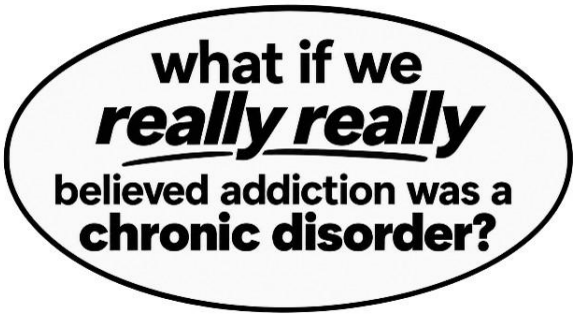
Revisiting the Article That Sent Shockwaves Throughout the Substance Use Disorder Profession

By Mark Sanders and Bill Stauffer



In 2005 historian William White, MA published an article in the Great Lakes ATTC Bulletin titled, ***Recovery Management: What if we Really Believed Addiction was a Chronic Disorder?*** The article captured the profession's attention and imagination as it challenged how we were currently doing business at that time (the Acute Care Model) and paved the way for the profession to think about how recovery outcomes would be different if we truly believed addiction was a chronic and progressive illness if we shifted from the acute care model solely towards a recovery-oriented system of care. White wrote:

> *Severe and persistent AOD problems have been collectively depicted as a "chronic, progressive disease" for more than 200 years, but their historical treatment more closely resembles interventions into acute health conditions (e.g., traumatic injuries, bacterial infections).* More closely resembling emergency room visits in comparison to how we treat chronic and progressive conditions like cancer and diabetes.

In the article White advocated for a recovery-oriented approach as he mentioned some of the limitations of the Acute Care Model, including:

- Failure to Attract. Less than 10% of individuals with SUD seek treatment per year and most of those admitted arrive under coercive influences.
- Failure to Engage/Retain. Half of those admitted to treatment do not complete it and 18% of those admitted are administratively discharged.
- Inadequate Service Dose. The majority of individuals admitted for acute care treatment do not receive NIDA's recommended optimal dosage of treatment (90 days of continuous support post discharge).
- Lack of Continuing Care. Only one in five clients receive continuing care following acute care treatment, in comparison with clients with cancer who are monitored for 5 years or individuals with diabetes who may be monitored for life.

Recovery Outcomes. We know more than we did in 2005. In respect to White's point on service dose, a study examining the NIDA principles of recovery in 2013 found that "clients (who) participated in treatment 12 weeks or more had virtually the same drug use outcomes as those with participation of less than 12 weeks." For services to have any impact at all, treatment and recovery support must extend to a minimum of 90 days. Even as we write this, most people in our nation do not get the minimum effective dose of care. We do not even know the number of who get the minimum effective dose of treatment. The U.S. addiction treatment system does not routinely ensure that everyone who enters treatment receives a minimum of 90 days of care, nor does it routinely follow everyone after discharge from acute or residential treatment to determine longer-term outcomes. The closest thing we have is the TEDS data set, but it only accounts for public funding. That data set averages around one in three getting the minimum amount of effective treatment by the measure of duration. For any condition we took seriously, knowing this number so we could remain focused on changing the outcome would be a fundamental measure.

The majority of individuals leaving acute care treatment return to drug use within the first year of leaving treatment, most occurring within the first 90 days of discharge. This leads to the revolving door syndrome, providing expensive care at the front end without bothering to assure long term outcomes through engagement after they leave an episode of care. We even at times see that those administrative discharges can occur when the needs of the people served are not matched with the capacity or design of the service setting. This can occur all too often when insurance providers ration and delay care. All of this increases the stigma of

addiction, and the belief that treatment does not work! History reveals that this leads to more punitive measures to address substance use disorder. The year that White wrote the article, the prison population was 2.5 million, disproportionately individuals with AOD challenges. A lesson we should learn is that we cannot incarcerate our way out of having a pervasive addiction challenge in America. Yet if we fail to build a more comprehensive, longer term recovery model that delivers results, history shows us that simply locking people up seems to be the all too common politically expedient outcome.

This was a dramatic increase from the estimated 400,000 incarcerated in 1985. It reflects how from a policy perspective we as a society saw addiction as a lack of morality or a character flaw to punish rather than a condition to assist people in resolving. White's call to shift the field towards a recovery-oriented system of care was ***Revolutionary****!* The article preceded his trailblazing recovery-oriented systems of care Monograph series.

In this post we will revisit White's 2005 groundbreaking article and provide commentary on how we are doing as a profession today as it pertains to the vision captured in the article. Today, the addictions profession is a ***Tale of Two Cities in a land that has not made the fundamental shifts that would transform our care system****.* Some programs and some geographical regions have clearly shifted from the acute care model towards a recovery-oriented system of care anchored in the natural environment. This is evident by the dramatic increase in Recovery Community Organizations (RCO's) nationwide, which are navigating our patchwork funding system grant to grant to strengthen recovery communities. The increase in recovery coaches providing ongoing, pre-treatment, in-treatment and post-treatment recovery support, ongoing, anchored in the natural environment, long-term recovery check-up, efforts to measure increases in recovery capital over time and the innovation of *Recovery Cities* as discussed by Dr. David Best.

Other programs and regions are continuing to do ***business as usual*** with a continued use of the acute care model solely, for numerous reasons:

- Some programs and systems of care "didn't receive the memo!" They have been so busy with assessments, admissions, withdrawal management, acute care services, treatment planning and discharge planning that they are unaware that a recovery-oriented systems of care revolution is occurring around them. Some programs have no recovery coaches on staff, are unaware of RCO's in their community and have never heard of recovery cities.
- Insurance reimbursement favors acute care treatment. Few Americans even have insurance plans that cover the minimum level of effective care in respect to duration of services. These systems aggressively meter out those services like we must use them sparingly even as the costs to society for failing to do so are immense. This becomes a cost shift to our public funding mechanisms as the acute interventions fail and insurance coverage is lost for the person who is addicted.
- State funding. Acute care programs continue to be funded by states whereas recovery-oriented programs and recovery community organizations are far too often considered specialty programs.
- Our documented outcomes are nearly always measured by treatment completion rather than longer term recovery outcomes focused on global improvement in health and functioning that are durable over time.
- Limited follow up. Many if not the vast majority of systems of care and related programs continue to treat "aftercare as an afterthought." They are unaware of the need for continuous care anchored in the natural environment. As a system we even lack the focus in our framing of post-acute treatment care and support. Consider oncology treatment. When a person gets a tumor removed or completes chemo, we do not think of the stages of care beyond those acute steps as “extra” we understand that achieving sustained remission is a multi-step process requiring a series of interventions, services and adherence to a longer-term care plan. The same is true for substance use conditions, particularly in its more severe forms. It is still the case that for our national treatment and recovery support system to routinely do so remains a radical notion two decades after this essay.
- Society still expects a cure or a simple intervention. A quick gold standard tool that resolves everything. Substance use conditions are some of the most complex conditions we face, and their resolution is equally

complex and multifaceted. Much of the general public is still unaware of the ebb and flow between treatment and a return of symptoms, sometimes repeatedly over years before there is sustained recovery.

- Treatment is viewed as separate from recovery. Some programs still view treatment as separate from recovery. We know that long term recovery is sustained in community, yet our focus far too often remains on the acute front end clinical interventions. To effectively shift to addressing addiction as a chronic disorder, we must make the connection to community.
- Greed as a pure profit motive. There are a small percentage of expensive high-end acute care programs that are too busy making money off of acute care residential treatment that they ignore all the evidence behind the need for longer term recovery management. These programs might fly clients into treatment on exotic islands or on both coasts overlooking the ocean. They might have a 5-star chef who serves dishes such as caviar and sushi and include spa treatment. Then, after 28 days, send clients home upon graduation with limited continuous care.

How we can begin to make a more complete paradigm shift towards a more complete recovery-oriented system of care.

- Measure recovery over the long term for every person in every community. Ensure that we continue to engage people into sustained remission for a minimum of five years following the initial intervention.
- Do a comprehensive analysis of recovery-oriented systems of care deserts in the country and begin to advocate for the need to provide recovery-oriented services beyond the acute care model. Include an assessment of the barriers and opportunities to the development and sustainability of recovery-oriented systems that center on the community.
- In the recovery-oriented systems of care deserts, share models of how to mobilize an entire community to work together to promote recovery Examples include: the Native American Wellbriety Movement, The Philadelphia ROSC Project initiated over a decade ago, the Illinois ROSC Council Project, and Scott County Indiana's successful mobilization of the entire county to reduce the spread of HIV, reduce overdose and increase referrals to treatment.
- Develop durable resources to support Recovery Management strategies. Even in areas that we are seeing groups move towards Recovery Management processes, far too often they do so by finding and fostering “work arounds” to support longer term recovery efforts. To highlight the challenge, consider that the primary funding mechanism for peer support in the nation is through Medicaid. We can’t help support people into meaningful lives if the funding to do so requires that they stay dependent on Medicaid.
- Single state agencies should offer training facilitated by those with expertise in fostering recovery efforts experientially to acute care providers about recovery management, RCO's, the benefits of recovery coaching post-discharge, recovery-oriented systems of care and how acute care treatment is a part of the ROSC continuum.
- Continue to make recovery focused research visible and accessible, grounded in what William White has termed multiple ways of knowing, facets that extend beyond academic insights into experiential knowledge. This includes outcome studies which demonstrate the effectiveness of longer-term recovery management anchored in the natural environment within indigenous recovery communities.
- Advocacy. As the recovery-oriented systems of care movement was taking hold, there was a simultaneous recovery advocacy movement occurring. The health of each of these processes is linked and interdependent on each other. In the future, the advocacy movement could focus on advocating for longer term recovery-oriented systems of care. Perhaps, even shedding light on programs which may be motivated by greed to continue with the status quo, leaving clients to be a part of the revolving door syndrome.

We Only Care About the Things We Decide to Measure….

Nothing substantively occurs unless it is measured in our field. If we care about long term recovery as a nation, we will insist on its measurement. While we have made some progress in moving our systems of care and its

associated systems away from an acute care focus, perhaps the most telling feature of how little progress we have made is that we do not document recovery trajectories beyond the completion of any of our system individual components. We will have no way to connect the various pieces and understand their efficacy without measures that extend from point of first contact and recovery initiation into long term recovery. Such a measure would show the stops and starts of individual interventions but within the mosaic of those processes, we would better understand how people actually do recover. We would learn how to think long term and to adjust our strategies based on key variables like the severity of the substance use challenge and the amount of recovery capital that is available to sustain recovery. We would perhaps understand how recovery trajectories vary across the life cycle and within subcommunities. We would better understand the relationship between formal treatment, recovery support services and informal community grounded recovery capital and the role of meaning, mattering and hope in the course of recovery for millions of Americans. We would understand how recovery is not just possible but extends to the highly probable when people get the proper dosage of care and support consistent with their strengths, needs and resources.

Without meaningful measures we will not achieve what William White posed as a question a generation ago which is a Recovery Management process that is consistent with the nature of the condition.

Conclusion

William White's visionary writings will continue to provide opportunities for decades for historians and researchers to look back in order to continue moving forward. His pioneering article, ***Recovery Management: What if we <u>Really</u> Believed Addiction was a Chronic Disorder*** provided such an opportunity two decades after it was written. As Yogi Berra once said, if you come to a fork in the road, take it! If we fail to take that fork, that path less traveled, we can be assured of poor outcomes well into the next generation. Twenty years from now we will be wondering what our systems of care would actually look like if we really believed addiction was a chronic condition. In the years between that moment and the one we are in right now, we will have failed to get more people into recovery than what we can achieve with our limited short-term focus. That sad fact would cement in one additional outcome. Untreated and undertreated addiction drives most of the costs in our society. When all the dollars get added up arguably make it our most costly domestic challenge. We would have wasted precious resources. If we actually believed that addiction was a chronic condition and invested in a recovery management model ground in recovery-oriented systems of care we would invest in it. That would save lives and resources. It is time we commit to that fork in the road and transform our systems of care accordingly.

Bios:

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