

The Transformation of American Communities of Recovery & The Future of Adolescent Addiction Treatment

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Presentation Goals

- Review recent changes in the culture of recovery in the United States
- Discuss implications of these changes for the treatment of adolescent substance use disorders, including calls to shift addiction treatment from a model of acute intervention to a model of sustained recovery management

AOD PROBLEMS

Etiology

Pattern

Treatment

Recovery



Clinical (Addiction Careers) Versus Community Populations (Maturing Out)

1. Higher personal vulnerability (e.g., family history, lower age of onset, atypical tolerance, victimization)
2. Higher severity (acuity & chronicity)
3. Higher rates of co-morbidity
4. Greater personal and environmental obstacles to recovery
5. Lower recovery capital (personal assets / family and social supports)

A Recovery Revolution?

- Growth & Diversification of American Communities of Recovery
- Recovery Community Institution Building
- A New Recovery Advocacy Movement
- Calls to Reconnect Treatment to the Larger and More Enduring Process of Personal/Family Recovery
- Shift from Pathology and Intervention Paradigms to a Recovery Paradigm

The Ecology of Addiction Recovery

1990: *Pathways from the Culture of Addiction to the Culture of Recovery*

1. The transition from addiction to recovery is often a journey between two distinct physical and cultural worlds.
2. Long-term recovery outcomes are as contingent upon *community recovery capital* as intrapersonal, familial or treatment program factors (White & Cloud, 2008).

My Early Definition of Culture of Recovery

- Focused on Twelve Step Groups (AA and NA in particular) and fledgling alternatives
- Spoke of "recovery community" in singular
- Recommended assertive approaches to disengaging clients from C of A and linking clients to resources within the C of R
- Today, the doorway of entry into recovery is widening as are resources to enhance quality of life in recovery.

Culture of Recovery Update

1. Growth/Diversification of Recovery Mutual Aid Societies
2. Rise of Recovery Community Organizations (RCOs) & Other Recovery Community Institutions
3. The New Recovery Advocacy Movement
4. Calls for Redesign of Addiction Treatment: "Recovery Management" and "Recovery-oriented Systems of Care"

1. History of Addiction Recovery Mutual Aid

- Begins in Native America (1730s)
- More than 25 formal pre-A.A. recovery mutual aid societies
- More than 70 recovery mutual aid societies formed after founding of A.A. (1935)—65 since 1970

Modern Recovery Mutual Aid Trends

- Growth of Twelve Step Groups
- Growing varieties of Twelve Step experience
- Geographical dispersion in U.S. and internationally
- Philosophical diversification of recovery frameworks (Religious, Spiritual, Secular)
- Growth of participation of adolescents and transition-age youth

Virtual Recovery

- Explosive growth of online recovery communities
 - Women
 - Adolescents
 - Status-conscious professionals
- Internet-based recovery social networking
- Experiments in voice/text-base telephone recovery support.
- Unlimited potential for applying new technologies to recovery support

Important Resource

Mutual Aid Resources updated every 30 days at Faces & Voices of Recovery Web Site

http://www.facesandvoicesofrecovery.org/resources/support_home.php

Implications for Treatment Institutions

1. Acknowledge Multiple Pathways of Long-Term Recovery
2. Acknowledge Response Variability: Optimal, Partial, Non-response, Injury
3. Move towards Choice Philosophy
4. Science-based Linkage Procedures
5. Monitoring Individual Responses with Assertive Recovery Coaching

2. Rise of Recovery Community Organizations & Other Institutions

A recovery community organization (RCO) is an independent, non-profit organization led and governed by representatives (individuals, family members) of local communities of recovery.

The sole mission of an RCO is to mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction.

Grassroots Recovery Community Organizations (RCOs)

- Organized by and on behalf of communities of recovery
- Focus on advocacy, education and peer support services
- Establishing Recovery Support Centers, e.g., CCAR's Network of RSCs in CT
- Some contracting to do telephone-based, post-treatment recovery checkups

Recovery School Movement

- High School and Collegiate Levels
- Association of Recovery Schools (2002)
- Key Elements
 - Active recruitment of people in recovery
 - Scholarships
 - On-campus recovery support
 - Academic mentoring
- * Early Evaluations (high rates of continuous recovery & academic excellence)

Recovery Home Movement

- Halfway Houses (1950s) to Social Model Rehabilitation Programs (1970s)
- Oxford House (1975) (1,200 homes, 48 states, 24,000 residents per year)
- Broader Recovery Home Movement
- Growing interest in development of recovery home models for adolescents

Recovery Industries

- Formats range from "recovery friendly" (Zingerman's Deli, Venturetech) to "recovery exclusive" employers (Recovery at Work)
- Preparatory or Permanent Employment
- Core Elements:
 - Skill training
 - Work-based peer recovery coaching
 - Linkage to recovery communities
 - Establishment of legitimate work history

Recovery Ministries, Churches & Colonies

- "Recovery friendly churches"
- Mega-churches with a "recovery pastor"
- Lay leaders of recovery support groups
- recovery-focused worship services and workshops
- Recovery Churches, e.g., Central Park Recovery Church in St. Paul
- Faith-based recovery colonies, e.g., Dunklin Memorial Camp in Okeechobee, Florida
- National Association for Christian Recovery

Implications

1. Extend assertive linkage procedures to these new recovery community institutions
2. Develop adolescent service and support tracks within these institutions

3. New Recovery Advocacy Movement

History

2001 Recovery Summit in St. Paul, MN

Influence of CSAT's RCSP and ATR

National Organization

Faces and Voices of Recovery

NCADD

Johnson Institute

Legal Action Center

Movement Goals

- **Political/Cultural Mobilization of Communities of Recovery**
- **Recovery-focused Public & Professional Education**
- **Advocacy of Pro-recovery Laws & Social Policies**
- **Promotion of Peer-based Recovery Support Services**
- **Recovery Celebration Events**
- **Promotion of Recovery Research**

Cultural Development Between (rather than within) Communities of Recovery

- Identity Reconstruction
- Reconstruction of History
- A New Language
- Values Definition
- New Symbols
- Musical Anthems
- Artistic Expression
- Literature

Implications

1. Where will young people in recovery fit within these growing recovery cultures?
2. Representation: How do we increase adolescent/family representation in the leadership of this movement?
3. How can service professionals support youth involvement in this movement?

4. RM & ROSC Update

- 2000-2010: Growth in interest in applying principles of chronic disease management to treatment of addiction (McLellan, et al, 2000; White, Boyle & Loveland, 2002; White & McLellan, 2008)
- Rapid growth in interest in models of recovery management and federal and state interest in creating *recovery-oriented systems of care*

RM, ROSC & Stage of Long-term Recovery

- Pre-recovery identification and engagement (recovery priming)
- Recovery initiation and stabilization
- Transition to recovery maintenance
- Enhancement in quality of personal/family life in long-term recovery (recovery management across the life cycle)

The Prevailing Acute Care Model

- An encapsulated set of specialized service activities (assess, admit, treat, discharge, terminate the service relationship).
- A professional expert drives the process.
- Services transpire over a short (and ever-shorter) period of time.
- Individual/family/community is given impression at discharge ("graduation") that recovery is now self-sustainable without ongoing professional assistance (White & McLellan, 2009).

Treatment (Acute Care Model) Works!

Post-Tx remissions

Substantial decreases in AOD use

Substantial decreases in substance-related
problems

Decreased threats to public health and safety

Lives of individuals and families transformed by
addiction treatment.

Treatment Works, BUT...

AC & RM Model Review

Comparison on key dimensions of service design and performance

- AC Model Vulnerability
- How RM Models are Addressing Each Area of Vulnerability

AC Model Vulnerability: Attraction

Only 10% of those needing treatment received it in 2002 (Substance Abuse and Mental Health Services Administration, 2003); only 25% will receive such services in their lifetime (Dawson, et al, 2005).

Substantial lag between early onset of AOD use/problems and first treatment admission

Why People Who Need it Don't Seek Treatment

- Perception of the Problem, e.g., isn't that bad based on comparison to media caricatures
- Perception of Self, e.g., he/she or we should be able to handle this on his/her/our own
- Perception of Treatment, e.g., ineffective, unaffordable, inaccessible or "for losers"
- Perception of Others, e.g., fear of stigma and discrimination

Source: Cunningham, et, al, 1993; Grant 1997

Coercion vs. Choice

The majority of people who do enter treatment do so at late stages of problem severity/complexity and under external coercion (SAMHSA, 2002).

The AC model does not voluntarily attract the majority of individuals who meet diagnostic criteria for a substance use disorder.

RM Model Strategy: Attraction

- Recovery-focused anti-stigma campaigns, e.g., Recovery is Everywhere campaign, Ann Arbor, MI
- Early screening & brief intervention programs
- Assertive models of school & community outreach
- Non-stigmatized service sites, e.g., hospitals & health clinics, workplace, schools, community centers

Principle: Earlier the screening, diagnosis & Tx initiation, the better the prognosis for long-term recovery

AC Model Vulnerability: Access & Engagement

Access to treatment is compromised by
waiting lists

High waiting list dropout rates (25-50%)
(Hser, et al, 1998; Donovan et al, 2001).

Special obstacles to treatment access for
youth

Weak Engagement & Attrition

Dropout rates between the call for an appointment at an addiction treatment agency and the first treatment session range from 50-64% (Gottheil, Sterling & Weinstein, 1997).

Nationally, more than half of clients admitted to addiction treatment do not successfully complete treatment (48% "complete"; 29% leave against staff advice; 12% are administratively discharged for various infractions; 11% are transferred) (OAS/SAMHSA 2005).

RM Model Strategy:

- Assertive waiting list management
- Streamlined intake
- Lowered thresholds of engagement
- Pain-based (push force) to hope-based (pull-force) motivational strategies
- Appointment prompts & phone follow-up of missed appointments
- Institutional outreach for regular re-motivation
- Radically altered AD policies (White, et al, 2005)

Altered View of Motivation

- Pain versus Hope (White & Cloud, 2009)
- Concepts of Recovery Contagion and Recovery Carriers (White, 2010)

AC Model Vulnerability: Assessment & Tx Planning

- Categorical
- Pathology-focused, e.g., problem list to treatment plan
- Unit of assessment is the individual
- Professionally-driven
- Intake function

RM Model Strategy: Assessment & Recovery Planning

- Global rather than categorical (e.g., ASI, GAIN)
- Strengths-based (emphasis on assessment of recovery capital) (Granfield & Cloud, 1999)
- Greater emphasis on self-assessment versus professional diagnosis
- Scope of assessment includes individual, family and recovery environment
- Continual rather than intake activity
- Rapid transition from Tx plans to recovery plans (Borkman, 1998)

AC Model Vulnerability: Locus of Service Delivery

- Institution-based
- Weak understanding of physical and cultural contexts in which people are attempting to initiate recovery
- AC Model question: "How do we get the individual into treatment"--get them from their world to our world?

RM Strategy:

Locus of Service Delivery

- Home-, neighborhood- & community-based
- RM question: "How do we nest recovery in the natural environment of this individual or create an alternative recovery-conducive environment?"
- "Healing Forest" metaphor; concept of treating the community

AC Model Vulnerability: Service Dose and Duration

One of the best predictors of treatment outcome is service dose (Simpson, et al, 1999). Many of those who complete treatment receive less than the optimum dose of treatment recommended by the National Institute on Drug Abuse (NIDA, 1999; SAMHSA, 2002)

AC Model Vulnerability: Frequency of Post-discharge Relapse and Re-admission

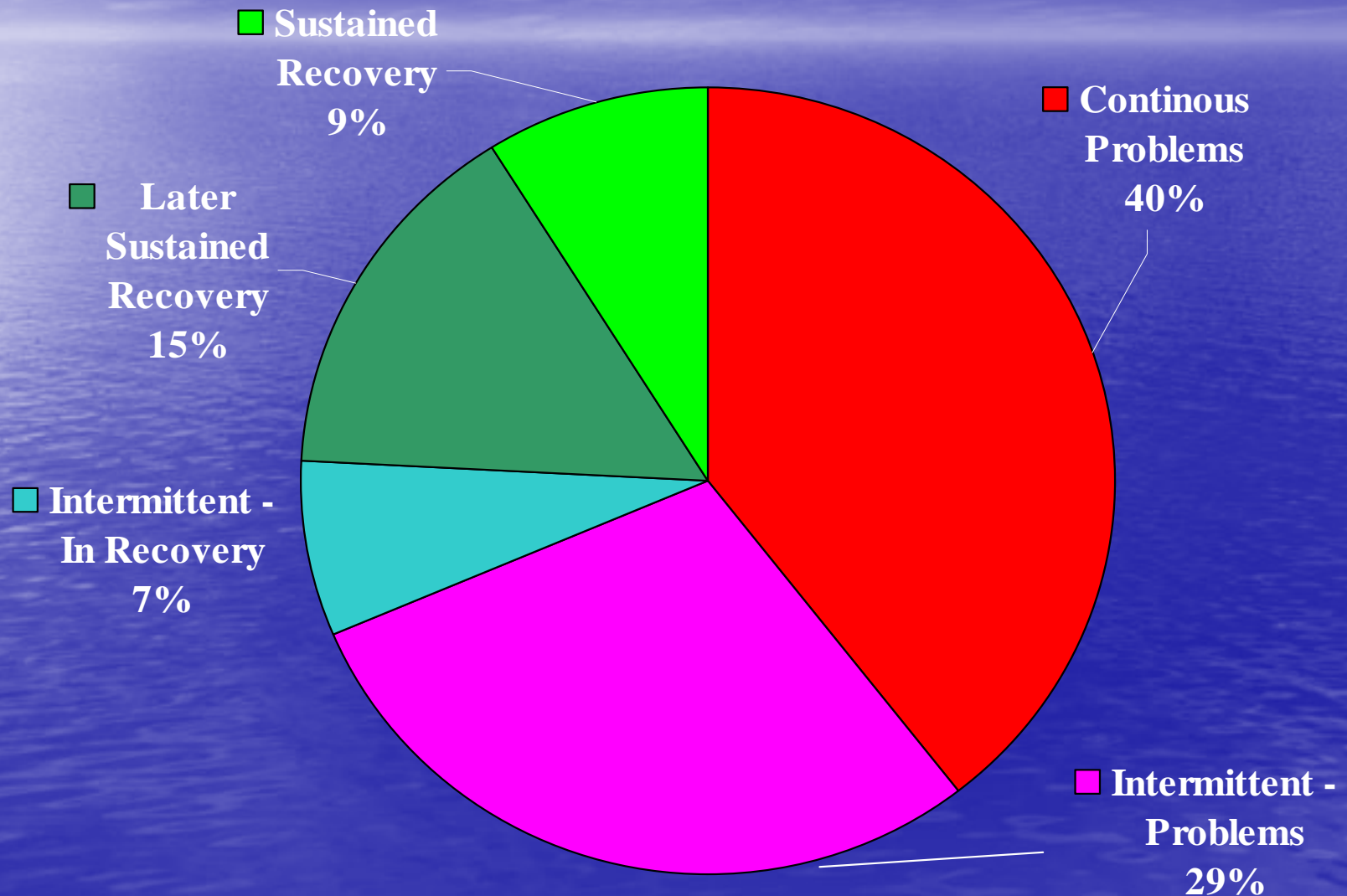
The majority of people completing addiction treatment resume AOD use in the year following treatment (Wilbourne & Miller, 2002).

Of those who consume alcohol and other drugs following discharge from addiction treatment, 80% do so within 90 days of discharge (Hubbard, Flynn, Craddock, & Fletcher, 2001).

AC Model Vulnerability: Failure to Manage Addiction/Tx/Recovery Careers

Most persons treated for substance dependence who achieve a year of stable recovery do so after multiple episodes of treatment over a span of years (Anglin, et al, 1997; Dennis, Scott, & Hristova, 2002).

Recovery/Relapse Patterns Over Twelve Months



Fragility of Early Recovery

Individuals leaving addiction treatment are fragilely balanced between recovery and re-addiction in the hours, days, weeks, months, and years following discharge (Scott, et al, 2005).

Recovery and re-addiction decisions are being made at a time that we have disengaged from their lives, but that many sources of recovery sabotage are present.

AC Model Vulnerability: Timing of Recovery Stability

Durability of alcoholism recovery (the point at which risk of future lifetime relapse drops below 15%) is not reached until 4-5 years of remission (Jin, et al, 1998).

20-25% of opioid addicts who achieve five or more years of abstinence later return to opiate use (Simpson & Marsh, 1986; Hser et al, 2001).

Fragility of Family Recovery

- "While recovery alleviates many of the family's historical problems, this early period can also be referred to as the "trauma of recovery": a time of great change, uncertainty and turmoil."
- "The unsafe, potentially out-of-control environment continues as the context for family life into the transition and early recovery stages...as long as 3-5 years."

Source: Brown & Lewis, 1999

"Aftercare" as an Afterthought

Post-discharge continuing care can enhance recovery outcomes (Johnson & Herringer, 1993; Godley, et al, 2001; Dennis, et al, 2003).

But only 1 in 5 (McKay, 2001) to 1 in 10 (OAS, SAMHSA, 2005) adult clients receive such care (McKay, 2001) and only 36% of adolescents receive any continuing care (Godley,et al, 2001)

AC Treatment as the New Revolving Door

Of those admitted to the U.S. public treatment system in 2003, 64% were re-entering treatment including 23% accessing treatment the second time, 22% for the third or fourth time, and 19% for the fifth or more time (OAS/SAMHSA, 2005).

AC Model Vulnerability: Relationship with Recovery Communities

Participation in peer-based recovery support groups (AA/NA, etc.) is associated with improved recovery outcomes (Humphreys et al, 2004).

This finding is offset by low Tx to community affiliation rates and high (35-68%) attrition in participation rates in the year following discharge (Makela, et al, 1996; Emrick, 1989)

Passive/Active Linkage

Active linkage (direct connection to mutual aid during treatment) can increase affiliation rates (Weiss, et al 2000),
But studies reveal most referrals from treatment to mutual aid are passive variety (verbal suggestion only) (Humphreys, et al 2004)

RM Model Strategy

- Staff & volunteers knowledgeable of multiple pathways/styles of long-term recovery, local recovery community resources and Online recovery support meetings and related services (White & Kurtz, 2006)
- Direct relationship with H & I committees and comparable service structures
- Recovery coaches provide assertive linkages to support groups and larger communities of recovery

AC Model: Service Relationship

Dominator-Expert Model: Recovery is based on relationships that are hierarchical, time-limited, transient and commercialized.

RM Model: Service Relationship

Partnership Model: Recovery is based on imbedding the client/family in recovery supportive relationships that are natural, reciprocal, enduring, and non-commercialized.

RM is focused on continuity of contact in a recovery supportive service relationship over time comparable to role of primary physician.

--Will require stabilization of field's workforce

Philosophy of Choice / Consultation Role

Closing Thoughts

1. ROSC and RM represent not a refinement of modern adolescent treatment, but a fundamental redesign of such treatment.
2. Overselling what the AC model can achieve to policy makers and the public risks a backlash and the revocation of addiction treatment's probationary status as a cultural institution.

Closing Thoughts

3. It will take years to transform addiction treatment from an AC model of intervention to a RM model of sustained recovery support.
4. That process will require aligning concepts, contexts (infrastructure, policies and system-wide relationships) and service practices to support long-term recovery.

Primary References

- White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, 9(4), 44-51.
- White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment*, 36, 146-58.

Primary References

- White, W. (2009). *Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation*. Chicago, IL: Great Lakes Addiction Technology Transfer Center & Philadelphia Department of Behavioral Health.
- White, Evans, Ali, et al, (2009). The recovery revolution: Will it include children and adolescents? Philadelphia: Department of Behavioral Health and Mental Retardation Services.
www.facesandvoicesofrecovery.org