

Substance Use Treatment and a Recovery-Oriented System of Care: Qualitative Insights on A National Perspective

Background

In its key report on improving the quality of healthcare in America, the Institute of Medicine ([IOM] 2001) stated that the “American health care delivery system is in need of fundamental change.” This report goes on to underscore that many doctors, nurses and healthcare leaders are concerned that the care delivered is not the care patients should receive (Donelan, Blendon, Schoen, Davis, & Binns, 1999; Reed and St. Peter, 1997; Shindul-Rothschild, Berry & Long-Middleton, 1996; Taylor, 2001). The Institute report points out that in today’s healthcare system the frustration levels of both patients and clinicians has likely never been higher. Corroborating this statement, a Commonwealth Fund report (2002) of a survey of health care systems in five industrialized nations reported that adults in the US were “least satisfied with their health care system.”

In 2004, the Institute for Research, Education and Training in Addictions (IRETA), home to the Northeast Addiction Technology Transfer Center, formed a group composed of national leaders in the addictions field tasked with examining addiction care in the context of America’s healthcare system. One of the specific issues with which they dealt was that of whether addictions was being addressed in a proper manner within the healthcare system. The group reported that substance use and dependence needed to be better understood in all medical settings (Flaherty, 2006). They went on to point out that addiction was usually treated as an acute disease (e.g., cold, flu, or headache) which has led to high rates of clinical failure, recurrent costs and societal frustration. However, based on the etiology of substance use disorders, it would be more appropriate to understand and treat addiction as a potentially chronic disorder (e.g., HIV, cancer, or diabetes).

In 2006, the IOM updated its 2001 report, with a new quality improvement report that recognized the need for and focused on improving care for substance use and mental health conditions. The IOM reached the same conclusion that the IRETA-led group of national experts and many others (McLellan, 2002; McLellan, McKay, Forman, Cacciola & Kemp, 2005; McLellan, Lewis, O’Brien & Kleber, 2000; Moos, 2003; National Institute on Drug Abuse, 1999; Scott, Foss & Dennis, 2005; United Nations, 2003; White, Boyle & Loveland, 2002) reached by highlighting the fact that substance use disorders, if scientifically, medically and experientially understood, were best treated as potentially chronic conditions. The report also recommended that substance use disorder treatment needed to be provided based on relevant and scientifically redesigned measures for high quality care (i.e., performance measurement, measures of quality, timely information, and cost measures) based on a chronic illness understanding rather than an illness-based, acute care model.

If this chronic understanding of substance use disorders is actually applied to care provided, the world of substance use treatment will be forever changed - for the better. Units of care would become episodes of care. Success would be measured not by completion of treatment at any level of care but by the individual's health and sustained recovery over a continuum of care or a lifetime. When entered, treatment would be provided for a period of time that would offer a realistic opportunity of medical stability and early and sustainable recovery. Aftercare, the historical step-child of outpatient treatment, would be a highly valued component of care and the best way to achieve and measure long term recovery. Redefining an illness from acute to possibly more chronic in nature would not only fundamentally change treatment delivery but also would also require a reassessment of policy, funding, research and other key elements related to addiction and recovery that would be affected by such a mammoth paradigm change. Moreover, the "chronic care model" (Wagner, Austin, Davis, Hindmarsh, Schaefer & Bonomi, 2001) itself empowers the patient to take responsibility for self-monitoring and self-managing the long-term course of their own conditions, with healthcare professionals serving as ongoing allies and consultants.

Conceptually, many, especially those in recovery, embrace this shift to a "continuum of care," because it is most similar to what worked for them, either as experienced personally or through the experience they have developed providing care to individuals over the years. All in the field also recognize the key role community-based supports will have to play in order to sustain recovery. Noted historian William White was perhaps one of the earliest and most prolific writers on the subject of recovery and the recovery experience as well as the best way to help individuals achieve recovery and support them in maintaining that recovery (White, 2008a; 2008b; White & Kurtz, 2006; White, Kurtz & Sanders, 2006).

Interestingly this grass-roots support for the paradigm shift described above is perfectly aligned with the "Ten Simple Rules for the 21st Century Health Care System" listed in the early IOM report focusing on quality of care (2001: 67):

Current Approach	New Rule
Care is based primarily on visits	Care is based on continuous healing relationships
Professionals autonomy drives variability	Care is customized according to patients needs and values
Professionals control care	The patient is the source of control
Information is a record	Knowledge is shared and information flows freely
Decision making is based on training and experience	Decision making is evidence-based
Do no harm is an individual responsibility	Safety is a system property
Secrecy is necessary	Transparency is necessary
The system reacts to needs	The system anticipates needs
Cost reduction is sought	Waste is continuously decreased
Preference is given to professional roles over the system	Cooperation among clinicians is a priority

So what is a recovery-oriented system of care (ROSC)?

If current approaches to substance use disorders ask how to get a client into treatment, a recovery-oriented system of care (ROSC) asks more broadly, “How do we support the process of recovery within an individual’s life and environment?” ROSCs “support person-centered and self-directed approaches to care that build on the *strengths* and *resilience* of individuals, families, and communities to take responsibility for their sustained health, wellness and recovery from alcohol and drug problems.” (Center for Substance Abuse Treatment [CSAT], 2007). While treatment focuses on the pathology of an illness and the consequences of that pathology, it can also be the vehicle by which a range of clinical support is offered to an individual to help sustain his or her recovery. For a diabetic this might mean learning about nutrition and food, exercise

and community support groups that can help. While often closely linked to formal treatment, a ROSC focuses on the:

- acquisition and maintenance of recovery capital (i.e., the internal and external assets required for recovery initiation and self maintenance);
- global health (physical, emotional, relational, and spiritual) and community integration and supports;
- building meaningful roles, relationships and activities, and building resiliency and wellness.

In 2008, Dr. H. Westley Clark, Director of the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment [SAMHSA/CSAT] (2008), further clarifies a ROSC as:

- offering person-centered and self directed approaches to care that build on the personal responsibility, strengths, and resilience of individuals, families, and communities to achieve sustained health, wellness and recovery from alcohol and drug problems;
- offering a comprehensive menu of services and supports that can be combined and readily adjusted to meet the individual's needs and chosen pathway to recovery;
- encompassing and coordinating the operations of multiple systems, providing responsive, outcomes-driven approaches to care; and
- requiring an ongoing process of systems improvement that incorporates the experiences of those in recovery and their family members.

Today's Challenge

From the federal government down to community-based providers of recovery support services and everyone in between, all are eager to improve addiction treatment outcomes and efficiencies. Both personal experience and early research supports the fact that a recovery oriented system of care can help service providers at all levels achieve this goal. The problem – how? More specifically, how should today's system begin to change?

An Addiction Technology Transfer Center Perspective on Change

As noted above, the paradigm shift to a ROSC is complex and will involve a massive coordinated change in both thinking and action. Fortunately, the Addiction Technology Transfer Centers, individually and as a national network, are designed and poised to undertake such a challenge. The fourteen SAMHSA/CSAT funded Addiction Technology Transfer Centers (ATTCs), are tasked with unifying science, education and services to transform lives and do this

by facilitating the transfer of science to practice in all states and territories of the United States. ATTCs do not operate autonomously as they are actually collaborative agreements with SAMHSA/CSAT. They work closely with SAMHSA/CSAT to meet the multi-directional and multi-dimensional, complex system needs of the federal government as well as states, providers, partners (e.g., NIDA), policy makers, those in recovery, the media, and many others.

The fourteen ATTCs, in addition to being individually representative of their specific regions, also operate as a collective network to facilitate technology transfer, promote communication, and maximize efficiencies related to technology transfer of research-based substance use disorder-related information. Within their network, they collectively can operate as a single voice or form a sub-group of ATTCs who work on an issue on behalf of the entire network. While the regional centers work together on a regular basis, they are not carbon copies of one another in different geographic locations. In fact, they pride themselves on the diversity of their expertise and cultural and clinical sensitivity to their regions, treatment systems, and providers they serve. This diverse perspective is very important when dealing with a complex issue that can, at times, appear unnecessarily threatening and potentially face opposition from some, like ROSCs.

ATTCs and ROSCs

Within the ATTC network, ten individual ATTCs self-identified themselves as a group collectively working on behalf of the network to address constructive transformation of the current substance use disorder care system to a ROSC. All ten of those ATTCs received five open-ended questions designed to elicit responses that would offer initial guidance as to how the above-described paradigm shift might proceed to assist providers so that they, in turn, will be able to improve outcomes for those seeking treatment and recovery. To date, six of the ten ATTC centers participating in the self-defined recovery-oriented system of care group provided comprehensive answers to the questions listed below that were coded using an iterative process and summarized as follows:

The first question consisted of two parts: (a) How would you describe the treatment system we have been moving away from – and (b) what do we expect to improve or replace with the recovery-oriented systems of care (ROSC) approach?

Respondents described the current system as a “one size fits all” acute care model of pathology-focused, crisis-oriented services. It is inconsistent with the concept of addiction as a chronic condition, largely neglects the dire need for post-treatment community-based recovery support services, and fails to involve and to capitalize on the resources and support of clients’ families and the larger community. Further, current services are delivered using a “top down” model where professional “experts” make clinical decisions without involving patients who are regarded as passive recipients of services.

Services are driven by administrative and fiscal concerns rather than by clients' needs. These services are also chronically under-funded and lead to burdensome paperwork, regulations and managed care restrictions for agencies. One of the consequences of this situation is that agencies experience high staff turnover, and clinical supervision is nominal. The following quote summarizes respondents' view of the current system and highlights what is in dire need of change: "The current system (funding environment) works against a broader recovery orientation. The funding squeeze, funding accountability measures for numbers of people served, and service limitations (no services for family members or for patients who have been discharged, no ancillary services) maintain an acute care focus rather than a recovery focus."

Given this current state of affairs, what changes do participants expect from a transition to the ROSC model? Participants look to ROSC to provide a conceptual direction for services provided. This model would reorient services so they were part of a continuum of care model guided by recovery as a goal. This model would also truly integrate prevention, intervention, treatment, and recovery through encouraging and at times requiring collaboration/coordination with other systems of care and by incorporating various support services needed for recovery (housing, telephone calls, recovery check-ups, medication, etc.) as part of the larger treatment-recovery context.

The next question posed to the participating ATTCs was, "***What is the primary philosophical or conceptual shift we want a ROSC to facilitate?***" Respondents envision the adoption of a chronic illness/continuum of care approach that promotes wellness, is client centered, and provides individualized services that are fully integrated across systems and build on the strengths of individuals as well as on naturally occurring resources from families and communities. Services must involve and empower clients and encourage them to take responsibility for their recovery, allowing for multiple client-chosen pathways to recovery. Substance use disorder services must also integrate evidence-based practices and result in improved outcomes for the individual and for society. The following quote is provided as a good summary of the respondents' perception of the primary conceptual shift they want ROSC to facilitate: "Shift away from a crisis-oriented, deficit focused and professionally directed model of care to a vision of care that is directed by people in recovery, recognizes the many pathways to healing for people with addiction challenges, and which focuses on building competencies rather than just reducing symptoms. The most important conceptual shift however, is that systems begin to move away from providing isolated, acute, episodic treatment to providing sustained recovery support that is embedded in people's natural environments."

Participating ATTCs were also asked what they regard as ***the major goals of a ROSC***. At the macro level, respondents believe that ROSC aims to build a vision of recovery in America, as well as a community and a culture of recovery (e.g., recovery centers, recovery schools, culturally-based recovery foci, recovery experts to liaise with behavioral health care managers in managed care organizations, and others). The respondents also view ROSC as a model that can

set the context for achieving a continuum of care that expands the focus of treatment and promotes long term recovery through individualized services that empower clients and capitalizes on strengths and resources from families and from the community. Some ROSC goals include developing community awareness and education (for families, the general public, and local government) about treatment and the benefits of recovery.

The next question focused on identifying *the major elements of a ROSC*. Key elements include a focus on life-long prevention and promoting long-term recovery while also addressing acute needs. A second key element of ROSC is its client-centered and strength-based nature which involves building on client strengths and resources as well as working to develop client strengths such as self-efficacy. Third, ROSC provides a holistic care model that integrates substance use disorder treatment into the larger system of healthcare and social services. Fourth, the model draws not only on professionals but also on the support of peers and existing resources naturally available from family members and the community.

The fifth question participating ATTC Directors were asked was specifically *what they see as CSAT's and/or the ATTC role (individually or as a network) in promoting the adoption of ROSC in the field*. Some of the answers were general while others were more specific to CSAT or to the ATTC. General answers fall into three major categories:

- (1) *Provide a framework*. Provide a framework and a working “continuum of care model.” Both the ATTC and CSAT should also provide continued communication related to this new framework and model, specifically that this is the direction in which the addiction field is moving so that all related disciplines can see their role and importance along that continuum and not just in the most acute phase of a substance use disorder.
- (2) *Help to facilitate motivation for transitioning to ROSC at the system and agency level*. This could involve developing a short list of specific operational steps systems and agencies can take in becoming a ROSC (e.g., change terminology and practice from “treatment planning” to “recovery planning”) and developing an organizational self-evaluation checklist for assessing the current degree of ROSC-ness and progress in that direction. As providers functioning in a ROSC should help individuals in treatment take advantage of existing family and community supports, so too should CSAT and the ATTCs help states and individual agencies strengthen existing practices designed to support and/or create effective continuing care services. They should also facilitate and/or support the coordination and integration of services across relevant systems, and foster collaboration between treatment professionals and peer-based recovery support services (P-BRSS).
- (3) *Educate providers and facilitate workforce development*. Although providers are just one link in the chain of a continuum of care, due to the current structure of the addiction care system, they are key to a comprehensive paradigm shift. Therefore, the ATTCs and CSAT must work to increase treatment providers’ awareness of how a ROSC would differ from the current system in terms of provider and agency roles and practices; educate providers about the

evidence basis that supports the ROSC paradigm shift; develop training curricula that will assist providers in developing recovery-oriented plans (rather than ‘treatment plans’); facilitate workforce development strategies that states can use to build interdisciplinary professional treatment providers and P-BRSS teams; and develop resources for peer recovery coaches (curricula, procedure manuals, sample certification criteria, and others).

CSAT-specific roles include continuing leadership and facilitation of a dialogue that will help all to better understand (and promulgate) what works, for whom, when and how. CSAT should provide funding and high level facilitative efforts to help build a bridge between treatment and the recovery community (in partnership with research) that leads to continual refinement of ROSC measures and a more accountable systems of care. CSAT should also actively work to support awareness among *all* provider disciplines (e.g., medicine, SU counselors, social work, psychology, nursing, pharmacy, and others), policy leaders, and public/private payers of the potentially chronic nature of substance use disorders and of scientifically validated, effective treatment in general. This work should be coupled with an effort to add a recovery-focused national outcome measure to the current national outcome measures system to encourage states and others to emphasize recovery outcomes and the initial transition to a ROSC.

The ATTC specific roles include fostering nationwide communication and information exchange about specific ROSC-related practices and transition efforts in different states and agencies that work and do not work so that ROSC becomes a reality rather than a vague movement; and organizing/coordinating national or regional meetings (virtual or in person) to communicate these developments (positive and negative) toward transitioning to and implementing ROSC.

Finally, highlighted below are some important points that were made, not in response to one of the five questions asked, but deserving of mention nonetheless. Broadly stated, they speak to the *central role that science (i.e., research) must play in the development, monitoring and evaluation of ROSC.*

- ROSC should be viewed as a model or hypothesis, not as THE solution.
- We must build a science of recovery to better understand the experience of recovery, and use that knowledge to strengthen both treatment (for acute needs) and the likelihood of recovery in all circumstances, ages, populations, cultures, etc.
- The development of a ROSC must be empirically driven. As one ATTC director stated, “We have to let the data guide us about what works and what doesn’t;” and “[We] need a science of early and sustained recovery.”
- A ROSC must have accountability that can be achieved through implementation of specific outcome measures.
- Quantifiable outcomes (i.e., wellness and recovery) must be determined and measured. This can be achieved by constructing an evolving, measurable definition of recovery that involves empirically derived markers for successive stages of recovery.

- ROSC outcomes must be rapidly communicated to the field, funders, and policy makers. CSAT and the ATTC network can look to successful communication models such as the Network for Improvement of Addiction Treatment (NIATx) to choose meaningful, inexpensive, readily accessible data and use it rapidly to communicate effectively within the system.

The intent now is to take this initial response back to all fourteen ATTCs for review, validation, and further comment. From this final validation an initial work plan will likely be derived that could support the beginning stages in a transformation of care.

A Final Note on why a Qualitative Understanding and Description

Science and learning are best advanced by a rigor that is both quantitative and qualitative in approach. Advancing a paradigm shift can be particularly daunting as it usually challenges the status quo (i.e., current understanding and practice). To some degree, access to any phenomenon (e.g., initially finding out the world is not flat, first appearance of H1N1 virus, first walk on the moon, the experience of one's own recovery or even, systemically, a recovery oriented system of care) first reveals itself by some new presence or awareness which eventually becomes evident and available to all for further analysis and understanding. Indeed, it seems that phenomena which initially seem unrelated often do have much in common and can be well understood and addressed through an understanding of that commonness. Yet, those same phenomena often also retain unique aspects (e.g., understanding the cultural relevance in learning; what constituted recovery specifically for Mr. John Jones; or (systemically) what does a recovery oriented system of care look like?) Additionally, understanding a recovery focus and a ROSC requires some kind of public verification of the existence of this phenomenon and an initial set of unique criteria that together define this new experience as a phenomenon unto itself. This can only be achieved through an effort which first seeks to understand individual experiences, then works to find the commonalities in those experience to set a foundation for further scientific study. This new understanding is not "anti-quantitative" in any sense, but is often the origin of quantitative study or, in later analysis, translational and a qualitative understanding of what was implemented and how or why.

Qualitative approaches use rigorous descriptive understandings (for external verification) that support and play a role in all scientific disciplines, particularly in studying experience and the interaction of that experience with knowledge. By asking the five questions detailed above, we obtained a small "n" quantitatively, but qualitatively we gained initial guiding insights that open the horizon of knowledge further to the possible existence of this newly described phenomenon (i.e., a recovery-oriented system of care) for further qualitative and quantitative examination. As reference I would offer just a few of the many respected and rigorous scientists and clinicians who worked within a similar framework to further see and augment clinical paradigm change

and our understanding of human behavior: Giorgi , 2009 & 1970; 1970; Laudet & White, 2009; James, 1902; Titchener, 1901; Allport, 1968; Piaget, 1974; among many others.

There is no recipe for success when working to build a recovery-oriented system of care. Such an undertaking will require a family cook book of everyone's favorite recipes - some that can only be made by specific people, but all of which work for at least one individual. It will reflect the absolute best of science, practice and individual, family and community experience. It will capture both a quantitative and qualitative understanding of the illness - now more clearly defined along a continuum of care from acute to chronic in nature - and that includes as highly relevant the actual experience of the nearly 25 million Americans living recovery daily.

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Enclosure

RAW DATA RESPONSES FROM EACH ATTC

QUESTION 1: How would you describe the treatment system we have been moving away from – and that we expect to improve or replace with the recovery-oriented systems of care (ROSC) approach?

GULF COAST

The current treatment systems are varied, across the country, but generally are an under funded attempt to deal with the acute crises that have led people to seek help for problems associated with substance abuse and addiction. The under funded aspect of treatment has led to systems that are designed to deal with presenting problems of an acute nature, and to offer a protocol of short duration, which is burdened by paperwork, regulations, and managed care restrictions. The focus is on service delivery, documentation, and billing.

The staffing and management of treatment programs is subject to high turnover rates and clinical supervision is nominal. The impact of the funding environment works against a broader recovery orientation. The funding squeeze, funding accountability measures for numbers of people served, and service limitations (no services for family members or for patients who have been discharged, no ancillary services) maintain an acute care focus rather than a recovery focus.

NORTHWEST FRONTIER

The current treatment system remains very focused on one-time treatment episodes and does not really have a perspective or a system that provides long-term care and follow-up for individuals. Nor is there much of a focus on early intervention and prevention. It seems to me that a recovery oriented system of care would truly integrate prevention, treatment, and recovery.

While agencies and clinicians speak of providing "individual treatment" the current system still seems to operate more on program driven services.

A ROSC would be much more proficient at providing integrated care and collaborating/coordinating with other systems of care. It seems like the current system still relies on the client to navigate his/her way through the multiple systems of care they are involved in.

The current system still remains very weak in it's focus on involving the family and accessing the greater community as recovery resources.

On a very practical level, I think counselor's would spend less time providing drug/addiction education in treatment and move to spending more time helping clients develop skills and strategies for living healthy lifestyles that are rewarding and fulfilling without the use of substances. As one kid from an adolescent focus group put it, "Why do they (counselors) just keep asking us why we use drugs? And teaching us about the effects of drugs. Why don't they teach us how to live our lives sober."

PACIFIC SOUTHWEST

The existing system has been a matter of communities attempting to respond to drug addiction problems as they best knew how and as proponents of treatment attempted to meet the needs of addicts in the community, and to a lesser degree how our clinical literature evolved an evidence base for treatments. A major shaping force was funding. Changes in funding occur in spasms and are generally beyond the control of providers (and in many cases policy makers). So if the “politically popular” issue of the day was women’s treatment, then communities got a spasm of money for community treatment; if the issue was criminal justice treatment, then we saw increases in prison treatment, diversion treatments, drug courts, etc. Spasms of funding created expansion of services. Economic downturns resulted in shrinkage in the system. Organizations that had competent leaders with some understanding of sound business practices stayed in business, those who didn’t became extinct. Over time, the funding increases and decreases resulted in a patchwork of services that were more the result of darwinian and political considerations than any systematic plan of service development.

The idea of a recovery oriented system of care is a positive development insofar as it gives the treatment system a conceptual framework. As described above, the existing system does not have a framework other than survival of the fittest. In fact, many of the treatment providers in California, for example, have a fundamental belief in a recovery orientation already. In most treatment programs, the very strong message is that treatment leads (or pummels) you into the 12-step program and that recovery support in a 12-step program is a life-long necessity. I think the novelty of the current movement is that the kinds of support (housing, telephone calls, recovery check-ups, medication, etc.) That are needed for many people to maintain sobriety are far more varied than the set of tools provided by AA.

Also, we need to be careful to be modest about the empirical evidence for recovery oriented systems of care. In fact, we don’t know if such a system will improve outcomes. And it may cost considerably more and we are not sure if the patients will actually comply with recommendations any better than they now comply with 12-step recommendations. We need lots of data to determine if this system is feasible economically, if patients will comply, and if it produces better impact on patients, their families, and communities. The recovery-oriented model should be viewed as a “model” rather than as the “truth.” It is better to have a model than chaos, but we are not sure if this is the best model for the majority of patients or if there are better alternative models. Prospective data should drive the emergency of the future system.

NORTHEAST

The current treatment system is predominantly pathology and payment driven and addresses addiction as an acute but reoccurring illness. It therefore naturally leads to a sense of treatment inadequacy, does not meet the public’s expectation of treatment expenditure for any illness and doesn’t match the experience of those in recovery for how they got well - except as medical

stabilization and *potential* launch of their recovery. This is the treatment-recovery gap. Over the past six – ten years the illness has been scientifically re-defined as more potentially chronic in nature and, in any case, best understood and addressed as such. We have not yet established a parallel treatment model to bridge this “gap” as payment methodologies, managed care and “medical necessity” et al have rigidly driven what is offered and defined as “treatment.” This is neither a criticism of science (e.g. EBPs) nor our oppressed providers but an understanding of where they are and their value now in a new emerging model that shifts treatment from an acute to chronic (CC) illness understanding/model enhanced by a focus on recovery (White: *Recovery*, NeATTC, 2006 and *Recovery Management and ROSC: Scientific Rationale and Promising Practices* (White: NeATTC, 2008). We have two major movements underway: treatment renewal based on CC understanding and recovery and wellness focused model of care, i.e. ROSC.

SU CC and ROSC Continuum:

Prevention (individual and community resiliency) -*intervention* (problematic use/sbirt)-*treatment/continuing care* - wellness & recovery

ROSC- Once we establish and link to the value of recovery supports, assessing individual and community recovery capital (and pathology) into

Treatment and recovery plans, recovery linkage, continuing care and follow-up we better identify the nature of the pathology (illness) and its cure or ways to manage it or bring about remission and recovery.

This combined pathology/recovery model is what we add or need to now build and measure – upon existing fragmented parts and along the same lines as HIV/AIDS, diabetes, hypertension, cardiac illness, depression etc.

GREAT LAKES

The treatment system that we have been moving away from has been characterized by:

- **A high intensity acute care (AC) model** providing brief biopsychosocial stabilization, which is successful in helping people to initiate recovery, but does not provide the necessary services, supports and opportunities to help people sustain their recovery in the community. Additionally, treatment is focused on reducing symptoms and substance use but not on helping people to build the skills that they will need to live a meaningful life in the community without the use of AOD.
- **A tendency to put the burden for successful engagement on the person seeking help rather than on providers.** The current system has evolved so that providers wait for people in need of help to "hit bottom" and reach out for help rather than assertively trying to engage people in treatment. Consequently, outreach and early identification play minimal roles in the current system. Additionally, there is not an emphasis on trying to

develop and build readiness in people. Instead, the typical approach is that readiness is an all or nothing thing. If people aren't "ready" (i.e. in enough pain), we don't invest as much time/resources in trying to help them. Or alternatively, we blame their inability to engage in treatment on their lack of readiness.

We should instead view motivation for treatment as something that can and will result from our concerted efforts at building relationships with people. In essence, the current system is focused on having people with severe substance use disorders meet our arbitrary standard of "readiness", rather than our being flexible enough to expand the points of intervention and meet them at whatever stage of readiness we find them.

- **Institution based treatment** in which service providers have minimal contact with the natural environments of the people they serve. This trend has been reinforced by an intra-psycho approach to treatment. Distress is believed to be rooted in the individual and not connected to the environment or social context in which the individual lives. As a result, the unit of intervention for most current addiction treatment approaches is limited to the individual. The limitation of this approach is that the environment/community/family is not mobilized as an active resource in the recovery process. Additionally, the institution based structure, does not afford people in treatment the opportunity to transfer their knowledge and learning from the institutional environment to their natural environment. This impedes their ability to develop recovery maintenance skills which are relevant in their natural community and which will help them to sustain their recovery over time.
- **An expert model of care** in which people in recovery are viewed as the passive recipients of service and professionals have all the answers.
- **A one size fits all approach** to treatment in which clients are expected to work the pre-existing treatment program, with no consideration of the individual's unique needs or preferences.
- **Minimal post treatment supports.** This means that when people are most vulnerable to relapse, following a treatment episode, they actually receive the least amount of support from the system.
- **Categorical, deficit based assessments.** These are focused on the main problem that has generated the current concern, with little attention to other areas of the person's life, such as their family, social environment, physical health and employment status. Additionally, areas of individual and/or community strength that can be mobilized to initiate and maintain recovery are seldom explored.
- **Limited service dose.** Despite the fact that we know that the best single predictor of post-treatment addiction recovery status is the length of service contact, the length of treatment in the current system is increasingly brief.

MID-AMERICA – based on feedback 30 AR, KS, MO, NE and OK Advisory Council (08/29/09) not sure what this line means

- Episodic care, fragmented, isolated from health care industry, inconsistent practices/approaches
- A lot of talk on the mental health side about recovery model; not so much talk on the substance abuse side (NE and OK)
- ATR has helped some states understand the broader scope of recovery services (MO,OK)
- Treatment service providers voice support of ROSC but when asked to make changes in how they do business, they resist. Treatment providers not the best group to get ROSC started (KS & NE)
- Difficult to make changes in rural areas given few resources available

QUESTION 2: What is the primary philosophical or conceptual shift we want ROSC to facilitate?

GULF COAST A chronic care management focus.

NORTHWEST FRONTIER

Movement away from episodic care and movement towards integration of substance abuse and mental health into general health care. This seems essential to decrease the stigma attached to substance abuse treatment.

Integrated care and true collaboration with other systems, also seems to be an essential shift that needs to take place.

The philosophical shift needed seems to be for the current treatment providers to widen their perspective of the resources and factors that impact recovery and find new ways to link clients with the necessary resources.

PACIFIC SOUTHWEST

As publicized in the current time magazine (June 29) the use of data is a key to improved health care, more efficient care and greater credibility for the field. Rosc has to integrate ebp and employ the use of data to examine efforts. A philosophical shift is wonderful if it leads to practices that improve outcomes. To shift just for the sake of shifting and following a new flag and mantra is meaningless if it doesn't produce better patient care, patient outcomes, and patient functioning and societal benefits. We won't know if that happens unless we measure and use our

results to modify our efforts. We have to be ready for our current ideas to be incorrect. We have to let the data guide us about what works and what doesn't.

We need to reconsider how we talk about treatment and present it to the public. We need to integrate the brain disease concept (the public gets this concept and it is compatible with advancements in other fields of health care) and new genetic science into this new model. (i.e., people need longer involvement and participation in treatment/recovery activities, possibly life-long, due to changes that drug use has made in their brains and/or due to genetics, some people are at much higher risk for addiction and relapse than others, etc) . We need to make sure the ROSC is not a return to a pre-Alan Leshner view of addiction as some kind of vaguely biological but weak statement of the neurobiological foundations of addiction.

I think that in the treatment of most chronic medical illnesses patients are treated with respect as adults who will take responsibility for taking an active role in addressing their illness, unlike much of addiction treatment which is far more paternalistic and basically says "do xyz, because it is treatment and because i think it is what you should do, without explaining the "whys" of treatment." In some ways this may have come from some of the old practices of aa sponsors, who would just tell sponsees what to do and their compliance without understanding was evidence of having the correct attitude. We have to develop better materials to explain to patients and their families and the public what treatment and recovery activities are, why they are important, how they help a person with an impaired brain and what the payoff will be. Right now our patient/family education materials are very crude and ineffective.

NORTHEAST

Somewhat stated above in #1. The conceptual shift is to align, build and measure wellness and recovery, (i.e. measure success! Lo and behold!!). We must build on existing science, practice and recoveree experience for an improved model grounded in a more chronic understanding of the illness and the ways and many pathways to its recovery. Our science has never been better (on the pathology and acute treatment) what we now need is a science of early and sustained recovery. This has been our "pleading" to NIDA and NIAAA.

GREAT LAKES

The Primary philosophical shift that we want ROSC to facilitate is a shift away from a crisis-oriented, deficit focused and professionally directed model of care to a vision of care that is directed by people in recovery, recognizes the many pathways to healing for people with addiction challenges, and which focuses on building competencies rather than just reducing symptoms. The most important conceptual shift however, is that systems begin to move away from providing isolated, acute, episodic treatment to providing sustained recovery support that is embedded in people's natural environments.

MID-AMERICA

- Chronic health care model that emphasizes wellness/prevention throughout lifetime, recognizes effectiveness of more than one approach to self-help (i.e., 12 - step) supports, focused more on improved functioning rather than “abstinence,” use of terminology that separates person from disease, more resources allocated toward research, importance of professional practice coupled with peer support. Increased involvement of family, community, social supports.
- Research has consistently focused on what works in the first year/initial years of recovery. Controlled research studies have shown AA/NA’s effectiveness in the first year/initial years of recovery. One of my person frustrations is that researchers have not “mined” the wealth of experience of those persons who are in long-term recovery – and who are not participating in 12-step meetings or mutual self-help recovery meetings. If we are going to address :recovery,” then we must define what constitutes “other roads to recovery.”
- Empowered consumers, increase in consumer affairs positions at state level, need to make decisions about allocation of resources between treatment and recovery support (KS, NE, OK)
- Get services to people now on waiting lists for months at a time; increase interim services available – (AR, KS, MO, NE, OK).
- Create credentials for recovery support specialists, more training, more holistic approach (AR, KS, MO, NE, OK)

QUESTION 3: What are the major goals of ROSC?
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GULF COAST

1. Promote chronic care oriented treatment systems in which all participants (staff and patients) are working toward the goals of long term recovery.
2. Engage multiple resources in collaborative efforts with recovering persons to address their recovery challenges.
3. Maintain a collaborative partnership in which peer recovery workers and treatment counselors are jointly engaged with recovering persons in successful development and implementation of personal recovery plans.
4. Empower recovering persons to be in charge of their own recovery.

NORTHWEST FRONTIER

1. To expand the focus of treatment providers to look at the two ends of the treatment/recovery continuum to put more focus on early intervention/prevention and long term follow-up care (i.e. recovery management.

2. To shift the focus from brief interventions that are expected to "achieve complete abstinence" to more realistic expectation of gradual change and reduction of use and harm with the eventual goal of abstinence (if indicated - for example: abstinence may not be the goal for at-risk drinkers and in some case individual with abuse)
3. To provide wholistic care to individuals with substance abuse disorders.
4. To maximize the use of nature sources of support for recovery and mobilize the strengths of communities and families to promote recovery.

PACIFIC SOUTHWEST

Improve the humanity of patient care; improve the outcomes of care; improve efficiency of care; improve accountability of care; improve education of patients, family members and the public about what addiction care is, how it works and how it benefits participants and communities.

NORTHEAST

- Build a common Vision for recovery and treatment in America
- Assist in constructing an evolving, measurable definition of recovery
- Identify and improve those ways that can enhance the measurable achievement of initial and long term recovery and make those ways known and available to all seeking treatment or recovery outside of treatment.
- Assist in the research (see: IRETA Research Brief, 2009) to better understand the experience of recovery and use that knowledge to strengthen both treatment (for acute needs) and the likelihood of recovery in all circumstances, ages, populations, cultures, etc. Assist in community awareness and education (e.g. local policy development); help science to capture the common elements in 27,000,000 recoveries.
- Build a safety net for those wanting to access recovery and/or treatment, assist in such and in sustaining that involvement in the short and long term
- Work with treatment agencies to support treatment involvement and *continuing care*
- Build recovery in each community as most appropriate to that community, e.g. recovery centers, recovery schools, culturally based recovery focus, recovery experts to Managed Care Behavioral Health Care managers, etc. (i.e. define roles for recovery support specialists at all levels of system and of continuum (above) of care).

GREAT LAKES

- Shorten addiction careers
 - Potential strategies might include:

- increasing pre-treatment identification and engagement
- Focusing on therapeutic alliance as a way to increase retention in treatment, etc...
- Extend recovery careers (help people to transition from recovery initiation to recovery maintenance)
 - Potential strategies might include:
 - linking people in treatment to long-term recovery supports,
 - increasing the dose of post-treatment monitoring and support
 - providing more family focused treatment interventions and supports, etc..
 - Provide people with more services that are embedded in their natural environment so that they can transfer learning
- Enhance the quality of life of individuals with severe substance use disorders.

MID-AMERICA

- Develop and articulate a new language of recovery (“Person First Language” has been a philosophy emphasized in mental health circles for some time now)
- Broaden definition of recovery
- Focus on answers – not the problem

QUESTION 4: What are the major elements of ROSC?

GULF COAST

1. Consists of a holistic and strength based approach.
2. Aims for client self-efficacy.
3. Takes the long view of recovery (as for other chronic disorders) in addition to addressing acute crisis issues.
4. Incorporates a continuing role for peer support

NORTHWEST FRONTIER

1. Recovery management services
2. Community mobilization
3. Recovery support services to include peer mentors

4. Integration of substance abuse treatment into the larger health care system

PACIFIC SOUTHWEST

There needs to be a clearly articulated system of care. Not simply a jumbled, disjointed collection of services. There need to be plans by funders about how to incentivize providers with incomplete networks of care to collaborate, cooperate, work together, and understand what each other does in order to promote patient flow across components of the system (this is a huge issue, which will destroy the concept unless it is given real attention). Some thought needs to be given about how to create a core language of care. It is very difficult to move patients between programs with a heavy 12-step emphasis and those with more of a medical or cognitive behavioral emphasis. Attention needs to be given about how to make treatment messaging nonconflicting across treatment components.

Right now there is much cheering and positive energy about a recovery oriented system of care and it sounds like a good idea, but we need data. And we need to take a page from NIATx and make sure we choose meaningful, inexpensive, readily accessible data and use it rapidly and communicate effectively within our system.

There has been very little discussion (that I am aware of) about the importance of engaging/involving the family of the patient into treatment. What should this involvement consist of? How can it be accomplished? What do family members need to know about addiction and recovery?

A humility about what we don't know and a readiness to change our approaches based on evidence and recognize that our personal beliefs are not the same as evidence.

NORTH EAST

SAMHSA/CSAT 2008 "White Paper" on the *Role of Recovery Support Services in ROSC* initially defines these major elements well (pp.6-7). William White's new (GLATTC, 2009, May) Monograph "*Peer-based Addiction Recovery Support: History, Theory, Practice and Scientific Evaluation*" covers this topic further by clearly defining the role and core characteristics of the Peer-Based Recovery Support Specialist (P-BRSS). He achieves this in contraposition to what is defined or typically regarded as "treatment" and in so doing he also defines the interplay but distinct nature of treatment, ROSC, PBRSS etc, - and gives over 20 examples nationally of PBRSS in action. Earlier White monographs (*Recovery*, NeATTC, 2006) (shows scientific data on impact of ROSC); *Recovery Management* (GLATTC, 2006) (defines varieties, pathways and stages of recovery and ways to link these pathways to treatment and provide continuing care); *Recovery Management and ROSC: Scientific Rationale and Promising Practices* (NeATTC, 2009) (shows how shifting from acute to chronic understanding better fits life course of AOD problems while establishing the initial ROSC system process and individual measures of recovery, value of recovery plans, family, etc.) all add to the further development of the elements

of ROSC. Critical to an enhanced view of the major elements of ROSC is the need for a mutual respect of and use of both treatment and PBRSS that by nature supports the same individual recovery but that does not usurp the independent value or very necessary role of either treatment or PBRSS.

GREAT LAKES

Some of the essential characteristics of a ROSC are a system which:

1. Provides peer based recovery supports
2. Tailors treatment to the needs of individuals and families
3. Provides pre and post treatment supports

QUESTION 5: What should be CSAT's and/or the ATTCs role in promoting adoption of ROSC in the field?

GULF COAST

1. Development of a short list of specific operational steps to take in becoming a ROSC (e.g. change terminology and practice from treatment planning to recovery planning).
2. Develop an organizational self evaluation checklist for assessing the current degree of ROSC-ness.
3. Development of training curricula for Treatment Providers on developing Recovery Plans instead of just treatment plans.
4. Development of resources for peer recovery coaches (curricula, procedure manuals, sample certification criteria, etc)

NORTHWEST FRONTIER

1. Increasing treatment provider awareness of how a ROSC would look different from the current system and helping to facilitate motivation to began making changes to the current system.
2. Promoting and educating providers in evidence-based practices which support a ROSC paradigm shift.
3. Helping treatment agencies and state systems strengthen practices designed to support and (in some cases create) effective continuing care services
4. Facilitate and support collaboration and coordination between the treatment system and other relevant systems.

PACIFIC SOUTHWEST

Provide a frame work and working model. Communicate what people around the u.s. are doing to operationalize rosc. Share what works and equally importantly what doesn't work (darwin wrote extensively about how much more he learned from times he was proven wrong than times he was proven correct in the development of his understanding of evolution). It is common for proponents of a particular model or approach to be reluctant to hear about when their model (or elements of it) don't work. Lessons learned have to include: "things we tried that didn't work". Again, however, in order to determine "work" or "doesn't work", we need to have data. The attc network needs to keep this reality as a foundation piece to the rosc and not simply get swept in the cheering and mission of promoting rosc.

I think national or regional meetings (in person and by web technology) to communicate developments (positive and negative about rosc efforts and strategies) is the essential role for the attc network.

NORTHEAST

CSAT's got it! They better understand ROSC even if others in the hierarchy of SU system don't therefore they are a/the leader (or at least the facilitator of leadership dialogue). Still, they could add an "R" for recovery after their "T" and drop the "A" in CSTRx. (x = keep distinct from research). ☺

CSAT can also really help by their continued leadership and facilitation to dialogue and better understand (and promulgate) "what works", for whom, when and how. By facilitating (e.g. funding) and being that conduit bridge between treatment and recovery (in partnership with research) that leads to refined ROSC measures and more accountable systems to support the awareness of all medical disciplines (e.g. medical schools) and confidence of policy leaders and public/private payers of treatment in general

CSAT can help by adding 1 recovery focused NOM so as to encourage states and others to make similar growth in understanding.

Share "continuum of care model" so all may work at the same Vision and measure progress and report this to OMB and others who keep looking for prevalence to decrease (an acute model expectation that leads to later higher acuity and higher healthcare or criminal justice costs). Remission and sustained recovery is what treatment is about.

Build stronger relations between treatment providers and PBRSS; take away fears (concerns about \$\$ and role) and show how this illness and its sustained remission is what they are uniformly about. Facilitate workforce development strategies that states might use to build interdisciplinary professional treatment providers and P-BRSS - with an opportunity to have P-BRSS to join professional providers if so chosen. Define addiction and SU along CC&R

Continuum so all disciplines see their role and importance along that continuum and not just its most acute phase.

GREAT LAKES

Increasingly communicating that this is the direction that the field should and will move in.

MID-AMERICA

- Recent monographs, commentaries and white papers have eloquently articulated and provide insight into the history, problems, and implications associated with current approaches to treatment and recovery. The ATTCs role is to translate ROSC for the workforce in a pragmatic way and shift focus from “here’s the problem” to “here’s what you should say, do, behave, and practice.” The workforce needs to hear reasons why ROSC will make their work easier and bring about better client outcomes.
- We need a clear and consistent message/position in support of ROSC. Would be helpful to have a compelling video, brochure, and accompanying PowerPoint to use at state conferences, SSA meetings, state advisory boards, etc.
- Advisory Council supportive of Mid-America’s support in bringing together 30MID-America FAVOR Recovery Stakeholders to discuss what’s happening in five-state area. Mid-America supported “FAVOR Media Training” in 2009 and will provide up to \$15,000 support for training initiatives geared toward collaboration between Recovery Stakeholders and treatment service providers in 5-state area.