

SPECIAL REPORT

A Unified Vision for the Prevention and Management of Substance Use Disorders: Building Resiliency, Wellness and Recovery — A Shift from an Acute Care to a Sustained Care Recovery Management Model

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INSTITUTE FOR RESEARCH, EDUCATION AND TRAINING IN ADDICTIONS

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MANAGEMENT OF SUBSTANCE USE DISORDERS:**

**Building Resiliency, Wellness and Recovery —
A Shift from an Acute Care to a Sustained Care
Recovery Management Model**

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and Training in Addictions (IRETA)**

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Institute for Research, Education
and Training in Addictions

In Memoriam

Herman Diesenhaus, Ph.D.

May 16, 2006

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BUILDING RESILIENCE, WELLNESS AND RECOVERY

A Shift from an Acute Care to a Sustained Care Recovery Management Model

1. Vision:

In a seminal report on the practice of medicine, especially as it relates to the management of chronic illnesses, the Institute of Medicine (2001) stated that the “American health care delivery system is in need of fundamental change.” Too often, patients do not receive care that “meets their needs and is based on the best scientific knowledge.” Further, in a survey of health care systems in five industrialized nations, adults in the US were “least satisfied with their health care system” (Commonwealth Fund, 2002).

In 2004, IRETA began facilitating a leadership group¹ to capitalize on the atmosphere created by the IOM report, study its assertion for the field of substance use treatment and seek to develop a common vision for the prevention and treatment of substance use disorders. Initially, the group explored the question: “Is substance dependence² an acute or chronic condition?” They concluded, based upon the definition of a chronic illness (see Wagner, 1998), that substance dependence most often becomes a chronic illness and that the vision for a model should comprehensively address substance use disorders effectively, accountably and in a manner similar to other chronic illnesses like depression, hepatitis C, HIV/AIDS and asthma (Institute of Medicine [IOM], 1990 and 2006a; McLellan, Lewis, O’Brien, & Kleber, 2000; RAND, 2001; Rawson, Crevecoeur, & Finnerty, et al., 2003; White, Boyle, & Loveland, 2002; Willenbring, 2001; Willenbring, 2005).

1 See Acknowledgments page 1.

2 In this paper the phrase substance dependence is being used as synonymous to substance use disorder/dependence or the more colloquial term “addiction.” Addiction or substance use disorder/dependence (hereafter referred to as substance dependence) is then the later and more severe stage of substance use disorders or problematic use. Substance dependence is further defined as described in the American Psychiatric Association (1994) Diagnostic Criteria from DSM-IV.

This is not to say that all individuals diagnosed with substance dependence will develop a chronic condition. Just like a small percentage of individuals who are diagnosed with diabetes may return to normal and stable glucose levels (Pozzilli et al., 2005; Scholin, Berne, Schvarcz, Karlsson, Bjork, 1999), a small (but varying) rate of individuals with a diagnosis of a substance use disorder (SUD), may return to asymptomatic use (Dawson, Grant, Stinson, Chou, Huang and Ruan, 2005; Vaillant and Hiller-Sturmhofel, 1996). However, one can argue that the factors that are associated with stable remission in an individual who has been diagnosed with a disease (SUD, hypertension, asthma, diabetes, etc.) typically requiring continuing care are the severity of the individual's disease and the individual's vulnerability profile (McLellan et al., 2000). Moreover, there is no consensus as of yet built from scientific inquiry regarding what types of clinical and vulnerability profiles predict with reasonable certainty (and safety) which individuals with a diagnosis of SUD may return to safe levels of drinking (Vaillant, 2003; Vaillant and Hiller-Sturmhofel, 1996). The group also believed that the vision they were developing must integrate proven strategies that prevent (see Glasgow, Orleans & Wagner, et al., 2001) the development of new (incident) cases, reduce the harm caused by continued use, and prevent the recurrence of illness (i.e., movement back to earlier stages of recovery) once recovery has commenced or has been established. Finally, they believed that, in so far as possible, their vision should bridge the most valid evidence derived from science, practice and the recovery experience by both strengthening the existing links and creating new links between recovery supports and treatment where possible.

The group also found recent encouragement for its work in the 2006 update of the IOM Quality Chasm Series (IOM, 2006a). In the report, the IOM discusses treating substance use disorders within a chronic care model (IOM, 2006a, pp. 51-65). The report defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (IOM, 2006b). The IOM report, similar to this paper, recommends that substance use disorder treatment move toward building its standards of care, performance measurement and quality, information and cost measures upon a chronic illness model rather than the current, acute illness-based, fragmented and deficient system of health care (see also McLellan, McKay, Forman, Cacciola, Kemp, 2005).

This paper reports on the process and results of building a common vision for substance use disorder care and offers a model which can form the basis for this new system of care.

2. Chronic or Acute — Building the Underlying Principles:

If substance dependence is indeed a chronic illness (McLellan, Lewis, O'Brien, 2000; McLellan et al., 2005; White, et al., 2002) the system of care, including treatment and funding mechanisms (Horgan, Reif, Ritter, Lee, 2001), must reflect the best methods and practices existent and proven to effectively achieve chronic illness recovery. During the consensus process, the contributors quickly identified that most health benefit plans and payment methodologies in America treat substance dependence as an acute illness (e.g., similar to pneumonia or the common cold) with limits on benefits (e.g., two treatment episodes of care in a lifetime) and treatment episodes, even if more treatment is medically necessary (ASAM, 2005; Kurth, 2003). The group also realized the negative effect of stigma associated with substance use disorders that prevent individuals from gaining proper and timely treatment resulting in increasing clinical severity that often leads to incarceration and even death.

In short, America may be treating a major health problem — substance dependence — with a treatment approach not appropriate to the nature of the illness. As a result, some would suggest, the public can become sceptical of the effectiveness of treatment, using statistics on relapse and recidivism as proof of failure rather than treatment success. The skeptics ignore the fact that when the system uses the wrong medical approach (i.e., an acute care approach) to treat a chronic illness it can lead to the wrong “dose” of care and outcomes that can hardly be better than if a system treated all cancer with one dose of radiation. O'Brien and McLellan (1996) support this by demonstrating that when treated as a chronic illness, the compliance and relapse rates of substance dependence are as good as or better than other chronic illnesses, e.g., diabetes, hypertension and asthma. Moreover, as pointed out by Dr. Ed Wagner during the consensus process, substance use disorder — if defined as a chronic illness — actually expands the understanding of how to approach other

chronic illnesses given its strong self-care or peer-supported programs that are only beginning to be applied in the management of other chronic illnesses (Coleman & Newton, 2005; Von Korff, Gruman, Schaefer, Curry & Wagner, 1997).

The implications of this shift are nothing less than profound for research, funding, prevention, intervention, treatment, recovery support, health policy, and health education. In addition, the shift to chronic illness care for substance dependence can help change attitudes of people who may still want to believe that substance dependence is self-induced by the individual's will or moral failing and, therefore, it should be the individual's problem alone to solve. The ultimate results of this belief are the billions of dollars America spends each year to treat substance dependence and its attendant social sequelae and the fact that "one out of four Americans report a history of tobacco dependence, and one out of seven have experienced alcohol dependency..." (Marlatt, 1997).

At this point, before attempting to build a common vision and model, the group asked: What would the principles of care look like if substance dependence was viewed as a chronic illness? The group developed the following as principles upon which substance use disorders can be addressed similarly to a chronic illness:³

- a. Care must be evidence-based and jointly planned (i.e., client-centered), incorporate proven guidelines and experience in a manner that best supports a continuous healing relationship and lead to improved wellness and the opportunity for maintenance of recovery.
- b. Care must be specific to the needs of individuals who require more time, offering a broad array of resources over a continuum of care and close follow-up by multi-disciplinary teams and others involved. The individual must maintain some sense of responsibility and control in all activities and the care-provider must respect the needs and values of the individual.

³ Principles a. – e. were adapted by M. Flaherty from the work of E. Wagner (2001). "The Chronic Care Model identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems" (*Improving Chronic Illness Care*).

- c. Care must provide coordinated, continuous “systemic”⁴ attention to the individual’s needs for information and behavioral change (e.g., counseling, education and information feedback) (McLellan et al., 2005); and care must be preventative⁵ while therapeutic and comprehensive (i.e., best practice and within a continuum of care) but avoid waste (i.e., be efficient and timely).
- d. Care must provide ready access to necessary clinical expertise (e.g., expert referral, patient and family education that is coordinated by all treatment professionals and a comprehensive support system that anticipates the need for future care).
- e. Care must have the necessary, “real-time” supportive information systems (e.g., patient reminders on “preventive” and “follow-up” care and suggestions on compliance or adherence to prevention and treatment) (McLellan et al., 2005).
- f. Care will recognize that effective self-care, prevention, intervention and recovery support and management strategies are complimentary and necessary. Together these strategies can prevent the development of incident cases (new cases) of substance use disorders, decrease the effects of chemical use which meet the clinical criteria as an illness that can cause health and social problems and prevent the recurrence of illness or the movement to earlier phases of recovery once recovery has commenced or has been established. Wherever the entry point occurs, the *continuity of care* must be prioritized and supported. Guidelines for this care must also be re-framed in non-discriminatory ways that reflect the idea of substance dependence as an illness and the goal of achieving wellness within this context.
- g. Care, based on the adoption of any proposed common vision, will require the carefully planned and executed involvement of leaders that cross the numerous social, medical, educational, political and economic terrains associated with the prevention and management of substance dependence. Care providers must recognize that the

4 *Systemic includes all agencies and systems which work on prevention, intervention, treatment of and recovery from SUDs.*

5 *Preventative care refers to care which is intended to both prevent the advancement of the illness and prevent occurrence of other related conditions*

systems addressed are *complex* and *adaptive* (Anglin, in press; Anglin, Kavanagh, & Giesbrecht, 2001; Holder, 1998; Spear, 2005; Zimmerman, 1999; Zimmerman, Lindberg, & Plesk, 1998). Thus, no one application will change these systems — however well applied or intentioned. Moreover, the literature clearly establishes that evidence alone, however compelling, will not change attitudes, behaviors (Addiction Technology Transfer Center [ATTC], 2002; Bradley et al., 2004, et al.) or even systems of care. Knowledge adoption, skill development, organizational change, financing methodologies, performance measurement, and strong leadership must all be part of any applied, successful ideological change. In addition, stigma itself must not create a barrier to clients receiving needed care or system change.

- h. Care is supported by the principles of recovery (e.g., Abt Associates Inc., 2005) as well as the principles of prevention (National Institute on Drug Abuse [NIDA] 2003) and the current SAMHSA/CSAP Strategic Prevention Framework (SAMHSA/CSAP, 2006), intervention (Center for Substance Abuse Treatment [CSAT], 2000), treatment (NIDA, 2000) and derived policies (e.g., Allem, 2004; Finney & Moos, 1998; Gerstein and Harwood, 1990; National Association of State Alcohol and Drug Abuse Directors [NASADAD], 2002; Physicians and Leaders for National Drug Policy [PLNDP], 2002; Weisner, 1992; White, 1996; et al.) in a *unified vision* that can assist individuals, the family and the community in a culturally relevant, appropriate manner. This vision should be as inclusive as possible and involve the most effective evidence science, practice and experience can provide to offer the best possibility for individual wellness and recovery. Financial mechanisms must support this possibility while remaining open to emergent ideas and challenges (e.g., Martin, 2005; Schaffer, 2004).

In the end, these principles would equate to one: the individual (family and community) receiving the right prevention, intervention and/or treatment and support, at the right level, for the right period of time by the right practitioner, agency or sponsor, every time. No more, no less. In this principle will be the assurance of *quality, efficiency and accountability to all stakeholders* and the assurance that *every individual has the best opportunity to achieve wellness and recovery*. All measures of success/failure, performance and outcome must stem from this principle.

3. The Foundation:

PURPOSE:

The model is an evolving and working draft commented on by leaders associated with all aspects of prevention, intervention, treatment of and recovery from substance use disorders. These leaders span many disciplines and perspectives inclusive of the 10 P's necessary for field evolution (Flaherty, 2003): **p**olicy development, **p**atient/family, **p**ractitioners, **p**roviders, **p**astors, **p**ress, **p**olice, **p**rofessors/research, **p**urchasers (commercial and government), and **p**ayers (commercial, public, philanthropic). The model represents an *integration* of current systems and commonly used strategies that address, often separately, substance use. This model is intended to demonstrate how, in current parlance, our view of existing systems and strategies will need to change in order to provide continuing care as defined by Wagner (1998, 2001) and others (IOM, 1990, 1998, 2001, 2006a; Substance Abuse Mental Health Services Administration [SAMHSA], 2000).

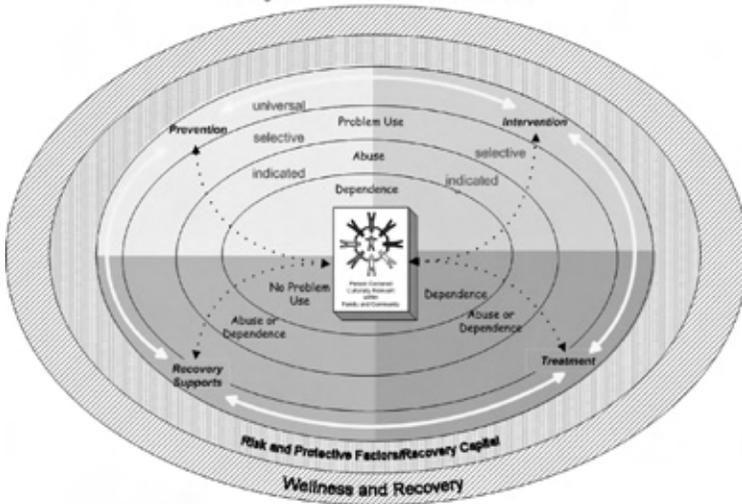
The overall focus of the model is to prevent and/or manage substance use disorders while focusing on individual recovery within a client's family and community in a culturally relevant manner with the fullest recovery support possible. This model also seeks to provide a *foundation* upon which the applications and lessons from this leadership group can be practically applied both today and in future systems in such areas as research, funding, health policy, cost-benefit analysis, et al. The changes that are suggested by this model and that will be suggested in future iterations are expected to inform the development of systems and strategies that can best meet the goal of preventing and managing substance use disorders — arguably America's number one health problem (Robert Wood Johnson Foundation, 2001) — while sustaining wellness and recovery. This model also attempts to bridge all other existing models, illuminating a *unified vision* from which we all might work and build.

Within a model based on building resiliency, wellness and recovery is the belief that all treatment is *personcentered* or driven by individual needs as assessed by a trained and competent practitioner. These individual needs will vary but must always be understood in a *culturally relevant* manner and viewed as factors that can maximize the opportunity for understand-

ing, acceptance and active participation of the individual (and family) in his or her wellness and recovery plan. In treating substance dependence, a continuum of care approach emphasizes the increasing but continuous participation of the individual in her or his care from treatment inception through wellness and recovery. Care, whether prevention, intervention, treatment or recovery support, is provided within a continuum understanding, at an appropriate level that anticipates related conditions and can prevent potential increases in severity. Care that is provided in such a way also will have an immediate and valuable impact on total community wellness. In short, both the family and the community play key roles in recovery and wellness and must be considered in all aspects of care, both as supports and/or barriers to wellness and recovery.

3.1 The Model (Pictorial)

Building Resiliency, Wellness and Recovery – A Model for the Prevention and Management of Substance Use Disorders



3.2 Definitions of Terms Used in the Recovery and Wellness-Based Model for the Prevention and Management of Substance Use Disorders

3.2.1 Prevention:

Prevention herein includes any service designed to reduce the probability of developing and exacerbating substance use and/or mental health problems (American Society of Addiction Medicine [ASAM], 2001). Prevention programs, within complex and adaptive systems understanding, should create communities in which people have a quality life including healthy environments at work and in school; supportive communities and neighborhoods; connection to families and friends and an environment which is free of alcohol, tobacco and other drugs (ATOD) and crime free (SAMHSA/CSAP, 2006). Referred to as SAMHSA's *Strategic Prevention Framework*, the mission of these initiatives is to build a community systems paradigm or model that represents a break from the narrowly defined individualistic and deterministic prevention strategies of the past decade (see NIDA, 1997). As Holder (1998, preface) described,

An individual's decision to use alcohol and the frequency, quantity, and situation of such use are the result of a combination of biological and social factors. Drinking is not only a personal choice, but also a matter of custom and social behavior, and is influenced by access and economic factors, including levels of disposable income and cost of alcoholic beverages.

Prior to the Strategic Prevention Framework, prevention was defined as an intervention in which specific groups, families or individuals were targeted (e.g., selected or indicated). The goal of this approach to prevention programming was to build individual protective factors while reducing *risk* factors (NIDA, 1997, 2003). Factors associated with greater potential for drug use are called risk factors, while those associated with reduced potential for use are called protective factors.⁶

⁶ A complete set of science-based risk and protective factors appropriate for individuals, schools and communities is available from NIDA (1997, 2003).

Prevention is normally delivered through one of three strategies:

UNIVERSAL: Targets a population that has not been identified on the basis of individual risk.

SELECTIVE: Targets individuals or a subgroup of the population whose risk of developing clinical problems is significantly higher than average.

INDICATED: Targets individuals with minimal but detectable signs or symptoms foreshadowing mental health or substance use disorders.

Within the Strategic Prevention Framework community prevention systems must (CSAP, 2006):

- a. bring the power of individual citizens and institutions together.
- b. create a comprehensive plan that everyone has a stake in and owns.
- c. foster continued systems approaches as the community experiences the outcome of its investments.
- d. hold community institutions responsible.

Further, prevention must be measured (CSAP, 2006):

- e. by consumption amount, consequences associated with consumption and success in preventing the problems associated with use.
- f. across the lifespan (not just with youth).
- g. based on evidenced-based research and empirical data.
- h. as outcomes at the population level (not just program level).

Practitioners can greatly enhance prevention to address any and all factors that may lead to the use and/or the lessening of wellness and/or the loss of sustained recovery by adapting current substance use prevention strategies to a Recovery and Wellness Model (grounded in a Chronic Care Model) in which the focus is on building resiliency. *Resiliency* is the strength individuals and communities attain by reducing risk factors and increasing protective factors (Hogan, Gabrielsen, Luna, & Grothaus, 2003). This enhanced prevention role, based on a community systems

perspective, differs from the risk and protective model in several critical ways (Holder, 1998):

1. Rather than addressing a single problem behavior or condition, it simultaneously considers a potential wide-ranging set of ATOD-involved problems.
2. Rather than focusing on individuals at risk, it studies the entire community.
3. Rather than basing prevention strategies on single assumptions about deterministic behavior, it employs interventions that alter the social, cultural, economic and physical environment in such a way as to promote shifts away from conditions that favor the occurrence of ATOD-involved problems.

While the building of resiliency and the identification of risk and protective factors remain critical in a continuing care vision of substance dependence, the broader connection and more complex understanding of the community is a vital addition to any model which addresses substance dependence within the everyday world. With this broader view, prevention can occur at any level of the continuum (i.e., prevention, intervention, treatment or recovery support) and includes a focus on both recovery and other potential health risks (e.g., formal screening for depression or related medical illnesses in recovering persons), enhanced self-care (e.g., managing a diet or staying away from triggers), or adding recovery supports (e.g., having a sponsor or mentor; maintaining a safe, stable, recovery-conducive living environment, using support of Community Treatment Teams, et al. — recovery capital — see section 3.2.4 below). Prevention, applied in this way, also accesses the “subsystems” (Holder, 1998) existent in the communities that support it. These two approaches are then integrated by the following guiding principles (SAMHSA/CSAP, 2006):

1. Prevention is an ordered set of steps along a continuum to promote individual, family and community health, prevent mental and behavioral disorders, support resilience and recovery, and prevent relapse.
2. Prevention is prevention is prevention. The components of effective prevention for the individual, family or community within the public health model are the same — whether focusing on cancer, cardiovascular disease, diabetes, substance use or mental illness.

3. Common risk and protective factors exist for many substance use and mental health problems. Good prevention focuses on the common risk factors that can be altered.
4. Resilience is built by developing assets in individuals, families and communities through evidence-based health promotions and prevention strategies.
5. Systems of prevention services work better than service silos.

3.2.2 Intervention:

Intervention includes substance use-related screening, identification, brief intervention, brief treatment, and referral to specialized treatment. It is implemented in a system, both at the community level and within specialist settings, which seeks to identify individuals with substance use-related problems (CSAT, 2003) at an early stage of problem development. Depending on the level of problem(s) identified, the system either indicates the care provider should conduct a brief intervention within the generalist (non-drug and alcohol) setting, or the care provider should refer the individual to brief or long-term specialized treatment. This might include training in self-management and involvement in mutual help groups, as appropriate (Workgroup on Substance Abuse Self-Help Organizations, 2003).

Within a wellness and recovery model, intervention also plays a critical role by offering health care professionals the opportunity to assess individuals earlier and intervene sooner when an individual exhibits signs of harmful use, thereby offering the patient an opportunity for treatment (and prevention) and connection to recovery supports at a less medically severe time (e.g., SAMHSA/CSAT, 1999; Morse, Gehshan, & Hutchins, 1997; SAMHSA/CSAT, 1997; SAMHSA/CSAT, 2002, et al.).

Harmful use implies alcohol or drug use that causes either physical or mental damage in the absence of dependence (Babor & Higgins-Biddle, 2000, 2001; Babor, Higgins-Biddle, Saunders, & Monteiro, 2001; Kelso, 2002; Watkins, Pincus, Tanielian, Lloyd, 2003; World Health Organization [WHO], 2001). Care at an earlier stage can prevent even greater medical and societal costs (e.g., incarceration, crime, emergency health costs, et al.).

3.2.3 Treatment:

Treatment, in general, is defined as any therapeutic service designed to reduce the length of time a disorder exists, halt its progression of severity or, if not possible, increase the length of time between acute episodes. For the substance use profession, ASAM (2001) defines treatment as any planned, intentional intervention in the health, behavior, personal and/or family life of an individual suffering from drug dependence. The treatment is designed to enable the affected individual to achieve and maintain sobriety, physical and emotional health and maximum functional ability. Treatment — in both definitions — is based on the assessment of existing “pathology” with the goal of clinically curing that pathology. Wellness, in comparison, is the measure of attained progress in treatment and, often, outside of treatment.

There are two categories of treatment interventions: (1) case finding and (2) standard treatment for known disorders which, in a chronic care model, includes interventions to reduce the likelihood of other and possible future disorders. Standard treatment is generally provided to individuals with a medical severity of illness which meets well described and defined diagnoses as found in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (American Psychiatric Association [APA], 2000) or the *International Classification of Mental and Behavioral Disorders: Diagnostic Criteria for Research* (ICD-10) (WHO, 1992). Once a care-provider makes a diagnosis, he or she can provide or refer a client for the appropriate level of care based on the clinical indicators and the severity of the client’s illness (e.g., ASAM, 2001; Addiction Severity Index (ASI), University of Pennsylvania/Veterans Administration Center for Studies of Addictions, 1990; VHA/DoD Clinical Practice Guidelines, Management of Substance Use Disorders Working Group, 2001; Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-Ar), Sullivan et al., 1989). During treatment, the client should be continuously monitored for clinical progress and evaluated for transfer to clinically appropriate levels of care which are either more or less restrictive (McLellan et al., 2005).

In the Resiliency, Wellness, and Recovery Model, providers would treat clients based on the medical severity of the client’s illness in the context of an individualized “treatment continuum” with the goal of providing the right treatment (level) to assist a client to reach recovery. A practitioner further ensures *continuity of care* for the client by providing treatment

which brings each level of care, i.e., inpatient, intensive outpatient, outpatient, recovery supports, et al., together. The management of care through the continuum is termed *care management*. Care management involves the use of specific clinical awareness, knowledge, skills and techniques that are evidence based to strengthen client motivation and continued involvement in care (e.g., McLellan et al., 2005; Prochaska, DiClemente & Norcross, 1992). In the proposed model, an “episode” of care would begin at intake and follow through a continuum of care that could lead to documented wellness and, eventually, recovery. Monitoring established performance indicators at each level, i.e., *performance measurement*, particularly when inclusive of recovery-oriented measures (e.g., Daley, Salloum, & Thase, 2003) and/or client-directed outcome measures (McLellan et al., 2005; Miller, Mee-Lee, Plum, & Hubble, in press; White & Kurtz, 2005, in press), can strengthen and document individual recovery and treatment as well as systemic success. In this emerging science, performance at each level is optimally measured in real-time for person, agency or system improvement. Performance is based on provision of treatment for each individual and each population served in a manner that provides continuous wellness measures and clinical quality improvement analyses while building accountability and sustainable and predictable *outcomes*, e.g., wellness and treatment progress and recovery. Clinical performance is often guided by one of several accepted Clinical Practice Guidelines (e.g., APA, 1995; ASAM, 2001; Magellan Health Services, 2004; SAMHSA/CSAT, 1993; et al.)

Medication, including some maintenance therapies, can be an essential component of treatment, particularly for clients with the most medically severe or co-morbid conditions. Recovery now may be defined as abstinencebased, moderation (use at a sub-clinical level) based or medication-supported (White & Kurtz, 2005). Recovery supports (see below), while not intended to replace treatment, can often surround or support formal treatment and ongoing efforts at wellness and recovery before, during and after formal treatment (White & Kurtz, in press).

Today’s prevailing acute, pathology-based model stands in contrast to a wellness and recovery model. With the acute care model, the client is managed at each level for severity of illness, cost and length of stay — in relation to the healthcare benefit plan available — and the “units” of care provided therein. Currently, managing cost and payment can become a

higher priority than the treatment continuum and client wellness — recovery (CSAT, 2003; Horgan et al., 2001). The acute model also fails to adequately incorporate the strong literature supporting intergenerational, biological and developmental vulnerabilities that may predispose a person or cultural group to substance dependence (Gale, 1991; National Institute on Alcoholism and Abuse, 2002; Robert Wood Johnson Foundation, 2001). The chronic illness framework and the Resiliency, Wellness, and Recovery Model, unlike the acute care model, incorporates an understanding of substance dependence as a condition influenced by environmental and genetic factors (e.g., Cloninger, 1987; Erickson, 1990; Cadoret, 1995; Tarter & Vanyukov, 1997, et al.).

In the proposed model, *use* is defined as low or infrequent doses; *abuse* is defined as higher doses and/or frequencies with sporadically heavy or intensive use — the effects of which are unpredictable and sometimes severe; and *dependence* is defined as the use of substances at high doses, frequently with compulsion, craving and withdrawal (SAMHSA/CSAT, 1999). Severe biopsychosocial consequences are almost always associated with dependence.

3.2.4 Recovery Supports:

A client's efforts to attain wellness and recovery are often enhanced by a range of supports. While not part of formal medical practice, recovery supports play an important role in substance dependence care. Formal recovery supports can include the support of a sponsor or mentor to help an individual navigate the treatment system or sustain early recovery. Informal recovery supports may involve a structured recovery environment or living with others in recovery. Recovery supports also have a "severity" or "case finding" role, as often very sick or chronically relapsing individuals find their way to these less formal, more accessible, resources as a way of seeking help and achieving ongoing, long term support. Recovery supports are, at the same time, both the oldest and newest asset to the Model. Their history parallels that of recovery itself (White, 1998). Still, as a component of a continuum of care, they are new, and even at times, cautious partners in the developing continuum model.

Within Recovery Supports is an emerging field where evidence-based treatment and recovery support services combine to form the foundation for *recovery management*.

Behavioral Health Recovery Management (White, Boyle, & Loveland, 2004) is the time-sustained, recovery-focused collaboration between service consumers and service providers, both traditional and non-traditional. All care providers share the goal of stabilizing and then actively managing the ebb and flow of severe behavioral health disorders until full remission and recovery has been achieved, until a patient can effectively self-manage his/her illness or until the illness can be effectively managed by the individual together with his or her family.

Recovery Management (RM) is defined as a system of support for professionally-directed treatment (which, in turn, should support RM) which adds emphasis to the experiences, needs and aspirations of the individual and/or families experiencing the disorder. Cost reductions, benefit management and general treatment considerations are desirable and anticipated in RM but are not the specific focus as with Disease Management (DM). Within RM, there are three phases: (1) engagement and recovery priming; (2) recovery initiation and stabilization; and (3) recovery maintenance. De Leon (1996) pioneered an earlier ten-stage recovery paradigm that care providers incorporated into traditional treatment. In DeLeon's model, recovery management was viewed as a support to treatment and vice versa. Many states are building on models such as De Leon's and developing recovery-oriented measures to strengthen the continuity of care and the likelihood of individual recovery.

Recovery is defined as overcoming both physical and psychological dependence to a psychoactive substance while making a commitment to sobriety (ASAM, 2001). Critical to the definition is the effort to link the attempt at recovery with sobriety or non-use of illicit mind- or mood-altering substances. If substance dependence is defined as a chronic illness, recovery also means avoiding the contaminant that causes or exacerbates the illness (i.e., triggers). In short, in a wellness and recovery model, recovery becomes as much a "process" as an end. As with other chronic illnesses, the absence of illness in an active phase does not mean it has forever gone away or that the individual can abandon self-care. Within this model, recovery status may be defined as abstinence-based, moderation-based (i.e., the sustained deceleration of

use to a sub-clinical and abstinence level) or medication-supported (i.e., medically monitored pharmacological support leading to recovery) (White, Kurtz, Sanders, 2006).

Wellness is defined as the movement of a client toward his or her maximum physical or mental health and recovery. Wellness may include medication and should include all aspects of physical and mental health — particularly those that might be risk factors for relapse that, if addressed, could reduce or prevent further illness. The total intrapersonal, interpersonal and community resources that are available to help initiate and sustain recovery from severe substance use disorders are termed *recovery capital* (Granfield and Cloud, 1999). In a continuum of care, recovery supports become critical to sustain the societal and individual investment toward wellness and recovery demonstrated by enhanced participation in evidence-based prevention, intervention and treatment, recovery support and self-help. In this sense, the fields of substance dependence and recovery supports actually have much to offer one another in appropriately addressing substance dependence as a chronic illness. Additionally, the existent peer and recovery supports established to parallel substance dependence treatment offer much as a model to all chronic illnesses and the chronic illness model in general.

With recovery supports as a component of a wellness and recovery-based model, a whole new picture emerges of the necessary ingredients for wellness and recovery. From this common vision, all elements of the battle against substance use disorders, including the role of criminal justice, can be brought together to halt substance dependence and bring about the best opportunity for sustainable wellness and recovery.

Conclusion

Today in America there is an emerging paradigm shift that promises a model which unifies the different levels of substance dependence care and encourages treatment in which providers are responsible for best practice and patient wellness and progress toward recovery. The model also can measure and analyze patient progress and provider performance and leads to the most accountable and efficient use of all resources.

The work of this group was to “envision” a model that could bring together all of the experiential and scientific capital available with the strength of peer and individual recovery supports to achieve the following: a model which can guide the provision of the right care, by the right practitioner, for the right period and amount of time while preventing drug use and/or further illness and presenting the greatest opportunity for wellness and recovery. Use of the Resiliency, Wellness, and Recovery Model, as designed, allows providers to offer such care by preventing, identifying and treating substance use disorders while enhancing performance and outcome through the linkage with recovery models to build resilience, wellness and recovery.

Moving away from an acute illness model of care, for both treatment and payment, toward a chronic care model, substance dependence care begins to shift toward a system which includes the measurement of the system, agency and provider with a focus on communities and families reaching preventive benchmarks that can enhance individual wellness and, ultimately, individual recovery. The care system derives this approach from the perspective that in its most severe form, substance dependence is a chronic illness and requires application of appropriate interventions based on the level of severity of illness to prevent its progression.

If this shift succeeds, it will move substance dependence care from a pathology-based to a pathology and recovery-based understanding of substance dependence. The shift will create an enormous challenge, opportunity and need to re-examine policy, research, performance, cost and cost-benefit, payment methodologies, prevention, intervention and treatment. It also will allow for a more unified approach to assisting the individual with his or her recovery, identifying any barriers to that recovery while documenting each step of attained wellness for all stakeholders. The individual and his or her progress becomes the most critical measure — not the health benefit or short-term cost. The real benefit will be in the reduction of reoccurrence, related illness, crime, community deterioration, et al., which are all long-term measures. System accountability and individual recovery will become linked as the common measure of progress and value.

Numerically, many more individuals with substance use disorders attain recovery outside of traditional treatment than within it (Epstein, 2002).

Still, for those whose severity of illness warrants involvement with treatment, such involvement should be the safest, quickest and most propitious option for individual wellness and recovery — not to mention the best method of reducing other societal and health costs. For this reason, the resources allocated to each quadrant within this Model (see above) would likely not be distributed equally. Treatment, like the severe illness it addresses, is costly. Therefore, prevention and intervention are investments in cost reduction. Recovery supports are the added awareness and actions that can best sustain the investments of all efforts — individual and societal. Knowing that adequate resources to ideally support all of the quadrants of the Model simply do not exist, we must struggle with the difficulty of prioritizing needs while providing sufficient resources to gradually reduce existing and future waste, improve effectiveness and still offer each individual the true opportunity to achieve wellness and recovery. Further, the fuller implications of this conceptual model and its potential unifying vision must be further clarified and understood through implementation or demonstrations based on it and its evaluated impact on health policy, research, funding and the prevention and treatment of substance dependence.

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