Building a Unified Vision for Resiliency, Wellness, and Recovery

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Why do we need a common vision for addiction treatment in America today?

This line from West Side Story seems to provide a complete social analysis of our response thus far to addictive disorders:

> "Officer Krupke…I'm down on my knees, 'cause no one wants a fella with a social disease."

In just my lifetime, a number of approaches to address addiction have been prevalent in our society:

- Moral models
- Temperance models
- Spiritual models
- Learning models
- Social learning models
- Cognitive models
- Psychological models
- Disease models
- Bio-psycho-social (-spiritual) models
- Characterological/personality models
- Conditioning models
- Socio-cultural models
- Systems models
- Public health models

The psychoanalytic model gave birth to our field. In the mid 1900's, after several concerted efforts, most clinicians were honest and said they couldn't treat it effectively, so they handed it over to the churches. But the churches couldn't provide the full answer either. A wide variety of models have since developed, many of them blending a number of important elements, but they've all been focused on the pathology of the illness and all essentially based on acute-care models.

Never, until now, have we had a model focused also on recovery; a model that tries to understand that recovery is the cure for the illness; a model that bases care on the experience of individuals who have successfully reached and maintained recovery.

Instead, we've kept on trying to build systems to address the pathology. We've organized our service systems and third-party payment systems around the pathology and around our incorrect understanding of addiction as an acute illness. For example, most insurers allow only two

episodes of care in the patient's lifetime. Where does that come from? The system is essentially telling individuals with this illness that they need to get treatment, and after that, s/he should be "fixed." If not, it is the individual's "fault."

We've also organized our research and our measurement of treatment effectiveness around the acute-care model. How has that impacted treatment and recovery?

Well, first it has meant very low treatment compliance. Fifty percent of outpatients drop out of treatment within one month (Hubbard, Flynn, Craddock, & Fletcher, 2001). Forty percent of court-ordered patients do not complete treatment (Watkins, Pincus, Tanielian, & Lloyd, 2003). But these outcomes are misleading: We've been reporting outcomes based on the "success" of a level of care or the "success" of an agency at retaining clients, rather than on the amount of recovery an individual actually attains. In short, by design we have been reporting more on the failures of treatment than on its success or the nature of the illness.

The research also shows that relapse rates are high. About 60 percent of patients use alcohol and/or drugs within six months after discharge from treatment. About 45 percent apply for residential treatment within 12 months of discharge (Hubbard, Marsden, Rachal, Harwood, Cavanaugh, & Ginzburg, 1989)

What this has led to is a belief that treatment doesn't work. Public expectations have not been met. Patients are not being "cured" at the rate that they should be if this is an acute and curable illness. Either our treatment is not very good, or we have the wrong model for understanding and addressing the illness and measuring the success of our efforts.

So this brings us to our need to build a new vision. It reminds me of a conversation with Queen Isabella of Spain, circa 1490, in which Christopher Columbus was reputed to have said, "My dear Queen, in spite of what all the maps say, the world may not be flat!" In spite of what our science or our payment methods may be saying to us, addiction may indeed not be an acute condition.

And what if it is not?

We have never known more about the nature of addiction, nor have we ever had better science to support that treatment. But in spite of this, there remains an all-pervasive sense of pessimism about poor long-term outcomes. And of all the people who need treatment, a majority do not receive it. In my neighborhood in Allegheny County, PA, it was reported that in 2007, only 20 percent of those needing treatment received it (Allegheny County Department of Human Services, 2007). It is estimated that today in America there are some 21.1 million needing but not receiving treatment for illicit drug and alcohol use (Substance Abuse and Mental Health Services Administration, 2007). So now we need a model and a vision that will allow us to use all of the resources, information and technologies we have—and to begin to imagine that the world may be round after all.

To that end, William White (2006) and others have described two emerging movements that allow us to address addiction with a new vision. Their success or failure will shape the future of how we look at and respond to addiction in America.

One of these is the Treatment Renewal Movement, which has been growing in response to the sense of pessimism and inadequacy that the acute-care model has generated. In this movement, we've begun to look seriously at:

- whether addiction is a chronic or an acute condition;
- whether we want to expand our vision to include the whole continuum of care, or continue to focus just on an individual unit or episode of acute treatment;
- whether we concentrate our research on performance measures or extend it to outcomes; and
- whether or not medication is part of treatment or of recovery.

These are just some of the questions we're asking in this movement.

Concurrent with the Treatment Renewal Movement is the new Recovery Advocacy Movement, which has a number of implications for treatment. Components of this movement include enhanced and earlier linkage to recovery supports (available to people in treatment, not just after treatment has been completed), to develop detailed recovery plans in which the addicted individual takes a central role, to involve peer mentors and sponsors in recovery plans and linkage efforts, and to accurately measure and monitor the recovery capital that individuals use to build strong and lasting recovery.

There is a growing body of research that supports these approaches, including research from NIDA and data from SAMHSA/CSAT's Recovery Summits and Recovery Community Support Programs, the Access to Recovery program, and Robert Wood Johnson's Advancing Recovery initiative**.** Through these movements and others, we hope to bring in new evidence based on real-world experiences that will inform the research community and policy leaders and improve treatment renewal and recovery support efforts.

The Northeast ATTC/IRETA has partnered with the Great Lakes ATTC and others to support William White, Ernie Kurtz, Lonnetta Albright, Mark Sanders, Charlie Bishop and others to produce five monographs to help begin this process. Four of these are included in your Symposium materials today. The first is a Special Report (2006) that presents a unified vision for the prevention and management of substance use disorders. Five years ago, IRETA began the process of developing the vision, in which we asked 60-70 national leaders in addictions to ask themselves whether addiction is a chronic or acute disorder? The consensus of that group is presented in the Special Report (2006). Almost unanimously, the group said that substance use disorders are best understood as being or potentially becoming chronic conditions and that our best understanding of their treatment would come from such an understanding. This does not mean that all who have this illness are "chronic." It does mean that treatment for all is best understood in the context of addiction's potential for developing into a chronic disorder and that the focus of care should be on preventing the advancement of the illness to its next level, as with other chronic illnesses.

This, of course, opened the door to the next question. If addiction is a chronic illness, why are we treating it with acute models of care? This sparked a discussion related to the data available and the implications of what is not available. Are we bringing the right dose of treatment to our patients? Is this the right medicine at the right time? Is the research really measuring the

effectiveness of treatment? Or are we just reporting on the results of an acute episode of treatment that may not be indicative of an individual's progress in recovery?

In the second monograph, supported by the Great Lakes ATTC, authors Bill White, Ernie Kurtz and Mark Sanders (2006) laid the foundation for a Recovery Management Model of care with special emphasis on types, styles and variations of recovery in individuals and diverse populations. Shortly afterward, in 2006, supported by the Northeast ATTC, White and Kurtz used the existing research to show how it supports both a recovery focus and the linkage of existing treatment systems with community-based recovery support resources. They further discussed ways in which treatment and recovery support organizations can assist in making the linkage stronger which would lead to more effective overall clinical outcomes. A new model was being born.

Four ideas or principles were articulated as the foundation of the new treatment movement, and each of these principles was backed up firmly by the research:

- Addiction is best understood as a chronic illness.
- Addiction requires continuing care, over a continuum of care, for life.
- Addiction treatment should adhere to proven practices and principles.
- Treatment is very effective when these ideas or principles are followed.

In 1999, the National Institute on Drug Abuse (NIDA) reported that, for people with substance dependence disorders, anything less than a 90 day continuum of care is not valuable financially and clinically. But think about it: How many people are really getting the full 90-day continuum?

In Tom McLellan's 2003 work, "What's Wrong with Addiction Treatment?" he presents data that show very high use of alcohol and other drugs before treatment, followed by much lower levels of use during treatment, followed by high levels of reoccurrence after discharge. He makes the point that, far from showing that treatment doesn't work, this pattern actually provides evidence that treatment does work.

With any other kind of medical intervention for a chronic condition, a decrease in symptoms during the intervention followed by reoccurrence after the intervention is withdrawn would be interpreted as a clear indication that the intervention is effective in reducing symptoms. It's only in treatment for a chronic condition that these kinds of results are appropriately interpreted as evidence that treatment doesn't work. We've been using an acute-care yardstick to measure the effectiveness of treatment for a chronic condition.

A lot of this can be attributed to the stigma directed toward addiction within our society, including stigma within the medical and other helping professions. So instead of calling a return of "symptoms" a "reoccurrence" in keeping with our understanding of chronic disease, we call it a "relapse." Relapse is a highly stigmatizing term, full of moral judgment. It both reflects and perpetuates the stigma that plagues people who suffer from this illness.

As a field, we need to think about "re-languaging." We need to start speaking of "people with addictions," rather than "addicts"; "positive" toxicology screens, rather than "dirty urines"; and "reoccurrence," rather than "relapse." We need to speak of the larger category of "substance use

disorders," and call "substance dependence disorders" what they are, rather than inaccurately using the highly stigmatizing terms "substance abuse" and "substance abuser" when we're talking about substance **dependence** disorders.

In their 1996 article in Lancet, Drs. O'Brien and McLellan showed that reoccurrence rates for addiction were actually lower than those for other chronic illnesses such as diabetes, hypertension, and asthma. Therefore, if we approach substance use disorders with a chronic model, we learn that we can do as well as, if not better than, treatment for other chronic conditions. Treatment compliance rates were also similar. And who knows what relationship exists between compliance with treatment for these other chronic diseases and the presence of alcohol in the equation?

The only substance which still results in troubling treatment outcomes is the addiction to nicotine, where we still have 70 percent reoccurrence rates. But a number of interventions have been in place for some years, and we're down to the hard-core smokers, who are having a devil of a time quitting. Either they don't have the support they need to quit, or they lack the will to quit, and many live in environments in which smoking is still socially acceptable.

We also have early data that show an enormous benefit/cost ratio when you look at a chronic rather than an acute approach to treatment. In their 2005 study relating the results of a lifetime simulation model, Zarkin and colleagues showed that a dollar spent on treatment for heroin users under the acute-care model yields a benefit of only $4.86, as opposed to a yield of $37.72 for the same dollar spent on treatment under the chronic care model.

And this is just one of the very early studies of the cost benefit of looking at the world as if it were round.

Let's look at some foundations of the Recovery Movement:

- Looking at addiction as a recurring illness—acknowledging this basic element of its nature—by definition destigmatizes and decriminalizes the illness and its symptoms, one of which is reoccurrence.
- This movement empowers the individual as the center of care, focusing on an individual analysis of recovery needs, recovery capital, and the care and support that are necessary for lasting recovery. This reaffirms person-centered care and promotes deeper levels of involvement by the individual in his or her own care (IOM, 2006).
- This movement also reaffirms our knowledge that ongoing or continuous care is best for recovery. It's not just "90 days and you're done." According to the American Medical Association standards, an illness is not considered "cured" until the patient has five years without a reoccurrence. A continuing care approach includes a focus on components such as aftercare, linkage to communities of recovery, and recovery support services.
- The recovery movement celebrates the existence of many pathways to recovery, including 12-step programs such as AA and NA, culture-specific programs (e.g., Wellbriety), gender-specific programs (e.g., Women for Sobriety), faith-based recovery communities, and the many other recovery options. There is no one way to recovery. It's clear that these peer-support networks and the connection to ongoing recovery supports enhances outcomes tremendously, and there's data in our monograph to support this.

It's important to emphasize that this new Recovery Movement is not something that speaks critically of treatment. Rather, it offers to act as a partner to treatment in order to enhance medical care and long-term recovery. The connection between treatment and recovery broke down about 55 years ago. In the early days, these two entities tried to form an alliance, only to abandon that alliance due to the scarcity of resources and their very real and practical sense that they had to compete for dollars. Out of this came a medical model and a very separate recovery model, and each has evolved on its own since. Only now have the two begun to talk again, giving us the opportunity today to build a combined resource that can only come from the synergy of these two very necessary collaborators. Finally, we have a chance to help individuals attain and sustain wellness and long-term recovery and measure the progress toward both. Substance use treatment providers become the "specialists" in the treatment of an illness with chronic capabilities but also with community solutions and support.

In this new movement, quality of care will be **concurrently** measured with recovery achieved. Both the quantity and quality of recovery will be taken into account, and treatment models will always offer opportunities for recovery support. Secondary measures—beyond just the length of abstinence—will include the individual's personal recovery achievements, status, level of recovery, and level of involvement in recovery. Reoccurrence will no longer always mean starting over from square one. Sometimes reoccurrence will warrant a smaller intervention, rather than a beginning the whole treatment process again.

Let's look at some more precise data on the promise of this new movement:

- Individuals will stay in treatment and/or recovery supports longer, which will enhance outcomes. Today only one in five individuals uses treatment and recovery support services at the same time. We hope this will soon become two in five, or three in five (Moos & Moos, 2005).
- An individual's risk of future relapse rates will drop below 15 percent if s/he remains in stable remission for 4-5 years (Moos & Moos, 2005).
- Individuals will find support, rather than rejection, when they experience reoccurrence episodes, based on our understanding that the resolution of severe problems can span a lifetime. The incorporation of recovery support and ongoing care will also minimize reoccurrences (Dennis, Scott, & Hristova, 2002)
- Fewer individuals will experience reoccurrence within 90 days after discharge from treatment. The current rate of reoccurrence within 90 days is 80 percent, and we expect lower rates when this movement has begun to have its full effect on treatment and recovery success (Humphreys, Moos & Cohen, 1997).
- This new movement will measure wellness and will increase individual wellness. I'll talk a little more about this in a moment. When we're not focused solely on the pathology of addiction, we also begin to appreciate the level of co-occurrence with other chronic conditions such as depression, hypertension, and diabetes, and the role these types of conditions play in complicating the illness and interfering with recovery (Moos & Moos, 2005).

Now I have a question to ask you. To understand recovery within this new movement, where would you like to have the science focused? Should we base our science on what goes on in

treatment, or should we go out and learn from the millions of people who have achieved lasting recovery and see what worked for them? Where would you put your money?

Then the critical question becomes this: When does recovery begin? To show you the difference between the chronic model and the old acute model, according to DSM-IV, we can't say an individual has reached early recovery until drinking or drug use has been in remission for six months. But we know that, for example, in an AA meeting, very real recovery can begin six hours after the person put down the last drink or drug.

In the chronic illness model, we measure the disease state, but we also measure the quality of life and the results of preventive approaches. We anticipate conditions of the illness and measure the results of the approaches we practice. For example, if we know that 70 percent of recovering alcoholics experience depression, then we know that by preventing depression—reducing its incidence down to, say, 60 percent, 50 percent, or 40percent—we can produce measurable cost-savings in terms of healthcare that will not be needed in the future, and take credit for helping people achieve greater wellness and a better quality of life.

I'm going to offer you a provisional, temporary definition of recovery. This is the definition developed in 2007 by the Betty Ford Institute Consensus Panel, of which I was a member:

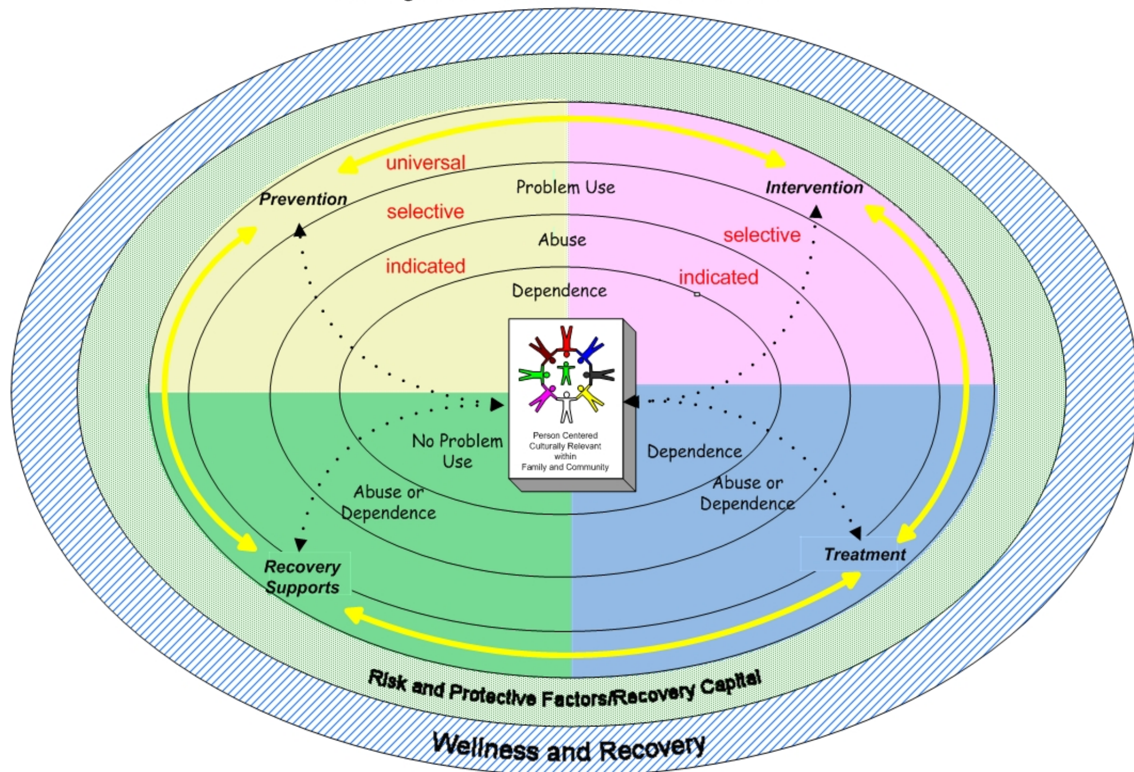
Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship. It includes:

- A lifestyle often best described as having an acceptance of one's illness and a gratitude, honesty, and increased sensitivity to service to others in one's family and community;
- Positive, supportive relationships
- Sobriety—abstinence from alcohol and all other non-prescribed drugs
- Improved quality of life for self and others, as measured in the following six domains:
  - Physical
  - Psychological
  - Independence
  - Social
  - Environment
  - Spiritual

What is most notable to me is the measurement of quality of life according to the six domains. We brought this forward to support the need for scientific measurements, while also valuing the characteristics of recovery that are described as being so valuable by people in recovery. These domains, developed by Bonomi, Patrick, Bushnell and Martin (1999), are the dimensions established by the World Health Organization, and the only broadly accepted measures we found to date that include spiritual well-being.

This leads to a thousand questions that we need to examine. We need to do this to understand recovery, and we need to bring these answers back into our treatment agencies. This provisional definition is intended to provoke dialogue, to begin the process of answering these questions. After all, how can we understand the illness if we can't understand what recovery from the illness is like?

In the pictorial below, the consensus group convened by IRETA that I mentioned above, tried to capture—as best we could, and in a culturally sensitive manner—what the entire continuum of responses to addiction in America would look like. We call this “Building Resiliency (Prevention), Wellness (Treatment), and Recovery: A Model for the Prevention, Intervention, and Management of Substance Use Disorders.”



In the yellow quadrant in the upper left, we have prevention, with its three target populations, universal (general audiences), selective (people whose risk factors make them candidates for additional effort), and indicated (people who show some symptoms of harmful substance use). Through the Strategic Prevention Framework (Center for Substance Abuse Prevention, 2008), we’re increasing our understanding of why people come to use these illicit substances and how we can work to prevent onset or escalation of use by advance attention to community factors and risk protection.

In the pink quadrant in the upper right, we have the new emerging science of intervention, focusing on selective and indicated populations. This is not the Johnson Institute model of an intervention for people with substance dependence disorders. Instead it is the development of a new method of earlier intervention into problematic use or a pre-DSM-IV substance use diagnosis (problematic use). Our experience with risky and problematic use has shown that people who evidence these levels of substance use far outnumber those whose dependence leads them into our treatment centers, and that the consequences of problematic use can be serious and far reaching, even though use has not progressed to dependence. Moreover, this earlier level of intervention promises both reduced economic and human costs if done correctly.

This new element has led to the birth of a new intervention discipline before our eyes. Examples of this kind of intervention are SAMHSA/CSAT's SBIRT Initiative (Screening, Brief Intervention, and Referral to Treatment), and the other forms of brief screening that are taking place in non-specialty settings such as primary health care, college campuses, prenatal clinics, and so on. We've seen these efforts rise along with our evolving understanding of how problematic use is leading to less than optimal outcomes, including significant levels of loss.

The blue section in the lower right represents treatment, whose target populations include both those with abuse issues and those with dependence disorders. When substance use disorders exceed the capacity of the technologies available in the first two quadrants, people are referred to the specialty care system. Here we have real science that allows us to match patients with appropriate levels of care and find the right intervention to treat the illness. But for every two people who belong in this category, there are eight people who belong in the previous category, Intervention. So we want to start to address the needs of those eight people—and ultimately to reduce the numbers of people in that category.

And finally, the green quadrant in the lower left represents recovery supports, whose target populations include both those in recovery who no longer evidence any problem use and those whose abuse or dependence has not yet reached stable remission. In this quadrant, people find linkage to communities of recovery and community partners who can help bring in needed resources and build models of support. In reality this quadrant should surround all of the quadrants and, as we evolve, it will.

The entire circle is surrounded by two larger, protective circles. The first of these, risk and protective factors/recovery capital, allows space to recognize and address individuals' risk factors and recognize and promote individuals' protective factors and recovery capital. All of this is set within the context of the largest circle – attainment of overall wellness and recovery. These two circles emphasize the many parallel elements in the nature of prevention and recovery.

Now, that little green man in the very center, he's my Irish uncle. He's surrounded by the community, because recovery is person-centered and culturally relevant within the family and the community. That little Irish uncle of mine is the primary focus and driver of the treatment plan. He has to be at the center of the development of that plan, and the plan must be rooted in the community and culture in which he exists. We can't look at his recovery as separate from all these elements of his life if we're going to have success in our concurrent measures.

When the group chose this title for its model—Building Resiliency, Wellness, and Recovery—they thought of resiliency as the focus on prevention, and wellness as the focus on treatment and the improvement of individual health care and quality of life.

To begin with, I would suggest that we all form a vision: "The right care, provided at the right time, by the right provider, for the right period of time, and with the right resources every time—no more, no less." If we have a common vision, we can rally and put the right model in place. The key word here is "right," though right will be determined only in retrospect. In retrospect we will always look at cases to find out if we were giving that individual the best opportunity to achieve lasting recovery.

At the end of the day, without a common vision, we will remain divided in our understanding and efforts. Even with a strong business case and well-established cost benefits, the addictions field will not be able to move forward without a common vision that prioritizes the value of addressing addiction in America. In the end, this value is what will turn the corner for an illness that affects:

1 in 10 Americans	1 in 8 Veterans
1 in 5 Families	1 in 2 Homeless
1 in 7 Workers	1 in 4 Elderly
1 in 20 Newborns	35% of School Students
80% of Incarcerated People	50-70% of Children in Family Services

The implications of this common vision and new model will be profound for the practice upon which people's well-being and survival depends, for the policies we need to develop and guide us, for the funding we use to address this challenge, for our attempts to research and understand, and for the ways in which we come to know and bring about opportunities for recovery.

You are the beginning. Welcome.

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