by arguing that treatment for substance use disorders is in short supply, as reflected by data comparing those whose reported behaviors and experiences with psychoactive substances warrant treatment with the numbers who actually enter and complete treatment programs. My 3 decades of studying national samples of treatment programs show that the argument for inadequate supply is twisted in an important way: while there may not be an inadequate supply of treatment, there is definitely an inadequate supply of accessible treatment.

This accessibility also lies largely in the external environment, not in treatment itself. It can almost always be linked to the way in which substance abuse treatment is funded and/or to the quality of information that is provided about treatment.

One is typically admitted to medical care in the U.S. with the expectation that the “presenting condition” will be addressed with the necessary amount of appropriate treatment to assure the greatest likelihood of relief followed by recovery. In SUD treatment it is not unusual to be told that financial arrangements need to be made (often at the beginning of treatment, after a few days of inpatient care, or after a relatively small number of outpatient sessions) because of limits that insurers have made on reimbursement.
Regarding treatment education, the public is likely well informed about 12-step groups, but likely sketchy on how they actually function. Most of the information diffused about formal medicalized treatment is that it occurs in either dangerous inner city settings or in seaside resorts, and that its most common outcome is failure.

But more important, should one ask a physician (or other potential “helper” such as a teacher or member of the clergy) about how to deal with a substance abuse problem of one’s own or among significant others, a suggestion of a 12 step program or names of treatment centers may be provided, but rarely can the physician or other helper provide any details about the content or duration of treatment, and certainly little or nothing about how treatment might be paid for.

Other factors may play a role as barriers to care, but most investigations show that inadequate financial support and general lack of knowledge are the biggies. This is the essence of the pre-treatment problem.

Perhaps our field’s emphasis and foundation in a recovery model embeds lessons that need to be diffused into the rest of medical care, with other specialties turning toward long-term models of deliberately structuring patients’ “mindfulness” toward their chronic conditions, regardless of what may still need treatment and what may be in remission. This would of course require additional financial supports from insurance or somewhere, but the Affordable Care Act seems to embed parts of this general philosophy, although there is still much to learn about effective implementation.

Conversely, the fact that this specialty is indeed primarily focused on recovery may suggest some costs of the now-finally-somewhat-successful struggle to define and incorporate SUD into the medical model and medical care. In dealing with the funding issue, it seems that, for better or worse, we have been able to couple the medical and recovery model through the heavy use of no-cost 12 Step programs and, to a much lesser but significant extent, the tightly coupled Oxford House network, augmented to an unknown degree by increasingly common “alumni programs” affiliated with treatment centers.

Funding for the Recovery Movement seems to rest on contributions but its current financial needs would appear modest in light of its rather vague goals. This seems in large part due to the fact that it has not really carved out a clear set of advocacy positions, except for the compelling but rather flaccid idea of eliminating stigma associated with SUD. As several commentators have pointed out, recovery is stigma. Further the Recovery Movement does not seem to have found its own boundaries. Ron Jackson points out that acceptance of those on medication maintenance with the Recovery Movement is ambiguous, and Mike Boyle asks whether the Recovery Movement would accept a inclusion of those whose recovery does not include abstinence.
On the funding front, credit must be given to the Recovery Movement for facilitation of the modest but notable success in supporting and being supported by successful lobbying efforts for public funding for recovery centers and related activities in several states and localities. More information is needed on the long-term impact of this rather unique funding. It is also unclear how this attraction of funding is becoming institutionalized where it was started or how it is diffusing across the nation.

As Dennis McCarty analyzes with such cogent precision, the National Council on Alcoholism changed considerably over time from an advocacy organization to a organization more singularly involved in issues surrounding treatment delivery. In fact, it essentially lost its impressive platform where effective advocacy was a bi-directional effort with its many local affiliates.

It also failed to develop into a channel for private donations and contributions, and thus SUD is probably the only disease condition that has no national foundation through which to generate support—support for efforts to enforce parity regulations and to assure that SUD is fully included across the board in the implementation of the ACA. It is doubtful that the government will fund efforts to police itself.

Moving to my last pair of observations: at least two components of the Recovery Movement could carry it in a commercialized direction, and perhaps undermine it in a manner similar to what evolved with the NCA and its descendant organization. First is the abundance of essentially commercial recovery housing that is emerging, perhaps in imitation of the success of the totally non-monetary Oxford House movement. Given one of the few unequivocal findings of SUD treatment research that more treatment is associated with greater treatment success, there is certainly support for the idea of step-down treatment experiences before patients’ support from the “bubble” of treatment completely disappears. The content and clientele of these step-down experiences are only beginning to be documented (with the exception of Leonard Jason and colleagues’ remarkable work on Oxford Houses), but common sense indicates that it is skewed toward the affluent since third-party coverage is typically unavailable.

There is no doubt that regulation of these residences creates huge challenges, and documentation of rip-offs and zero professionalism in a few settings is found in the mass media. Of concern is the unlikely possibility of “educated consumers” choosing among these options for themselves and their loved ones, since there has been such a failure to educate the public about what is and is not reasonable to expect from any level of treatment and what to pay for treatment. A national association promises that it can offer a great deal in controlling quality and generating accreditation (and perhaps honesty) among recovery residences but this is currently a black box.
IN MEMORIAM
Michael Garvin Boyle
January 31, 1947-May 7, 2015

Mike Boyle was a member of the Editorial Board of The Bridge since its inception, and contributed to every issue. Very shortly after submitting his contribution to this issue, which appears above, Mike passed away after a very brief illness.

He will be greatly missed by all of us who knew him, and benefited from his intellectual depth, his energy, his reliability, and being an all-around really nice guy. He was taken far too early and we will surely miss his contributions here. His good humor and kindness offer great memories and an exemplar of how to leave a mark on the world.

Mike was a native of Lafayette, IN, and received his B.S. degree followed by an M.S. in psychology from Bradley University. Starting as a beginning counselor, he worked his way to being CEO of a major treatment organization, Fayette Companies, in Peoria, IL. Following retirement and his move to Lakewood Ranch, FL, Mike formalized his association as a research associate with the Center for Health Enhancement Systems Studies (CHESS) at the University of Wisconsin’s Department of Industrial Engineering. While CEO at Fayette, Mike learned of the early efforts to form the NIATx project, and became a volunteer in demonstrating the introduction of change into his own organization’s patient management processes.

In order to commemorate Mike’s contribution to The Bridge, we reprint below several quotations from his essays published over the last several years.

Nuggets of Treatment Wisdom from Mike Boyle

On Relapse Prevention
“The answer when someone relapses is often more of the same treatment with a longer length of stay – literally more of the same. And following longer treatment, they are once again discharged without a job and perhaps homeless. And we expect different results? These people often have nothing left to lose and nothing on the near horizon to gain from abstinence except avoiding punishment such as imprisonment or loss of children to the child welfare system. We should attend to assisting people to obtain employment and/or begin GED or community college classes while in treatment. Building the positive side of their personal ledger may give an incentive for continued abstinence that provides reasons to use the skills acquired in treatment.”
On Using Technology to Strengthen Recovery
“A re-designed system (incorporating recovery) could tear down artificial walls and silos. Recovery supports could begin immediately upon a person beginning to receive any service. In reality, many treatment organizations have implemented a similar system for decades by “introducing” people to 12 step programs. The problem is that this was the only “choice” for recovery support being offered. Other mutual aid and faith based options should be offered to each patient so they may choose the best option for them. Services such as GPS notification of approaching a high risk location and the panic button to alert selected individuals for their support could be utilized at the start of a treatment episode rather than only after completion of treatment. Use of the new technologies could combine treatment within what is now deemed continuing care. Patients may want “booster” sessions on how to address specific problems. These could easily be selected and delivered through technology without having to return to the formal treatment setting. Further, the new technologies have the capacity of delivering a face-to-face counseling session on a 24/7 basis.

A challenge is that dozens of computer programs and mobile apps are being marketed to address substance use illnesses, but most have not been subjected to clinical trials. I fear that some of these, perhaps developed with good intent, may be viewed as or actually be the equivalent of the “snake oil” remedies of the 19th century. I believe there is a role for behavioral health clinicians in the implementation of these technologies but it will be a very different approach than what exists today. The sessions will be 15-30 minutes rather than the traditional “50 minute hour”, individual or family services rather than delivered in groups, tailored to the patient’s progress and very focused. Delivery will utilize phone, tele-health and other technologies in addition to face-to face services. An ideal setting to model this new delivery system is in Federally Qualified Health Centers (FQHCs) particularly with the expansion of Medicaid coverage that is occurring in many states. The Center for Medicare and Medicaid Services mandate that states cover the delivery of behavioral health services by licensed psychologists and social workers within FQHCs. Further, the FQHCs are paid an enhanced rate compared to other primary care providers or community based substance use treatment and covered under an event mode rather than the time spent by a clinician. Thus, there is a financial incentive for brief interventions and a disincentive for hour-long discussions.”

On a Major Financial Barrier to EBP Implementation
“Many of the evidence based treatments require a substantial amount of the treatment be delivered in individual sessions with the patient and concerned significant others. Yet, the vast majority of treatment sessions are provided in group formats within existing treatment programs. Groups can be used to teach people about the stages of change and for skills practice through role playing but the practice of motivational interviewing requires individualized sessions. Thus, the structure of programs would have to be radically changed if evidence based practices are to be incorporated. The challenge to such a change is that groups tend to be an efficient way to earn reimbursement. While reimbursement structures vary among states and insurers, group services
with high attendance will usually earn more revenues per input of staff time than providing an individual session in the addiction field. The simple premise is “providers do what they are paid to deliver.” The payment system for substance use disorders usually rewards group treatment over individual or family sessions. For example, the state where my organization was located paid for treatment through fee-for-service. The individual hourly rate from Medicaid or state payments was $60.32. The group rate was $22.80 per hour. Thus, when we provided a group session with eight patients, the revenue per hour of clinician time was $182.40, representing a three-fold increase over the payments for a typical individual treatment session. Insurance and managed care contracts offer similar incentives for provision of group treatment. One managed care company we worked with paid $121 for an individual session and $45 for a 90-minute group. The financial benefits of providing group services were clear. Executive leaders face a dilemma even if they support using evidence-based treatments (EBPs): “How can I afford to reduce our revenues by two-thirds and remain in business?”

On Public Support for the Use of Medications
“The general public is not aware of the fact that medications are available to treat specific substance use problems. The media and the constant stories of public figures acknowledging a problem and announcing that they are “going to rehab” shape their view of what treatment entails. Thus, the general population is led to believe that going to a residential treatment program is the preferred approach to addressing substance use problems. Where are the stories of people who resolved their problems with the use of medication combined with outpatient cognitive behavioral therapy? Of course, the public has been so indoctrinated with the concept of going away to rehab, that many would probably not believe the person who chose an outpatient treatment was “really serious” about addressing their problems!”

On Integrating Substance Abuse Treatment into Mainstream Medicine
“If general medicine assumes responsibility for treating substance use illnesses, it is important that the best psychosocial approaches be incorporated. Professionals such as psychologists and social workers who are highly trained in evidence-based cognitive behavior treatments need to be part of the treatment teams. In fact, the experience of using behavioral change techniques for substance use problems may lead to the adoption of these practices to address other healthcare conditions. Patients should also be encouraged to join and attend mutual aid groups. Voluntary attendance in mutual aid has been shown to increase positive outcomes. It is time for the head and body of the treatment of SUDs to be reconnected, and the medical field offers the best opportunity for a rapid transformation to occur. Lack of resources, adherence to tradition, and resistance to changes directed toward the decades-old model of community-based substance use treatment make it unlikely that the current structures can adapt to the changing demands that will occur with continuing implementation of the ACA.”