

# Building a Systemic Vision for Resiliency, Wellness and Recovery: A new age, a stronger profession

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# Building a Systemic Vision for Resiliency, Wellness and Recovery

With grateful acknowledgement to:

William White, M.A.  
Chestnut Health Systems

Alexandre Laudet, Ph.D.  
NDRI

SAMHSA/CSAT

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## Presentation Goals

1. Provide an overview of the emerging recovery movement and the concept of recovery oriented systems of care.
2. Outline the “workforce crisis” in the addictions field and the national and regional efforts to mitigate the crisis.
3. Discuss the importance of workforce within the emerging recovery movement.

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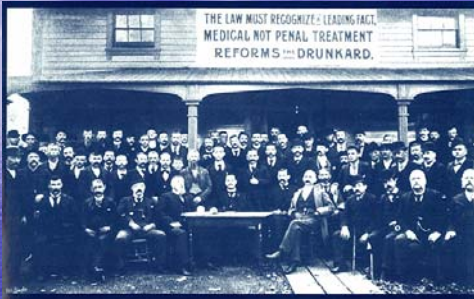
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# In the beginning ...



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# In the beginning ...



Courtesy Illinois Addiction Studies Archives  
Boston Washingtonian Home

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# In the beginning ...



Addict Receiving Electroshock Treatment at Lehighton



Navy Patients Standing in Line for their Injections

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## In the beginning ...



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## In the beginning ...



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## Where We Are Today...

- **The Acute Care Model:** professionally driven, acute care episodes, pathology-based, limited lifetime episodes of care, fee-for-service, "graduation" from treatment, and low compliance.
  - Only 20% of those who need Tx receive it (Hoge et al., 2007)
  - 50-64% dropout between call for appointment and first treatment session (Gottheil et al., 1997).
  - More than 50% of clients admitted to Tx do not successfully complete it (OAS/SAMHSA 2005).
  - 50% drop out in first month (Watkins et al., 2003).
  - High waiting list dropout rates (25-50%) (Hser et al., 1998; Donovan et al., 2001).
  - 80% of relapses occur within 90 days of discharge (Hubbard et al., 2001).

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### Where We Are Today (cont'd)...

- Still, AOD use decreases by 87% & substance-related problems decrease by 60% following Tx (Miller et al., 2001).
- Misleading outcomes because these measures do not capture changes in lives of individuals and families due to addiction treatment.
- What aren't we discussing?...

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# Recovery!

**How can this be implemented in services offered and for service professionals - currently and in the future?**

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### **First Task :** Build a Working Definition of Recovery

- Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life (CSAT, 2007).
- Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship (The Betty Ford Institute Consensus Panel, 2007).

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## Second Task:

### Design a Recovery-oriented System of Care (based on Principles of Recovery)

Provisional Definition: Recovery-oriented systems of care (ROSC) are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by severe substance use disorders. The *system* in ROSC is **not** a treatment agency but a macro level organization of a community, a state or a nation.

Kaplan, 2008

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## Second Task (cont'd):

### Design a Recovery-oriented System of Care (based on Principles of Recovery)

- Build National, State and local infrastructure and adaptive capacity (See IOM, 2001, Appendix A; IOM, 2006; Hoge et al., 2007, Goal 1; Whitter, 2006).
- Modify funding/reimbursement strategies to align with recovery goals (Kaplan, 2008; SAMHSA NOMs).
- Require an ongoing process of systems improvement that incorporates recovery voices (IOM, 2001; Clark, 2008).
- Set all within the context of a new model for addiction care which focuses on building resiliency and helping individuals achieve recovery and total wellness (Flaherty, 2006).

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## Second Task: Build a ROSC

### Barriers:

- difficulty in moving from deficit-or-problem focused thinking to a strength-based focus and a chronic model of care
- weak infrastructure and staff turnover
- lack of protocols and finances to support recovery

### Challenges:

- maintaining quality and accountability ... and uniqueness!
- maintaining the "peer-ness" of peer recovery
- resisting pressure on budgets – both recovery and treatment are needed
- obtaining reliable data

- Kaplan, 2008

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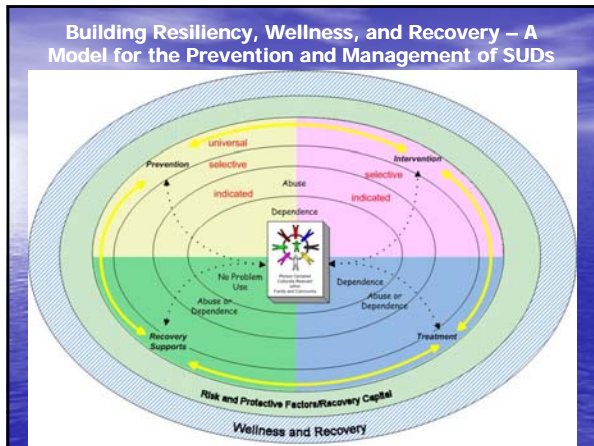
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**Guiding Principles of Recovery**

- There are many pathways to recovery
- Recovery is self-directed and empowering
- Recovery involves a personal recognition of the need for change and transformation
- Recovery is holistic
- Recovery has cultural dimensions
- Recovery exists on a continuum of improved health and wellness

(CSAT, 2007)

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**Guiding Principles of Recovery (cont'd)**

- Recovery emerges from hope and gratitude
- Recovery involves a process of healing and self definition
- Recovery involves addressing discrimination and transcending shame and stigma
- Recovery is supported by peers and allies
- Recovery involves (re)joining and (re)building a life in the community
- Recovery is a reality

(CSAT, 2007)

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## Third Task: Measure Everything!

- Build an agenda for recovery research (Laudet, 2008; White, 2007; White, in press)
  - Why is this important ? (evidence-based practice)
- Build:
  - **System level** performance measures of recovery – e.g., access to care, achievement of recovery, infrastructure development and training readiness; SAMHSA NOMs
  - **System and agency intermediate** service measures – early identification, engagement, and retention
  - **Individual and agency long-term** recovery measures – resolution of alcohol or other drug problems, health, safety, and life meaning.

White, in press

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## Third Task: Measure Everything!

- Concurrently measure treatment progress and recovery (McLellan et al., 2005; Flaherty, 2006) – practice-based evidence
- Measure cost of individual recovery in the context of the whole system and to society (i.e., chronic disease framework; Zarkin, et al., 2005; Pelletier & Hoffman, 2001)
- Convey results of measurement to all stakeholders (10 P's) – person/patient; parent/family; pastor, police, press, payer, purchaser, philanthropist, policy maker and professor/researcher (Flaherty, 2006).

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**What would a true  
ROSC look like?  
(10 dimensions of care)**

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## 1. Attraction

- Should be attractive – reduce stigma (e.g., Recovery Month events)
  - change public perception of Tx and recovery
  - Acceptable to seek help, be in Tx, or be in recovery
- Provide Preventative Care (Strategic Prevention Framework w/Risk and Protective Factors)
  - Prevent increasing severity – improve public opinion
  - Integrates general medical and behavioral care

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## 1. Attraction (cont'd)

- Treat SUD like a chronic disorder
  - More successful Tx – specialty and non
  - Improved life functioning (better public perception)
- Publicly accepted and available Tx
- Non-stigmatizing service sites
  - Integrated care (hospitals, PCP, community centers, etc.)
  - "No wrong door"

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## 2. Access and Engagement

- Streamlined intake processes
- Assertive waiting list management with pre-treatment clinical supports
- Adaptable and flexible service programs that address conditions and wellness
- Insurance/reimbursement parity
- Appointment prompts/phone follow-ups
- Hope-based motivational strategies
- Fair AMA and AD rates

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## 2. Access and Engagement (cont'd)

### Altered View of Motivation in ROSC

Motivation for change is no longer seen as the sole province of the individual, but as a shared responsibility with the treatment team, family and community institutions (White, Boyle & Loveland, 2003).

Motivation is seen as important, but as an outcome of a service process, not a pre-condition for entry into treatment. A strong therapeutic relationship can overcome low motivation for treatment and recovery (Ilgen et al., 2006). Motivation is understood with recovery capital.

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## 3. Assessment and Service Planning

### Plan for Recovery:

- Globally (e.g., use ASI, GAIN)
- Strength-based (emphasis on assessment of recovery capital)
- Individual is assessed in the context of total recovery environment (family, community, etc.)
- Emphasis on self-assessment and client-driven goals
- Continual interaction with individual

(Borkman, 1998; White & Kurtz, 2006)

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## 4. Service Elements

- Emphasis on EBPs and promising practices. Practice-based evidence also gaining acceptance!
- High degree of individualization/adaptability using real-time feedback
- Built-in time for clinical supervision and skill-building opportunities

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### 5. Composition of Service Team

- Interdisciplinary service team
  - Medical and non-medical personnel
  - D&A providers are specialists
- Integration of community-based resources
  - Recovery community centers (White & Kurtz, 2006; Valentine et al., 2007)
  - Ancillary services like housing, employment assistance, child care, etc.
- Central role of community and volunteer programs, consumer councils, alumni associations, and culturally appropriate services

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### 6. Locus of Service Delivery

- Home/family, neighborhood, and community-based.
- Emphasis on integrating recovery into the natural environment
- "Healing Forest"

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### 7. Service Dose and Duration

- Service dose and duration based on scientific evidence (NIDA, 1999)
- Use of assertive continuing care strategies (Scott et al., 2005)
- Assertive management of individual in recovery for up to five years

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**7. Service Dose and Duration (cont'd):**  
**Assertive Approaches to Continuing Care**

- Post-treatment monitoring and support (recovery check-ups; Scott et al., 2005).
  - For all individuals
  - Use technology
- Stage-appropriate recovery education and coaching.
- Assertive linkage to communities of recovery.
- Continuity of contact - disease management.
- Individualization of contact based on clinical data.

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**7. Service Dose and Duration (cont'd):**  
**Data Supporting Use of Assertive Continuing Care**

- Durability of alcoholism recovery is not reached until 4-5 years of remission (Jin et al., 1998).
- 20%-25% of narcotic addicts who achieve 5+ years of abstinence return to opiate use (Simpson & Marsh, 1986; Hser et al., 2001).
- Family recovery can take up to 3-5 years (Brown & Lewis, 1999).
- Post discharge continuing care enhances recovery outcomes (Godley et al., 2001; Dennis et al., 2003), but:
  - Only 10-20% of adult clients receive continuing care (McKay, 2001; SAMHSA/OAS, 2005).
  - Only 36% of adolescent clients receive any continuing care (Godley et al., 2001).

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**8. Relationship with Recovery Communities**

- Staff and volunteers knowledgeable of:
  - multiple pathways/styles of long-term recovery,
  - local recovery community resources, and
  - alternative methods of accessing support (online forums, meetings, etc.; White & Kurtz, 2006).
- Direct relationship with Hospitals & Institutions committees and comparable service structures.
- Assertive linkages to a range of support groups (not just AA or 12-step-based programs) and larger communities of recovery.

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## 9. Service Relationship

- Based on the partnership model – embed the client/family in recovery-supportive relationships that are:
  - natural
  - reciprocal
  - non-commercialized
- Focus on continuity of contact in a recovery-supportive service relationship comparable to a PCP.
- Service providers play more of an ongoing consultation role and adhere to a “philosophy of choice.”

**This requires a stabilization of field’s workforce!**

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## 10. Evaluation

- Focus on effect of interventions at multiple points in time (McLellan, 2002).
- Focus on long-term recovery processes and quality of life in recovery.
- Greater involvement of clients, families, communities, and elders in design, conduct, and interpretation of outcomes (White & Sanders, in press).
- Search for most effective service combinations and sequences.

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## 10. Evaluation (cont’d) Examples of Recovery Measures

Goal	Measures
Effective connection to recovery support groups	<ul style="list-style-type: none"><li>• % of clients involved in recovery support mtgs in first 30 days after discharge</li><li>• Total and average number of weekly mtgs attended in first 90 days after discharge</li><li>• Pct of individuals referred to 12-Step groups who have temp or permanent sponsors in first 30 days after discharge</li><li>• Post-treatment reoccurrence rates</li></ul>

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## But...

No systems transformation or even major changes to the existing system of care can occur without addressing the additions workforce crisis

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## The Workforce Crisis

- Difficult to recruit and train a sufficient number of qualified professionals to meet treatment demand (Gallon et al., 2003).
- Lack of job growth opportunities (Knudsen et al., 2005).
- Few opportunities for training to build skill due to fee-for-service structure.
- Hard to attract and/or retain individuals with higher degrees due to low pay.
- Salary and benefits for certified or licensed SUD professionals are significantly lower than for related fields like Mental Health and Nursing (U.S. Department of Labor, 2003).

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## The Workforce Crisis (cont'd)

- Large amounts of time spent on administrative duties (instead of clinical care)
  - Directors spend 73% to 87% of time on admin duties
  - Staff spend 36% to 42% of time on admin duties (Knudsen et al., 2005; RMC Research Corporation, 2003)
- Staff turnover rates in community agencies are high – 20% to 25% annually (Knudsen & Gabriel, 2003).
- No uniform standards (DHHS, 1998; 2000).
- Shortages and geographic maldistribution (CSAT, 2000).

\*\*\*Operational Readiness Capacity\*\*\*

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But don't be too discouraged.  
We are working on it...

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**Historical Workforce Development Efforts (National)**

- **1956:** APA Committee on med education - psych education in med schools
- **1972:** NAADAC founded
- **1978:** President's Commission on Mental Health - call for systematic training, cultural competency, and multidisciplinary training
- **1993:** SAMHSA - *Workforce and Training for Mental Health Systems*; ATTC Network established
- **2000:** CSAT - *Changing the Conversation*
- **2003:** President's New Freedom Commission – The mental health field needs “a comprehensive, strategic plan to improve workforce recruitment, attention, diversity, and skills training” (New Freedom Commission on Mental Health, 2003)

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**Two Recent Examples:**



The image shows two book covers side-by-side. The left cover is titled 'An Action Plan for Behavioral Health Workforce Development' and features a blue and green design with abstract shapes. The right cover is titled 'Strengthening Professional Identity: Challenges and Solutions for the Addictions Treatment Workforce' and features a blue and yellow design with a stylized figure.

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## Workforce Development Efforts (Regional/Local)

- ATTC Network
  - improving standards of education and treatment
  - dissemination of research-based strategies
  - tools at the community level
  - Example of NeATTC – 3-state effort with regional summits to keep all focused
- CAPT Network
  - training and development of prevention specialists
  - use of evidence-based practices in the design of community prevention programs

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## Workforce Solutions

**Building the Workforce:**  
*Selected Priority Recommendations – Strengthening Professional Identity (Wittier, 2006)*

- Develop, deliver and sustain training for clinical and recovery support supervisors, who serve as the technology transfer agents for the latest research and best practices
- Improve student recruitment with educational institutions, focusing on under-represented groups
- Include training on addictions as part of education programs for primary health care and for other health and human service professions
- Support the development and adoption of national accreditation standards for addictions education programs

**Where is recovery??**

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## Workforce Solutions (cont'd)

**Broadening the Concept of Workforce:**  
*Goal 1 - Annapolis Coalition (Hoge et al., 2007)*

- Significantly expand the role of **individuals in recovery**, and their families where appropriate, to participation, ultimately direct and accept responsibility for their own care; educate the workforce.
- Objectives:
  - provide information about recovery
  - develop shared decision making skills
  - significantly expand peer and family supports
  - increase employment of recoverees and families as paid staff in treatment
  - engage those in recovery in all training, roles

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## Bringing Recovery Back into Treatment

- Growth & diversification of American communities of recovery - 20 million Americans have a message to tell!
- A new recovery advocacy movement built on an informed history
- Recovery community building (Arizona, Connecticut, New Mexico, Alaska, Florida, North Carolina, Pennsylvania, New York, et al.)
- Need for payers to reconnect treatment to the more enduring process of personal/family recovery

White, 2004; 2005; 2006; 2007; in press; Flaherty, 2006; Kaplan, 2008

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## Bringing Recovery Back into Treatment (cont'd)

- Shift from pathology and intervention paradigms to a "Resiliency, Wellness and Recovery" paradigm
  - \* Fundamental shift in how providers interact with clients
  - \* New tools, e.g., CT DMHAS Agency Recovery Self-Assessment; Recovery-oriented SA Tx checklist
- Need for leaders to see wellness and recovery to ensure their ongoing support and end their disillusionment!

White, 2004; 2005; 2006; 2007; in press; Flaherty, 2006; Kaplan, 2008

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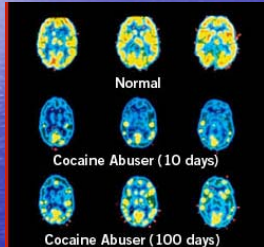
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## Signs of a Paradigm Shift

- Science-based conceptualizations of addiction as a chronic disorder (Hser, et al., 1997; McLellan et al., 2000; Dennis & Scott, 2007); **Consensus-based** (Flaherty, 2006).



PET scans of normal brain and brain of cocaine user (Brookhaven National Laboratory, 2006).

Science is catching up to experience!

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## Signs of a Paradigm Shift

- Accumulation of systems performance data on limitations of an AC model of Tx (White, in press); emergence of recovery focused performance measures.
- *Recovery* as an organizing construct for behavioral health care policies & programs (e.g., IOM, 2006; CSAT's RCSP & ATR programs; RWJF's Advancing Recovery Program)
- "Recovery-focused systems transformation" efforts (Clark, 2007; Kirk, 2007; Evans, 2007; CSAT, 2005; Kaplan, 2008)

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## Signs of a Paradigm Shift (cont'd)

- Calls for a recovery-focused research agenda (White, 2000; White & Godley, 2005; Laudet, 2008; NIAAA and NIDA)
- Efforts to create a new and newly nuanced language, e.g., efforts to define *recovery*, *recovery-oriented systems of care (ROSC)*, *recovery capital* (Granfield & Cloud, 1999), *recovery supports* and *recovery management (RM)* (e.g., The Betty Ford Institute Consensus Panel, 2007)

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## Signs of Paradigm Shift

- Building the Science of Recovery
    - How many people in the US are in recovery and how did they get there?
    - Are we curing addiction?
    - while we share many characteristics of other chronic illnesses, we are also unique and must be seen as such to sustain remission.
    - when does recovery begin?
    - what are the paths to recovery?
    - is someone on methadone or buprenorphine in recovery?
    - is recovery different in different ages and groups?
- Laudet/IRETA, 2008

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But we are not there yet...

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### How Will This Change Occur?

- Measurement (of current practices, change in practices, etc.)
  - Use and monitoring of performance improvement strategies (NIATx, POLaRIS)
- Change in Policies
  - Mental Health Parity!
- Change in Attitudes (down with stigma!)
  - Broad-based educational efforts
- Unification of Field (Recovery and Tx together)
  - Need to address fears of all stakeholders, especially regarding what they think they will lose.
- **Stabilize and build workforce...**

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### Key Elements for Effective Recovery Oriented Workforce Development

- Greater inclusion of individuals in recovery and their families
  - Provide workforce education based on lived experiences
  - Better connect these individuals with educational support so they can enter workforce
- Concerted recruitment and retention efforts at all levels. Especially focus on:
  - Increasing cultural and linguistic diversity of workforce; cultural competence

Hoge et al., 2007

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## Key Elements for Effective Recovery Oriented Workforce Development

- Changes needed to educational methods and course content (e.g., RI)
  - All should be teaching students to view Tx through a recovery-orientation
  - Methods should follow implementation science (Fixsen et al., 2005)
  - Certification/uniform standards for individuals providing recovery services
- Connect with the local community – Build its capacities, offer support, accept support from it.

Hoge et al., 2007

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## Closing Thoughts

1. ROSC is a fundamental redesign of modern addiction treatment. (White, 2008)
2. Overselling what the AC model can achieve to policy makers and the public risks the further loss of confidence and further backlash and the revocation of addiction treatment's probationary status as a cultural institution. (White, 2008)

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## Closing Thoughts

3. It will take years to transform addiction treatment from an AC model of intervention to a ROSC.
4. That process will require unified implementation of a new model to direct care, a clear understanding of recovery, and a focus on recovery.
  - a. Nationally replicate efforts already underway to support long-term recovery. (Kaplan, 2008)

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## Closing Thoughts

Recovery focused care is **person-centered** (IOM, 2001; 2006) and:

- highly individualized
- responsive to culture and personal beliefs
- community-based
- committed to peer services
- involves families and other supports
- ongoing with monitoring and outreach

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## Closing Thoughts

Recovery Focused Care is Cost-Effective and:

- \* outcomes oriented
- \* anticipatorily practiced
- \* competency-based
- \* built on collaborations and partnerships
- \* involves continuity of care
- \* research-based
- \* flexibly funded

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## My business case:

*At the end of the day without a vision for individual and community recovery and the related supportive system changes, we will remain divided in our understanding, efforts and results. Even with a strong business case and well-established cost benefits, the addictions field will not be able to move forward without this unified vision that re-prioritizes the hope and value of addressing addiction in America. In the end, only this value, stimulated by measurable recovery, will turn the tide in addressing an illness that effects:*

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## Addiction Effects:

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	80% of those in jail
35% of all school children	60% of CYF referrals

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Knowing is not enough; we must apply.

Willing is not enough, we must do.

- Goethe

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## Building a Systemic Vision for Resiliency, Wellness and Recovery

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