center for Study of Addictions & Recovery

NDRI NATIONAL DEVELOPMENT AND RESEARCH INSTITUTES, INC.

BUILDING THE SCIENCE OF RECOVERY to guide Recovery-Oriented Systems of Care

Alexandre B. Laudet, PhD

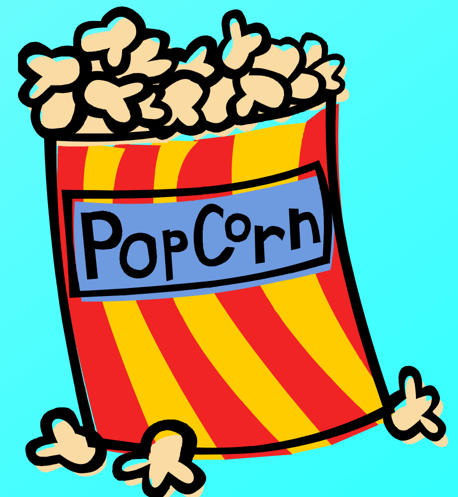
Correspondence: laudet@ndri.org

State Systems Developmental Programs Conference

Washington DC, August 21, 2008

A play in six acts….

With no intermission



ACT ONE
WHY ARE WE HERE TODAY?

Why are we here today?

- Growing evidence that drug and alcohol dependence ('addiction') is *a chronic disorder* (on par with diabetes, asthma etc…)
- WHAT DOES THIS MEAN?
  - Addiction can not be *cured* but it can be arrested or *managed*
  - For some, it may require ongoing care of various intensities over time (e.g., intensive services, stepped down or after care, recovery checkups, 12-step)
- Thus far services have been provided according to an acute model of care (assess, treat, discharge)
- Short-term episodes of intensive care are ill-suited to manage a chronic condition
- We have focused on symptoms, not on promoting wellness

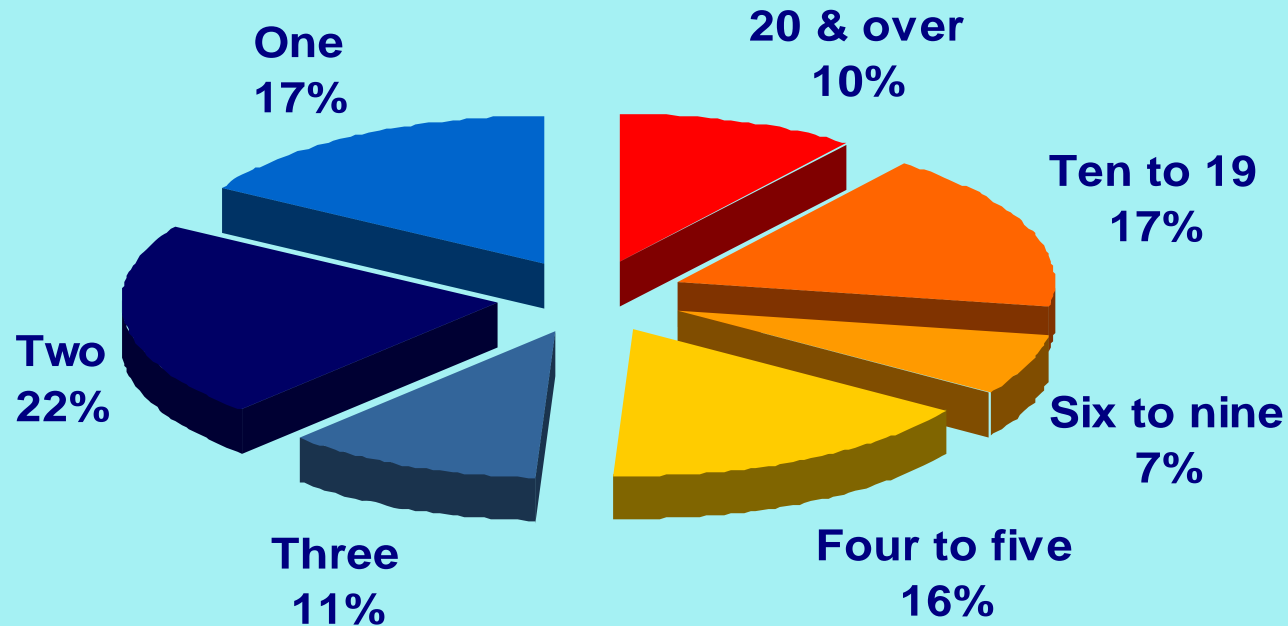
Addiction

- PRIMARY SYMPTOM: substance use

- SECONDARY SYMPTOMS/CONSEQUENCES include impairments in:
  - Physical health
  - Emotional/mental health
  - Family and Social functioning
  - Vocational functioning
  - Housing
  - Finances
  - Legal status
  - Spiritual well-being
  - AS WELL AS threats to public health and safety (crime and infections disease)

Addiction career *Number of abstinent periods one month or longer followed by return to drug use prior to current abstinence**

50% reported 4 or more abstinent periods followed by return to active addiction

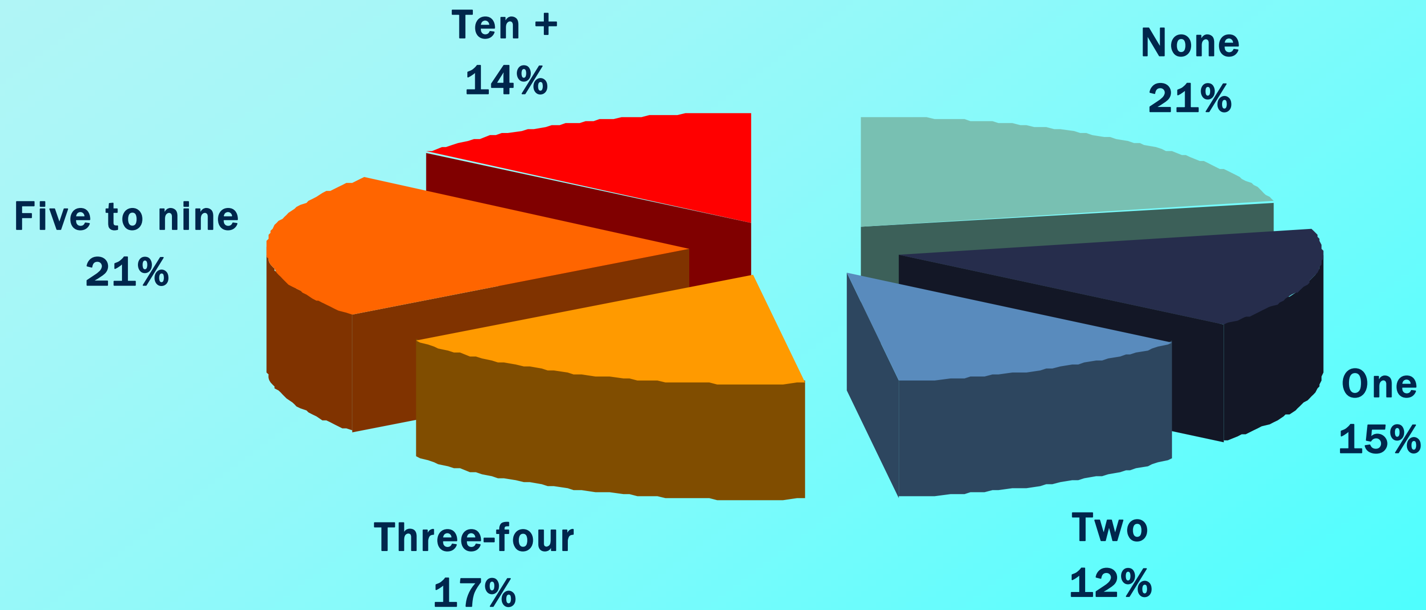


Range 1 to 90 Mean = 7.56; Std dev= 10.6

* Outside of controlled environment, among those who report one or more such periods: 71% N=248

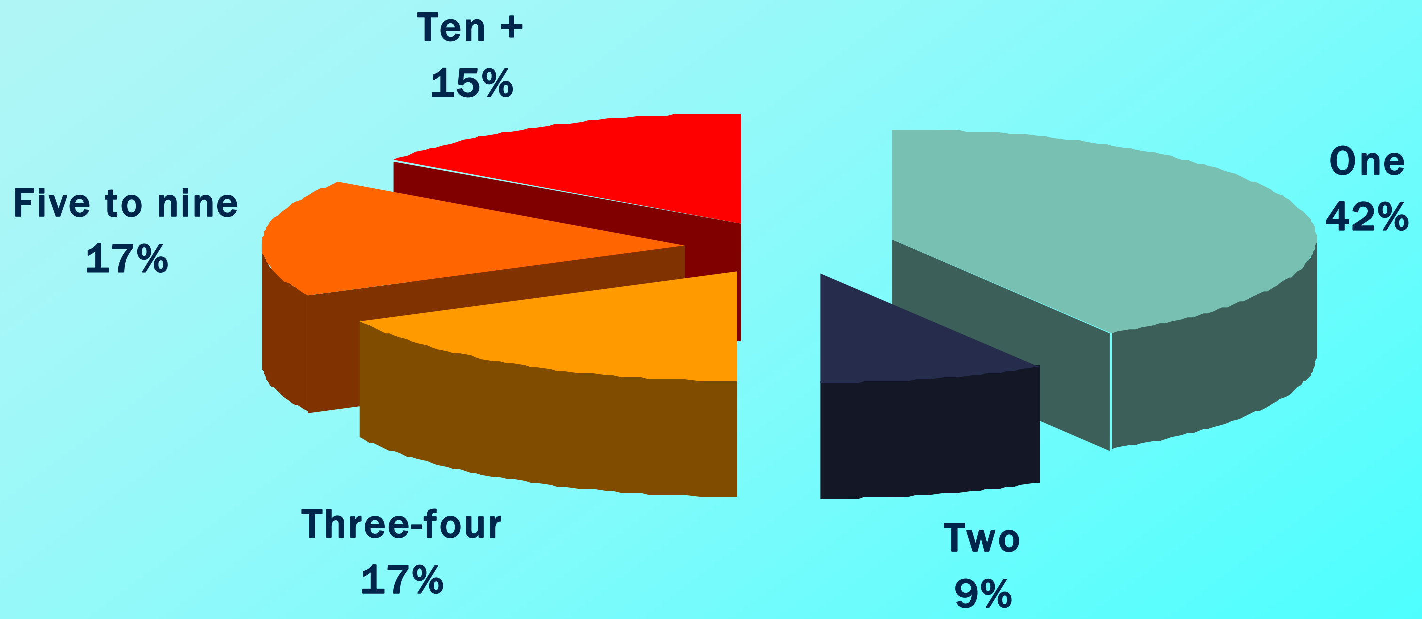
Treatment Career: Number of prior episodes

Over half of outpatient clients have had 3 or more previous episodes

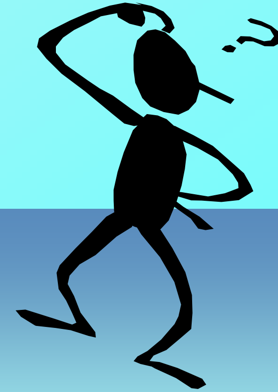


12-step career among 'ever attenders'

49% have had 3 or more interrupted 12-step episodes



QUESTION…



Is that 50% '*treatment-resistant*' or

can we do better?

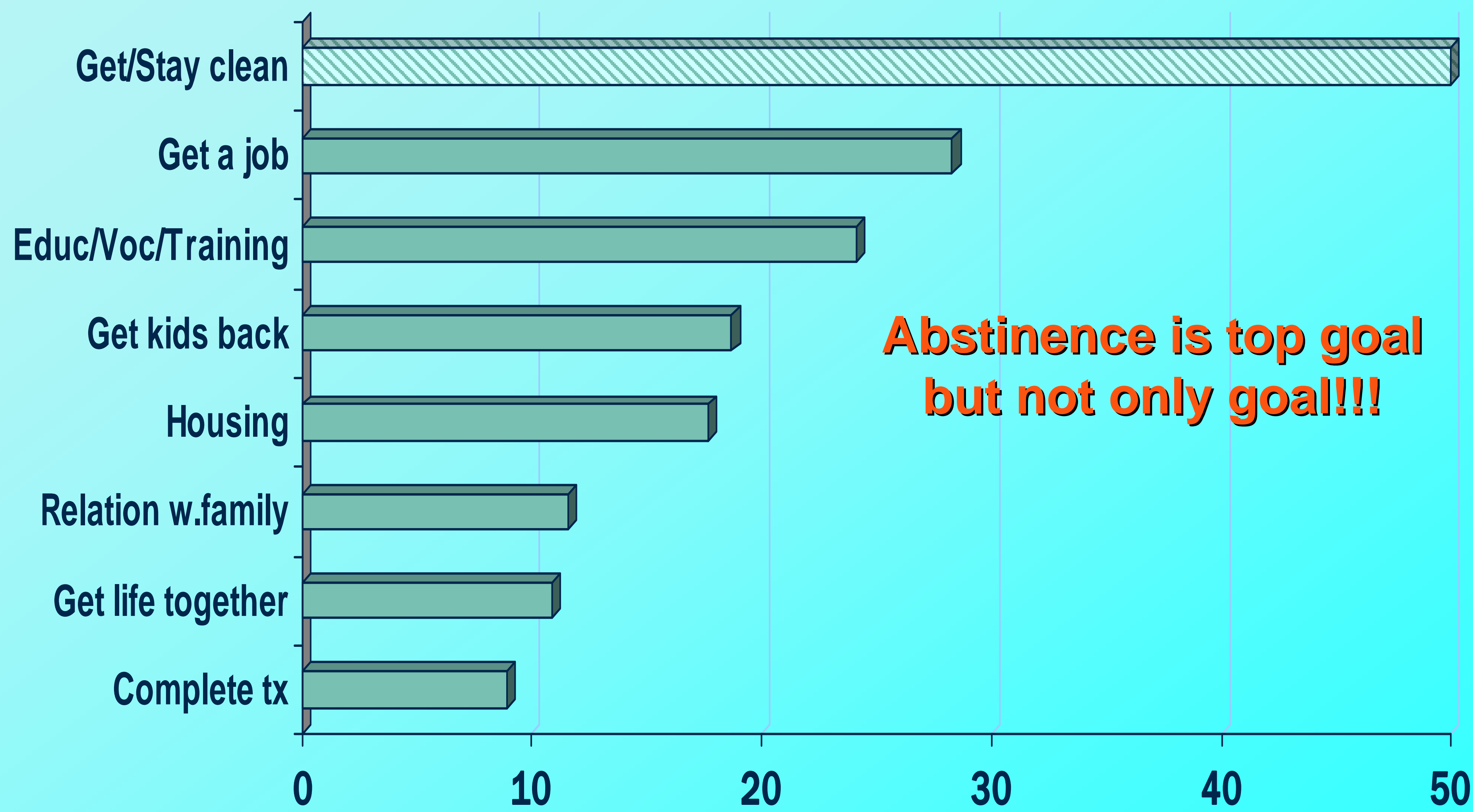
SAMHSA 2006: The concept of recovery lies at the core of SAMHSA's mission, and fostering the development of recovery-oriented systems of care is a SAMHSA priority.

Toward Recovery Oriented Systems

Recovery is more than abstinence from alcohol and drugs; it is about building a full and productive life in the community. ***Our treatment systems must reflect and help people achieve this broader understanding of recovery.*** (Dr. W. Clark, 2007)

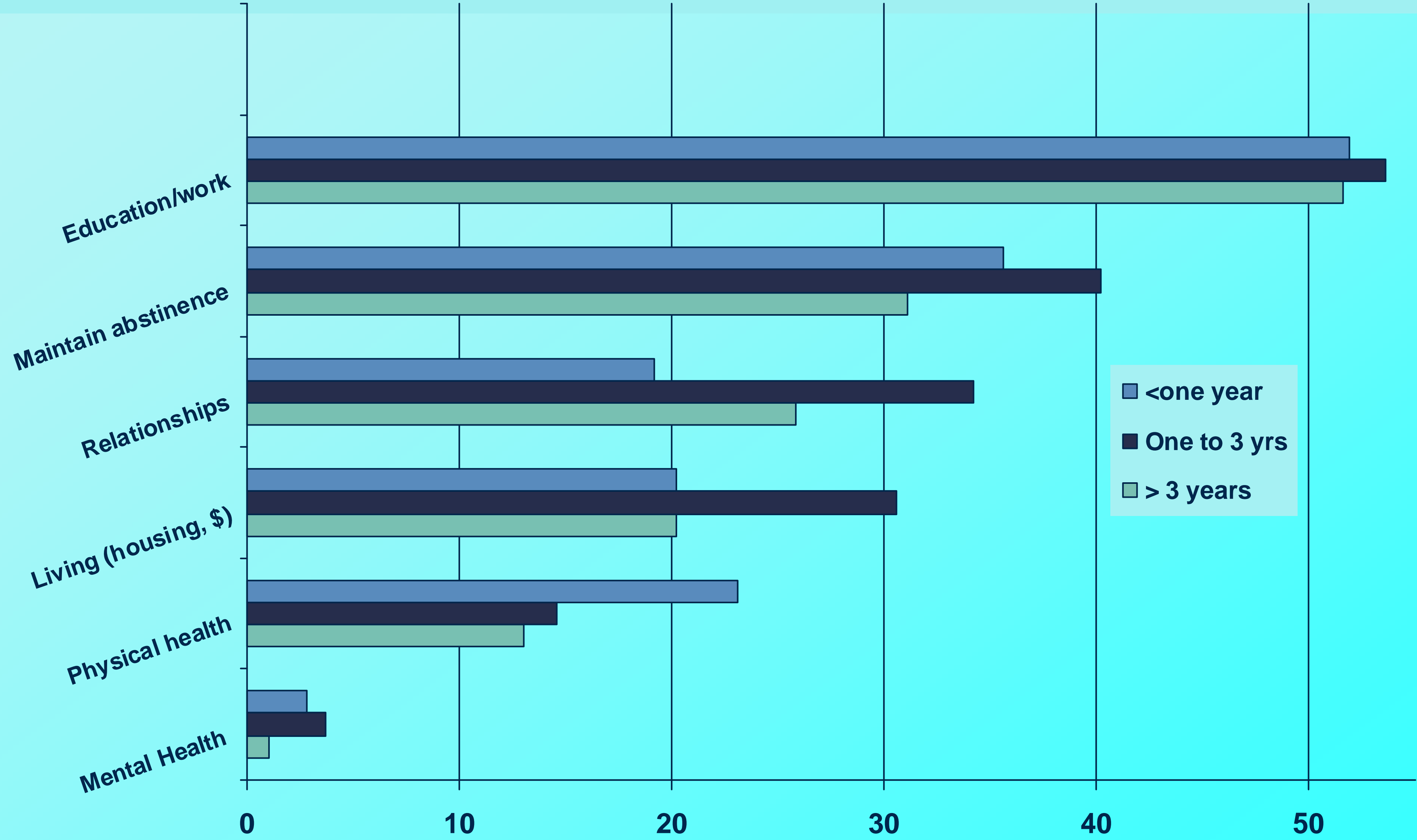
Priority areas at outpatient admission

What are the priorities in your life right now? (N = 314)



Add to > 100% because up to 3 answers were coded

Life priorities in recovery as a function of abstinence duration *"What are the priorities your life right now?"* *(N = 354)*

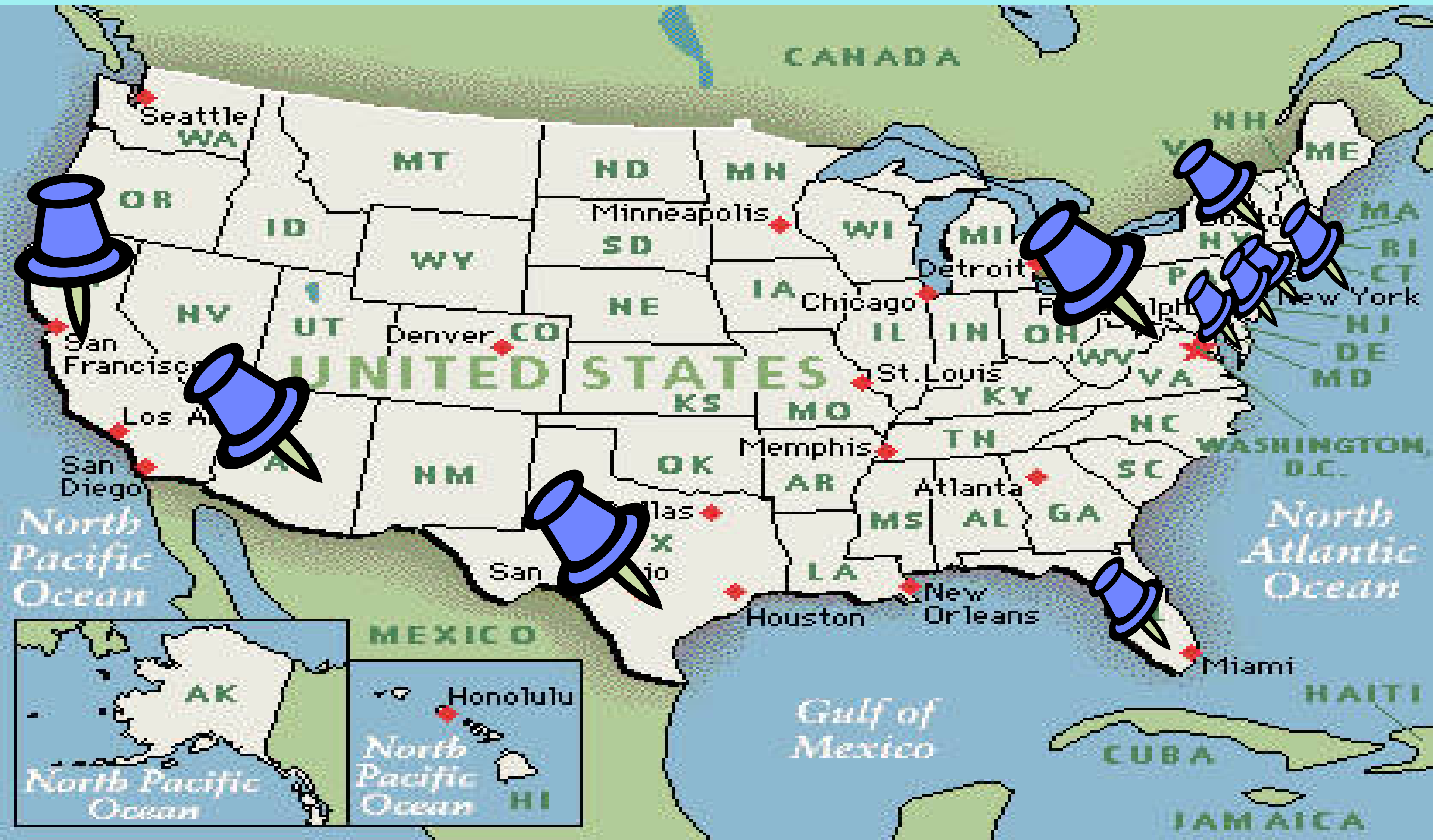


Add to > 100% because up to 3 answers were coded

ACT TWO

RECOVERY-ORIENTED SYSTEMS of CARE

Over a dozen states have begun transitioning to ROSC… We hope you are next!



Cautionary notes

- **For some, 'Recovery' means AA, the 'recovery movement' conjures up ideas of strong 12-step emphasis ('cult') from the 1980's and 'recovery-oriented systems of care' sounds like *déjà vu* all over again**
- **For the present purpose, 'RECOVERY' is used as shorthand to refer to a global and sustained improvement in the lives of people with substance abubse/depedence problems, <u>not a specific path to wellness or treatment orientation</u>.**
- **Let's not let semantics get in the way of changing our systems and improving lives**

Elements of Recovery-Oriented Systems of Care

- Person-centered
- Family and other ally involvement
- Individualized and comprehensive services
- Systems anchored in the community
- Continuity of care
- Partnerships
- Strength-based
- Culturally responsive
- Responsive to personal belief systems
- Commitment to peer services
- Include recovering people and families
- Integrated services
- System-wide educational and training
- Ongoing monitoring and outreach
- Outcomes-driven
- Research-based
- Adequately and flexibly funded

From W. Clark, CSAT, Generic ROSC talk

Recovery-Oriented Systems of Care is NOT (just) ‘putting the word *recovery* on everything’

That’s insanity//old wine in new bottles

Paradigmatic shifts needed to implement ROSC

- From intense episodes of acute specialty care to **multi-systems, person-centered continuum of care** (chronic care, HPB/diabetes model)
- From addressing pathology to **promoting global health/wellness/recovery**

Recovery Oriented System of Care

- THIS SOUNDS VERY GOOD
- THIS MEANS BIG CHANGES
- HOW DO WE GET THERE?
  - NEED TO KNOW
    1. What recovery means;
    2. What helps/hinders the process
    3. How this can be translated into services and policy
       - At the program level
       - At the system level

ACT THREE

WHY DO WE NEED A SCIENCE OF RECOVERY?

Why do we need a science of recovery?

- Decades of federally-funded research have contributed a vast knowledge base about the nature (etiology, ‘causes’), course, consequences and treatment of addiction.

- Information on the prevalence of alcohol and drugs use in the past month/year is easily accessible through a few mouse clicks, analyzable by age, gender, ethnicity, region and employment status.

ile Edit View Document Comments Tools Advanced Window Help

Search Create PDF Comment & Markup Send for Review Secure Sign Forms

Select 73% Help Note Tool Text Edits Stamp Tool Show

Skip To Content

- National data
- State level data
- Metropolitan and other subState area data

State Level Data on Alcohol, Tobacco, and Illegal Drug Use

NEW State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health (HTML) (PDF format)

State level estimates of alcohol, tobacco, and illegal drug use for all the individual States are available from OAS since 1999. This innovation resulted from the implementation of a national survey design with representative State samples, increased sample size, and newly available analytic software.

- Topics with State level data (underage drinking, alcohol, mental health, mortality, treatment gap, etc.)
- **Full reports by year:** 2006, 2005, 2004, 2003, 2002, 2001, 2000, 1999 1991-93
- Short reports (also see Topics with State level data above)
- **Variables:** Alcohol, drug use, & mental health by State: 2004 2003
- **Trends:** Substance use by drug, age group & State includes changes between years
- **Maps:** 2005, 2004, 2003, 2002, 2001, 2000, 1999 Youth only
- Links to specific States
- State treatment planning areas

This page has been accessed 28715 times since November 11, 2007.

This page was last updated on March 6, 2008.

Why do we need a science of recovery?

- What exactly IS *recovery*?
- How does one *get* there?
- How does one *stay* there?

Why do we need a science of recovery?

- Treatment can be effective but relapse rates are high and other areas of functioning do not always improve significantly
- Only a third or fewer of people with drug or alcohol dependence ever seek treatment.
- HOW DO WE ‘SELL’ SERVICES TO THOSE WHO NEED IT?

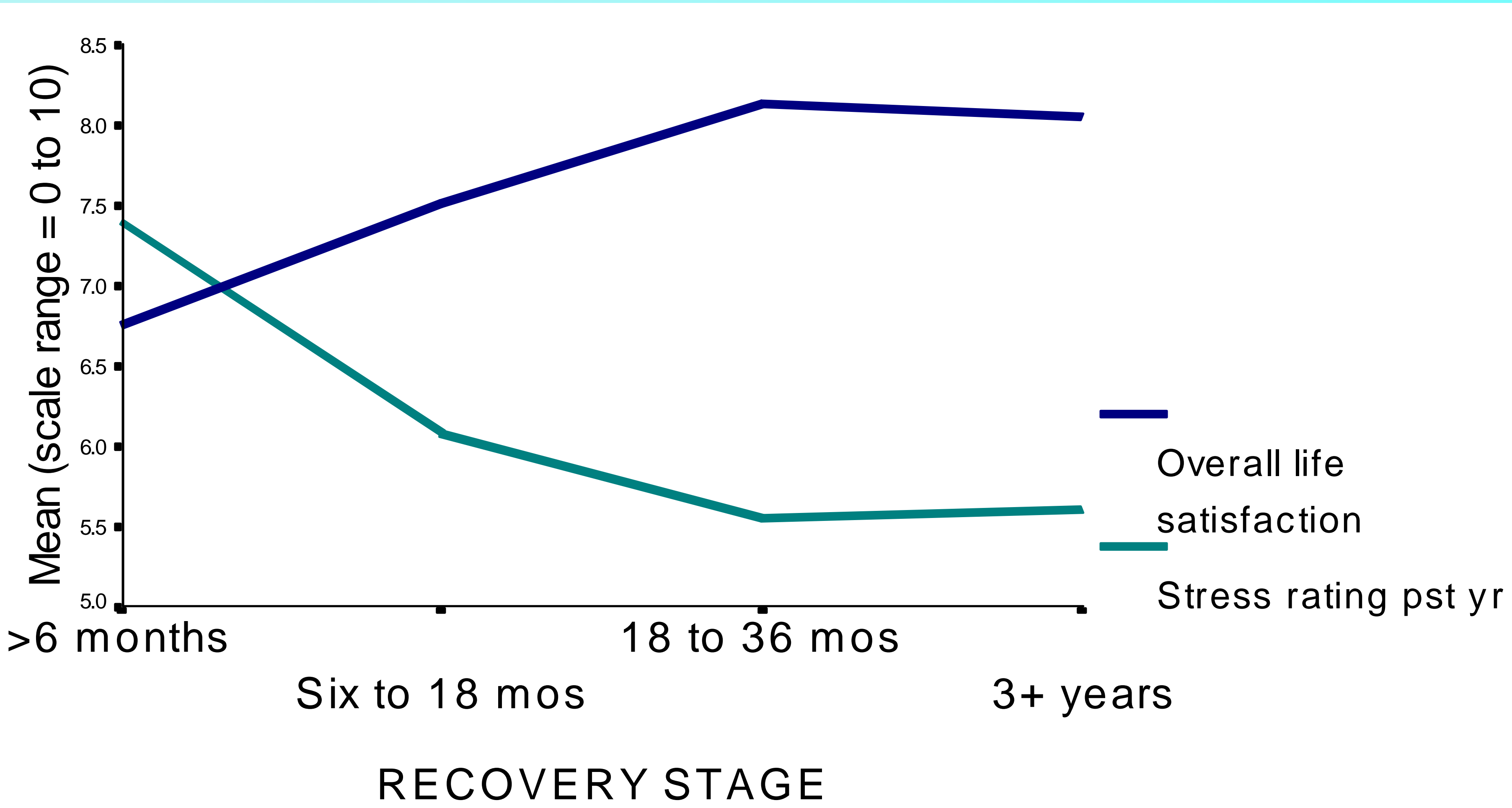
Why do we need a science of recovery?

- Medications are being developed and tested that help achieve (and maintain?) abstinence – primary symptom management.
- ARE WE CURING ADDICTION?

What is Recovery?

- **Field is only recently tackling the question**
- **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 2005 National Recovery Summit)**
- **My definition of *recovery is life*. Cause I didn't have no life before I got into recovery. (Pathways study participant H.W. 42 years old Af-Am male)**

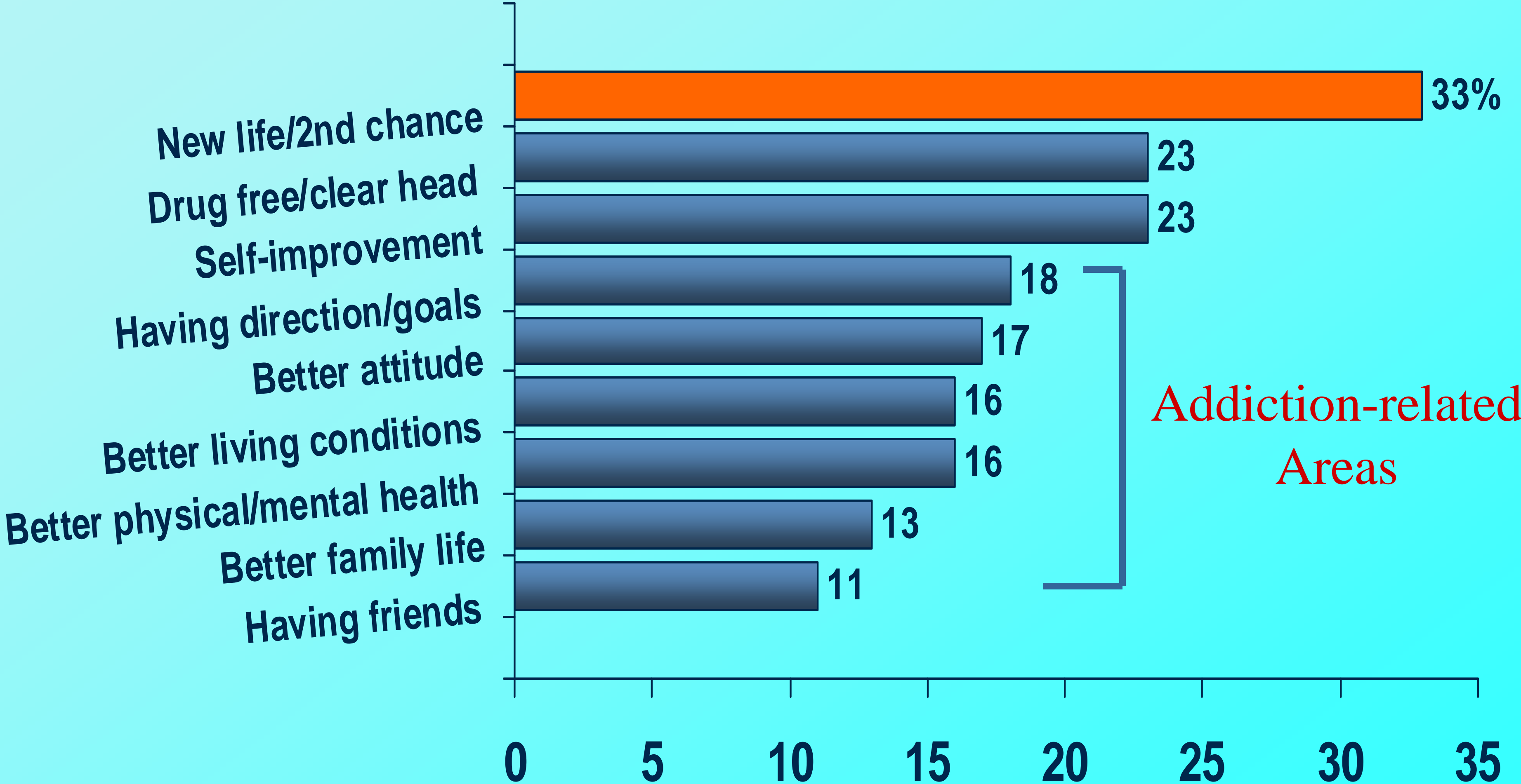
Stress and Life Satisfaction as a Function of Abstinence duration (N = 354)



Laudet et al., Alcoholism Treatment Quarterly, 24: ½, 33-74, 2006

Benefits of recovery:[a] RECOVERY = A BETTER LIFE

What, if anything, is good about being in recovery?



Add to > 100% because up to 3 answers were coded

center for Study of Addictions & Recovery

NDRI NATIONAL DEVELOPMENT AND RESEARCH INSTITUTES, INC.

ACT FOUR

WHAT DO WE NEED TO KNOW?

Recovery research agenda: Sources of input

Topics for the recovery research agenda were identified with **input from key stakeholder groups**:

- The recovery community
- Service providers nationwide representing diverse treatment modalities and therapeutic orientations, funding source, agency size, and geography; and
- The research community

What do we need to know to guide ROSC?

WHAT EXACTLY IS *RECOVERY*?

- Specifically what are the required ingredients: abstinence PLUS WHAT?
- In which life areas are improvement required for there to be ‘recovery’?
- Does that change over the *recovery career*? How so?
- How are the improvements attained and jeopardized/lost?

What do we need to know to guide ROSC?

WHAT IS *LONG-TERM* RECOVERY?

- How long is ‘long enough” that the risk of return to active use is essentially nil (is there such a point of no return?)
- What are the critical milestones of recovery?
- Does this vary by primary substance? Age? Gender? Comorbid status? Path to recovery? Level of recovery capital?

What do we need to know to guide ROSC?

HOW DOES RECOVERY START (RECOVERY INITIATION) Not just cessation of substance use but **initiating the change process**?

- What needs to click?
- What happens within the person when this 'clicking' occurs – what changes?
- How can it be facilitated?
- Does someone really need to 'hit bottom'?
- Does this process differ according to age? Gender? Ethny? Comorbid status? Recovery capital?

What do we need to know to guide ROSC?

SUPPORT AND SERVICE NEEDS

- Which services/ supports did people in recovery access
  - To initiate recovery?
  - To sustain recovery?
- Helpfulness of services/support received
- Services needed but not accessed or sought?
- Barriers to seeking/accessing recovery services/supports over the course of recovery?
- Do these barriers vary according to gender? Age? Race? SES? Geography? parenting status? Comorbidity?

What do we need to know to guide ROSC?

LONGITUDINAL RECOVERY PATTERNS

- Where (in which domains) can we expect to see improvements and when?
- What promotes and hinder transitioning from early to stable to sustained recovery?

What do we need to know to guide ROSC?

PATHWAYS TO RECOVERY

- It is often said that many people have recovered without the help of addiction treatment. HOW DID THEY RECOVER?
  - Self help groups?
  - Religion?
  - Natural recovery (self-change)?
  - Indigenous/culture specific supports (e.g., White Bison/Red Road?)
- How can we tell what is the most effective recovery path for whom and when?

What do we need to know to guide ROSC?

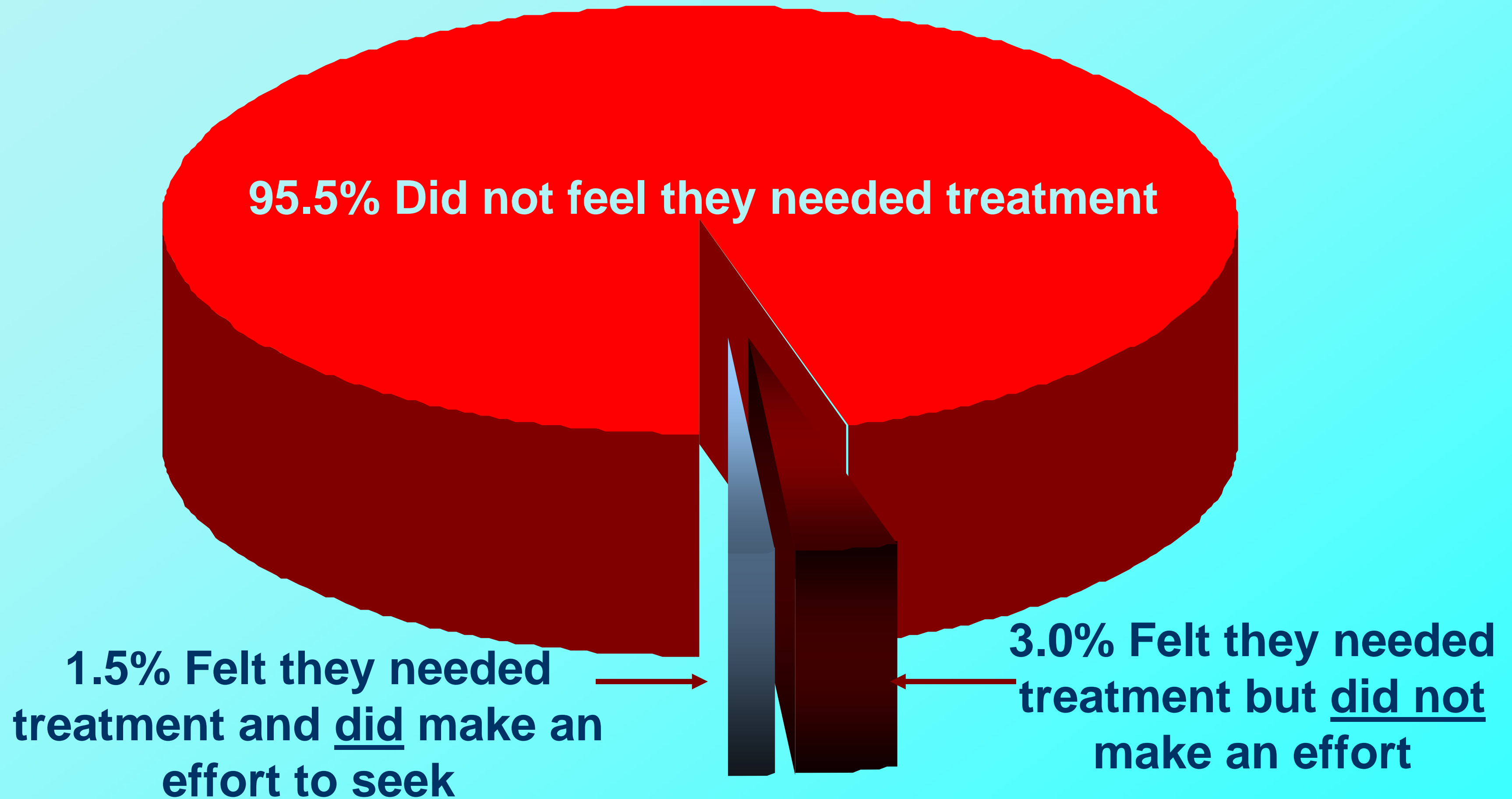
EFFECTIVENESS AND COST-EFFECTIVENESS OF VARIOUS RECOVERY PATHS and SERVICES

In terms of:

- Lives reclaimed
- Dollars saved
- Communities restored
- Crime, infectious disease, medical consequences of addiction

Treatment Gap

21.1 Million People Needing But Not Receiving Services



Source: NSDUH/SAMHSA (2006)

How do we sell recovery to the 21.1 million Americans who need but do not seek help?

- How do we disseminate the message of hope
- Ho do we increase the attractiveness of recovery services?
- We are not selling abstinence (treatment) successfully to most potential ‘customers’ - HOW DO WE SELL WELLNESS?

RECOVERY-Oriented Systems of Care

How can we promote effectively an outcome

we have barely examined or defined and poorly understand?

We need a science of recovery to inform Recovery Oriented Systems of Care

FOTOSEARCH

ACT FIVE

WHAT WILL THE SCIENCE OF RECOVERY TELL US THAT WE DO NOT ALREADY KNOW?

What will the science of recovery tell us?

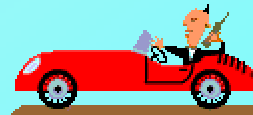
The science of recovery will COMPLEMENT the science of addiction and lead to additional and diverse effective strategies to promote healthy, satisfying, productive lives among formerly dependent persons.

What will the science of recovery do?

- Making recovery a bona fide area of science will help disseminate the message that RECOVERY IS ATTAINABLE
- That alone will help minimize the stigma and discrimination of addiction that hinder many in their recovery efforts
- Making wellness (recovery) the goal (vs. abstinence) may also increase rates of help seeking and ultimately, of recovery

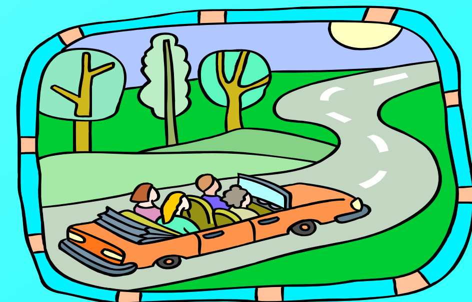
What will the science of recovery tell us?

- ***Destination: Where are we going?*** **Specifically what are we trying to promote (what is *recovery*? *long-term recovery*)?**



- ***Roadmap: How do we get there?*** **What to put in our recovery-oriented services toolbox to best serve our clients as their needs change?**

- ***Are we there yet?*** **How can we measure recovery outcomes? (for service monitoring and quality improvement, accountability)**



What will the science of recovery tell us?

- Provide a **menu of recovery options** that providers and clients can review and select from as they do strategies to address high cholesterol depending on the individuals' blood levels, medical and family history, and lifestyle.
- Provide stakeholders (clients, families, providers, service payers, policy makers) with **realistic expectations** as to what to expect at successive stages of the recovery career
- **Identify recovery milestones** where individuals may be at especially vulnerable to returning to active use

ACT SIX

HOW DO WE BUILD THE SCIENCE OF RECOVERY?

All we need *(besides funding)* is .....

- The determination to change our perspective and our systems, to conduct and use empirical evidence from studies that:

  - Make wellness (recovery) the primary outcome

  - Develop and use psychometrically sound comprehensive (concise!) measures of recovery
    - To track change over time and
    - To examine how these changes are facilitated/hindered by individual's psychosocial context and by services/supports

  - Adopt a developmental '*recovery career*' approach to elucidate the full recovery course, its patterns and determinants (LONG-TERM studies)

  - Identify and consider the multitude of pathways to recovery, and recruit accordingly (not just treatment samples)

The research questions and methods may differ but the same scientific standards must be upheld so that ***the science of recovery is as good (or better) as the science of addiction***

A recovery program for the substance abuse field: The 12-steps of Addiction Professional Anonymous

1. *We admitted we were powerless over the realities of addiction and that our revolving door system had become unmanageable.*

2. *Came to believe that our systems can be restored to sanity:* *Insanity*= Doing the same old thing and expecting different results (acute, symptom focused model of care to treat chronic condition)

3. *Made a decision to turn our service models into empirically-based systems that promote wellness and sustained recovery, not just abstinence*

4. *Made a searching and fearless moral inventory of ourselves*. Hmmm…

5. *Admitted to ourselves and to each other the exact nature of our wrongs.* NO PAIN NO GAIN!!!

6. Go to it!

We seek progress, not perfection

Let’s make it Happen!