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### **Preserving our Historical Distinctiveness within Service Integration Initiatives**

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The ONDCP National Drug Control Strategy, SAMHSA's latest policy directives and numerous health care reform initiatives all call for greater integration of addiction treatment and the broader arenas of primary and behavioral health care (McLellan, 2011; Rosenberg, 2012). What is open to discussion is not whether service integration will occur, but how that integration can best proceed. We are witnessing the opening salvos in the mainstreaming of addiction treatment in the United States.

In our speeches and publications, the authors have advocated and led experiments in bi-directional service integration. In Philadelphia, we are currently examining the degree to which various integration projects achieve earlier intervention into a broader spectrum of alcohol and other drug problems; deliver addiction treatment within non-stigmatized service sites; provide more comprehensive, holistic and family-centered care; expand venues for post-treatment recovery check-ups and support; enhance long-term recovery outcomes (particularly for persons with multiple co-occurring disorders); and improve stewardship of shrinking economic resources (Evans, 2007; Achara-Abrahams, Evans & King, 2011).

As we proceed as a field, the question is not, "Could persons seeking addiction treatment benefit from increased integration of medical and psychiatric services into their care?" Nor is it, "Would primary and psychiatric health care benefit from great infusion of addiction treatment and related recovery support services?" Those answers, based on existing experiential and scientific knowledge, are a resounding, "Yes!" The question is instead, "What core understandings and core service technologies drawn from addiction treatment must be promoted and protected as addiction treatment achieves greater integration with the larger arenas of behavioral and primary health care?"

The addiction treatment field and NAATP's own membership span diverse settings, philosophies and service menus, but most share a set of core ideas that have informed and distinguished addiction treatment from other service arenas. These include the following:

- 1) Severe and persistent alcohol and other drug problems constitute a primary, self-perpetuating disorder and not superficial symptoms of other personal, family or environmental stressors.

- 2) The multiple life problems flowing from addiction can be best resolved within a personalized program of recovery initiation and long-term recovery management.
- 3) Individuals with high problem severity/complexity (biological vulnerability, high severity, co-morbidity, etc.) and low “recovery capital” (internal/external recovery support assets) are best able to achieve and sustain stable recovery through a process of sustained professional and peer assistance.
- 4) That assistance is best provided by those who possess special knowledge of the multiple pathways and styles of addiction recovery and special expertise in facilitating the physical, psychological, cultural and often spiritual journey from addiction to recovery.
- 5) Well-intentioned but uninformed attempts to treat substance use disorders can result, and have resulted, in significant harm to individuals and their families.
- 6) Addiction recovery is a reality in the lives of millions of individuals and families—a foundational belief and source of hope within addiction treatment milieus.
- 7) Critical sources of hope within addiction treatment have included the representation of recovering people in the addiction treatment field’s paid and volunteer workforce and close linkages between treatment settings and indigenous communities of recovery.
- 8) Brief biopsychosocial stabilization should not be mistaken for sustainable recovery from addiction; recovery is not durable until it is firmly nested in the community—within the physical and cultural environment of each patient/family (White, 2008).
- 9) The fruits of addiction treatment are contingent upon access, affordability, competency, service breadth, service duration, and continuity of post-treatment monitoring, support and, when needed, early re-intervention.
- 10) There is a strong scientific and experiential basis for effective addictions treatment, which should be brought to bear in service delivery regardless of the setting.

The field as a whole needs broad discussions of the sources of such distinctiveness. Our ability or inability to collectively answer this question will shape our perceived legitimacy or illegitimacy as a cultural institution. We would be well served within such discussions to address three related questions: 1) What do we as a field want to achieve through service integration initiatives? 2) What potential harm must we as a field avoid within service integration initiatives? 3) What new ideas and service technologies could be drawn from other fields to elevate long-term recovery outcomes? NAATP could provide a great service to the field by leading these conversations toward consensus and helping us formulate guidelines to help us move through these uncharted waters.

Addiction treatment could disappear within the rubric of service integration leaving in its wake the illusion that addiction treatment is still available to our citizenry. As a field, we cannot let that happen. Bidirectional

service integration holds great promise for higher quality and more holistic addiction treatment as well as reaching a far greater portion of affected individuals and families. As a field, we must advocate for processes of service integration that achieve precisely those outcomes.

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