White, W. L. (2013). Addiction recovery and public policy: An interview with Michael T. Flaherty, PhD. Posted at www.williamwhitepapers.com

Addiction Recovery and Public Policy: An Interview with Michael T. Flaherty, PhD

William L. White, MA

Introduction

Revolutions in social policy and clinical practice in the addictions arena require pioneers from multiple disciplines who are willing to invest enormous amounts of energy over a sustained period of time before the fruits of their efforts are visible. The story of how addiction treatment began to reinvent itself from an acute care model of intervention to a more assertive and sustained model of recovery management (RM) nested within recovery-oriented systems of care (ROSC) would be incomplete without recounting the role Dr. Michael Flaherty played in this process. If there is a Johnny Appleseed or Pied Piper of RM and ROSC at the policy level this past decade, it has been Dr. Flaherty. He has been an articulate and tenacious advocate as he carried the need for addiction treatment systems transformation from one end of the country to the other. In August 2013, I had the opportunity to interview Dr. Flaherty about his professional career and his involvements in policy level recovery advocacy. Please join us in this engaging conversation.

Early Career Retrospective

Bill White: *Could you begin by describing how you came to specialize in the treatment of addiction?*

Dr. Flaherty: My personal interest began growing up in Shenandoah, a small hard coal town in northeast Pennsylvania. Alcohol was part of that environment growing up: from its many bars, my Irish ancestors' bootlegging, the Molly Maguires and the dignity they left us, to the fact that if you had a nickel you could get a beer – just if you were as tall as the bar. One day, the barkeep said to me, "why are you hanging around here watching the miners change shifts night after day, get out now or you won't ever get out." I thought that over and, to make a long story short, joined the Navy. I got out. Many of my friends didn't. Sadly, I then saw year after year how important, to borrow from Yogi Berra, it is to know that when you come to a fork in the road, you take it.

Professionally, my interest was forged when, after four years in the Navy and while in graduate school, I worked in the local penitentiary as a therapist. Nearly everyone I saw, to my naïve disbelief, was there for either alcohol- or drug-related crimes. I was overwhelmed that there was so little acknowledgement of that! To boot, in various ways, it continued in the prison as men used bread to filter the alcohol from aftershave lotion or vanilla extract and then fought over the bitter liquid they obtained. I was amazed by the power of the drug and in disbelief over

our denial to recognize the consequences of it for our society, at least for those incarcerated and their families.

After working at the prison, I went to the St. Francis Medical Center in Pittsburgh. St. Francis was steeped in the early history of treating alcoholism. Some say that the first medical diagnosis of alcoholism as an illness was made at St. Francis in 1945 by William Brown, MD. It was a great place run by wonderful and compassionate Sisters. I was the director of "drug treatment" programs in the community while the alcoholics could go to the hospital for their care.

There, I worked with those addicted to opioids and was again amazed by the power of addiction. Something from my ancestry made me rebel at the loss of one's freedom to a drug or an obsession to get high. One day, a small pregnant woman who was on methadone but still using heroin came in and after extensive clinical appeals, I very wrongly hollered at her! What did she think? She became very silent, cried, and looked at me and said, "I can't say no. I don't have an addiction. It has me." I never forgot that. Shortly after, I watched with amazement as her newborn came through controlled withdrawal in the NICU we established. That child came in to life through detox. I asked what did the drugs do to the baby through its development in utero and for its future? Once detoxed, I watched it seek its mother and thrive to suck and be alive. More than the addiction, I was forever impressed by the innate power of recovery both for the newborn and the mother. Thankfully, I developed a close and guiding relationship with two generous mentors in Philadelphia, Drs. Loretta Finnigan and Karol Kaltenbach, who shed so much understanding and guidance then and over the years.

Later, I became the head of St. Francis's Institute for Psychiatric and Addictive Disorders. It was a wonderful opportunity and challenge. At that time, St. Francis was the largest treatment center in Pennsylvania for Psychiatric and Addictive illnesses. We had 13 community programs, 4 specialized behavioral ERs, a complete psychiatric and substance use hospital and rehab with 600 acute and sub-acute beds, heck we even had therapists who could use sign language in the practices. We surrounded ourselves with great staff, many in recovery, and AA, NA, Al-Anon, etc. One day, I did some internal research and learned that 86% of all patients in "Psych" had co-occurring disorders; even more alarming, 42% of the patients in the separate medical hospital had illnesses that originated in some form of substance use. That was evidence of major societal denial, and I was hooked into a lifelong career trying to lessen that denial whether in an individual or a health policy. I also personally came to own the values of those in recovery—the need for acceptance and to be humble and give back what you gain if you ever expect to own it. The 12 Steps and the wisdom for life gained in the rooms.

Bill White: *I see you serving in so many roles – clinician, administrator, policy advocate, educator, research scientist, a cheerleader of clinical innovation. How do you primarily see yourself?*

Dr. Flaherty: Primarily, I am a clinician or, in today's jargon, a provider. Throughout my professional life, I always saw patients or their families. It was my daily proving ground and my grounding. Even as a hospital administrator, author, or adviser to government, I speak from clinical practice, knowledge, and experience. Sometimes in a delusional moment I say to myself, "you know what works. Now prove it." I keep trying to do that at whatever level of the discussion I am afforded the opportunity to be at. At first it was hard. There were failures and over identifications with the person. Ironically, my early teachers told me addiction treatment

was a simple cookbook and my valued clinical training would be squandered by focusing on people who were addicted. That was 40 years ago and I still am learning about addiction – and recovery – everyday. Guess I was a slow learner. There were also and continue to be many, many successes. My graduate training at Duquesne University played a critical role in teaching me the value of qualitative understanding and the uniqueness of each person in treatment. I've always tried to bring best practice to the unique in my work. That way I learned too.

Founding IRETA

Bill White: *What led to your founding of IRETA?*

Dr. Flaherty: Frustration. While at St. Francis, we had a wonderful mission to provide the best care to all regardless of means. The Sisters were very clear about that. But we were in a "perfect storm" because of it. We had third party payers, non-insured, underinsured and insured but managed, as well as a huge Medicaid and Medicare population to serve. Truth be told, the uninsured and managed were the populations we lost the most sleep over. The numbers of uninsured were growing and outpatient and government-funded services were at their limit. And, in those days, the managed care population would often conflict with what we knew the patient needed. These both translated into clinical and financial challenges that frustrated everyone.

There were also the issues of best science and practice not being funded or obstructed by antiquated regulations or guidelines and their subsequent audits and forced retrospective compliance. It would take on average 10 years for a new, effective innovation to get into the actual daily treatment plan that could be funded. Daily we faced the problem of providing best practice to meet the presented need. Increasingly to do that, we were unreimbursed or only minimally reimbursed for cost. There was also what I refer to as the "lie" of managed care, i.e., that volume will replace lower reimbursement. That never happened. We had the volume all right but we lost our shirts learning the truth.

So a huge frustration in how fragmented, siloed, under-funded, and under-prioritized behavioral care was coupled with society's denial of the mammoth role mental health and substance use play in health care, coupled with inadequate and antiquated policies and standards, coupled with changes in health care delivery (managed care, diminishing commercial care) and growing numbers of patients and families, particularly in the addictions, led to the frustration that began the Institute for Research, Education and Training in the Addictions (IRETA). No one can serve a Mission forever without a margin. Oh yes, we were also frustrated by having to start over explaining the illness and its societal costs after every major election. Everyone campaigned on "locking them up," and we spent the next two years showing that newly elected official that this didn't make financial or clinical sense. We would ask ourselves, why can't we politically and socially evolve?

IRETA was designed to be separate from St. Francis as a 501(c)3 that would seek, in a totally apolitical and non-judgmental manner, to align policy, practice (prevention, intervention, and treatment), research, education, and training in the addictions for recovery. By addictions, we also included co-occurring disorders. This focus naturally led us into nearly every aspect of care including policy, funding, managed care and medical necessity, insurance and benefits, cost and cost-offsets, specialized care for distinct populations (veterans, sexual minorities, ethnic and cultural groups, etc.). Also, by being independent, we weren't aligned with any one university or large agency and therefore could work equally with any expert or all experts to get the best

solutions to the issue presented us. And that is just we did. Our then Pennsylvania state drug and alcohol director, Gene Boyle, joined with myself and St. Francis' Scientific Director, Dr. Jan Pringle, to get it going. We gathered leaders from across Pennsylvania as our advisors, and IRETA received initial grants from two private foundations, the Scaife Family Foundation and the Jewish Healthcare Foundation, to start. Later, the state seeing the value of IRETA for its policies and the skills of its providers, offered a state grant. Our first Director was Dr. Barbara Bazron, who was top-notch as an educator and trainer. That was in 1999. The rest is history.

Bill White: *What has it been like to work within the Center for Substance Abuse Treatment's Addiction Technology Transfer Center (ATTC) network?*

Dr. Flaherty: That has been a highlight of my career. They are a skilled, diverse, smart, talented, and totally dedicated group of professionals. The whole concept of regional ATTCs that also comprise a "national network" is sheer genius on the part of the Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Substance Abuse Treatment (CSAT). Whether you're seeking to address the skills and needs of the addiction treatment workforce for training or building the science of technology transfer and knowledge adoption, they are the "go to" professionals whether locally, regionally, or nationally. They bring the tire to where it hits the road and make sure it can reach performance. They write curricula and seminal monographs, design implementation of science for practice, and support a workforce with a breadth of expertise and nationally diverse leadership that no single university or agency could. As a national network, they have the capacity to get important information to all of the country and its providers literally in minutes. You want the expert on pregnancy and addiction? They can get her on the phone or in a webinar that day. It's an awesome experience to work with them. In a field so often defined narrowly by each Guild and historical stigma, you have an illness needing to be addressed politically, socially, scientifically, economically, experientially, and medically at the same time. They're the folks who can do that. They're great. They deserve a national tip of the hat for what they do.

Bill White: *What do you see as the untapped future potential of the ATTC network?*

Dr. Flaherty: The ATTC Network and the ATTCs themselves are the gem of SAMHSA/CSAT in my mind. They keep evolving to the challenge, which is what makes them so vibrant and continually valuable. As the Principal Investigator for the Northeast ATTC, I saw our first customer to be our states and the providers even though we were in a collaborative partnership with SAMHSA/CSAT. We helped our states address their needs, and that was "gold" to them. The ATTCs are a true national, state, and local partnership united by a common purpose – improving care and service. Beyond individual ATTC responsibilities, as a Network, they also have specific national projects. Blending NIDA best practices was one such national project. Our particular Center specialized in building recovery-focused care, in workforce development and the development of clinical practices with SBIRT and Veterans services. Today, specific ATTCs are dedicated to overarching priorities such as the special needs of Native Americans, Hispanic, and LGBT populations and technologies such as SBIRT. When all the ATTCs gather as a network, you have best science and most of the SAMHSA Strategic Priorities covered quite well by experts in those issues and in technology transfer methodologies and geographic and cultural diversity. To me, they are 24/7 communicators of best science and practice for anyone

addressing substance use and the addictions. Prevention too has its CAPTs, which are similar to the ATTCs. The MH community must envy all this, and that is another potential to be expanded and realized. In this global age of technology transfer, they also have an international potential that is yet to be discovered.

The ATTCs are not topic, agency, or university constrained. They are illness and expert focused and that allows them, with their collaborative partner SAMHSA/CSAT, to educate all. Therein lies their greatest challenge, i.e., they are enormously under-resourced. Still, they pull off miracles daily on budgets that often quickly reach their limit. Their true potential is still untapped for the addiction professionals *and* for our mental health colleagues in all related disciplines. They could build, unify, and integrate a workforce offering inexpensive continuing education for all disciplines. They could educate consumers and add an empowering recovery focus for all care. They could understand a nation's vision and help implement it. They could help states where the states need help most. They could reach special populations. They are an engine for the unifying purpose of what we do and its implementation. They could lead the way in new technologies, better business and practice methods, training in electronic records, integrating care, community involvement. You name it. Just be sure you put the resources to get it done right and they will do just that. Their potential is unlimited. They are game builders and game changers.

ATTCs and Workforce Development

Bill White: *Through your work with the ATTC network, you have been very concerned about workforce development within the addictions field. How would you describe the current state of the addiction treatment workforce?*

Dr. Flaherty: Wow, what did the poet Coleridge say, "Water, water everywhere but not a drop to drink." The addictions workforce is, like most of the behavioral health workforce, in need of major prioritization, resuscitation, and redefinition. If we honestly addressed the true cost of addiction to our society, we could dramatically reduce our national debt. I often ask myself why not build jobs there – put people to work there. In the words of ONDCP, eliminate demand. We're missing the message. Sure there will be added healthcare costs but significantly below the level of savings and increased productivity. Our wars are tied to drugs; immigration is also. This is perhaps our greatest "denial" today. Our jails are 60-80% drug users as are our courts and children and family services. Local jails are now at capacity serving as revolving doors for public safety. We live in "denial" with a capital "D."

That said, the disciplines should then better collaborate to treat an "illness" first and build their skills and competencies from there. Doing it in reverse builds silos and creates unnecessary polarities and professional aloofness. Let the "illness" and its "recovery" build and unify all practice and workers as a unified team. We need a workforce for the full continuum of care – prevention, intervention, treatment, and recovery – that includes all disciplines working together for the individual, family, and community. My own estimates are that with only 10%-15% of those needing care today in treatment and with the implementation of the ACA reform and expanded insurance coverage found therein that we will need about another 100,000 SU workers by the end of 2014 if we truly face the problem. That is more than twice what we have today! We need everyone involved today plus 100,000 more from all disciplines. There will be no shortage of work – only workers.

People have to stop being defensive and get honest to solve the problem. Roles need clarification, especially for the new peer roles and workers, but that will come with their further inclusion. Professional addiction counselors should not be threatened by this expansion. They too should grow into a full specialized profession, defined by the illness and its recovery, with terminal doctoral degrees and educational specialization and programs for all levels of preparation and practice along the treatment continuum. Peer supports are perhaps our greatest new resource to address the experiential supports and relationships needed to attain and sustain recovery of this chronic illness. By being honest with the facts and facing the issue in a truly collaborative workforce, we will all grow and have the best opportunity possible to succeed in building a healthier society. Two small examples of this growth would be for all disciplines to offer the full scope of CE credit for all workers at major conferences – this is no small change with potential real dialogue and impact over time. Also for all workers to recognize that nothing is more culturally sensitive than to focus on attaining the health, wellness, and recovery of each individual, nothing. That is our purpose.

RM & ROSC

Bill White: *You have been one of the driving forces behind the national and international promotion of recovery management (RM) and recovery-oriented systems of care (ROSC). Describe how this role emerged.*

Dr. Flaherty: My own clinical practice, years at St. Francis, and involvement with the ATTCs were the cornerstones of that emergence. Each day in my practice, I learned what worked and for whom and what didn't. When the Institute of Medicine report came out in 2001 on "*Crossing the Quality Chasm – A New Health System for the 21st Century*," it left out the addictions as a top 20 illness to be addressed. America's most costly and preventable illness wasn't mentioned! I began to see that the clinical denial, minimization, rationalization, and projection observed daily in each actively addicted person was similarly present in our society. Moreover, major efforts were beginning to reign in healthcare costs. Managed care and new terms such as "medical necessity" were being bantered about to pay for the care. This implied that once a person was medically stabilized or physically safe, the treatment, or at least the payment for it, was done. We fought daily with payers to understand that with the illness of addiction, physical stability wasn't wellness or cure. And without the added tools of cognitive function, continuing care, and recovery support, another acute care episode was a short-term predictability. Balancing their budgets came into conflict with getting their "covered" patient well.

From St. Francis, we opened IRETA to gather all involved and discuss the true nature of the problem and its solution. We convinced those who weren't already so that getting the person well was the least expensive cost over time. The good payers stayed at the table while the carpetbaggers silently left the room. This led to similar round table discussions with all stakeholders at state and later national levels. We asked in this managed fee-for-service model if we were losing the very purpose of treatment. We shared the IOM report with the ATTC directors who similarly saw the "gap" and shared similar concerns. They actually volunteered to meet after working hours to discuss the feared possibilities. At IRETA, we organized 50 national leaders in the addictions from all of what we called the "10 P's needed for progress in the addictions": policy makers, providers, payers (public and private), purchasers (e.g., MCOs), philanthropy, professors (researchers), pastors, patients and families, police and press and openly

discussed these concerns and what worked in treating this illness. We quickly agreed that our approaches to the addictions were generally built upon an acute model of payment and care while in reality we were addressing what was often a chronic illness or one certainly best treated by a chronic illness approach. Further, payment authorization and methodologies should not be equated to quality, desired care, or medical judgment. We also began to ask how we might change a system of care where the agencies providing that care were so payment dependent and still applying an acute illness or episodic model.

That group compiled a consensus document from these meetings in 2006 entitled "*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*." It's readily available as a free download at www.ireta.org and is still in demand and used today as a defining and foundational work. In it, we all agreed that building resiliency while attaining wellness and recovery was the least expensive and most qualitative solution for all involved. Piecemeal care was only a patch and overtime aggregated a much greater individual and societal cost. Borrowing from your 2004 work, Bill, with Mike Boyle and David Loveland, we offered an early ASAM definition of recovery and identified both professional behavioral health and personal "recovery management" as tools to attain it. Behavioral health management was the recovery-focused collaboration between service providers and consumers, both traditional and non-traditional, over time to attain and sustain personal recovery. Recovery management was a system of support for professionally directed treatment, which further strengthens the recovery and experiences, needs and aspirations of the individual and/or families living with the illness. Each person also needed a personal recovery plan to guide them. One member of the group was George DeLeon, who had pioneered an earlier ten-stage recovery paradigm and recovery-oriented measures within what he called a "recovery-oriented integrated system" of care, i.e., an individualized system that had the best likelihood of building individual recovery for all.

These were key moments in our evolution and the awakening of a new paradigm that saw both the value of addressing the pathology while building the resiliency from it, individual wellness, and recovery. When promulgated, those in recovery smiled and told our esteemed group that "that was what they have been doing all along – they were glad we were finally getting it." One woman, a scholar and leader in recovery, with tears in her eyes said, "the scientists are inviting us back into the conversation and we've been waiting oh so long. This is a great day." It was an emotional and intellectually exciting time, and I was privileged to play a part as a person, facilitator, and fellow clinician.

With your leadership, Bill, and in collaboration with leaders at the GLATTC, the Philadelphia Department of Behavioral Health and Developmental disAbility Services, and the New England ATTC, we've published seven more monographs on topics as relevant as recovery-oriented methadone, the nature and value of peer supports, building a recovery science, and many articles on variations of this paradigm change for specific populations and cultures, prevention, policy and practice. Personally, via ATTC Network disseminations, from 2009-2011, I traveled and spoke to 32 states about ROSC and how they might develop a local recovery-oriented system of care and workforce. The power and role of the ATTCs cannot be overstated. Governments and communities were excited and invested to work together, as that is what recovery management does. One African American gentleman and provider called it "finding what was in our DNA all along to be and do." Sadly, this natural progression is being somewhat marginalized by economic strains and other new priorities such as building integrated models of

care or the implementation of the ACA. These have caused a de-focus from building ROSC, but the interest is still there, and it will come back now that we have found it. It's only natural. Thirteen countries are now working with building ROSC, and new research findings are emerging daily. To borrow from Plato, once you see the light, it's hard to go back into the cave.

Bill White: *You were involved in hosting the first national RM/ROSC leadership conference. Could you discuss these two events?*

Dr. Flaherty: The 2008 Recovery Symposium in Philadelphia was an early seminal event. With momentum growing and a need to disseminate the work of those working with recovery and building ROSC, expressed interest was for a national symposium where all leaders and all disciplines might gather to learn and share ideas and examples of research and practice. In life, recovery practice was evolving beyond what the National Institutes of Health (NIH) reported as best practice. We were acutely aware that while we had a body of science that included hundreds of research articles related to recovery, most, if not all, of our NIH-supported research was focused on the biology of the illness, i.e., the intervention into and understanding of its biological pathology.

Another "gap" was identified, the need for more NIH (National Institute on Drug Abuse, NIDA/ National Institute on Alcohol Abuse and Alcoholism, NIAAA) supported research on recovery. In the movement from acute to chronic understanding of the illness, we were lacking our own Institutes' science about what is recovery, for whom and how it can be cultivated, sustained, and measured. IRETA contracted with Alexandre Laudet, PhD. to conduct a survey of those researching recovery to compile what questions would be key for a science of recovery to answer. NIDA and NIAAA both made important contributions to the conference and began a dialogue with the other researchers so anxious to study this new paradigm. State and community government leaders presented their models of ROSC and the outcomes being achieved while those in recovery spoke of examples of recovery supports and peers adding to improved clinical outcomes and gender and cultural sensitivity. SAMHSA/CSAT and providers spoke of a new day and a fear of change that even they admitted would be for the better. Bill, you and Dr. Tom McLellan spoke of the historical and immediate value, urgency, and challenges of this paradigm change. Dr. Laudet presented her fellow researcher-derived consensus questions for a science of recovery to take root and advance. Both NIDA and NIAAA heard and responded to that. In fact, immediately after the Symposium, both NIDA and NIAAA appointed key staff as Recovery Liaisons. It was indeed the day where the new paradigm of recovery-focused care came to a first fruition.

Bill White: *What has been the role of the ATTCs in the promotion of RM and ROSC?*

Dr. Flaherty: It literally couldn't have happened without SAMHSA/CSAT and the ATTCs. The ATTCs were in attendance at the Philadelphia Symposium. You have to remember the ATTCs were all doing recovery work because they saw it as critical for their constituents. They received no additional funds and already had severely strained budgets. Yet from that day in 2003 when they all stayed after dinner to talk about the 2001 IOM report and the chronic disease model and what it meant for those seeking help for addiction in our country – to today – they all have committed staff and kept the recovery momentum going. It's amazing to see what has been done by SAMHSA/CSAT, a group of severely overworked and underfunded ATTCs, states and

providers all stretched beyond their limits, and individuals and families in recovery across the nation. It's truly amazing. Talk about purpose-driven work and miracles. Dr. Westley Clark, Herman Diesenhaus, Karl White, Cathy Nugent, Donna Doolin, and others were all just continuous sources of wisdom, intellectual support, and guidance. It was 'above and beyond' service by all involved.

For example, following the Philadelphia conference, the ATTCs did a national qualitative survey to benchmark within themselves where each ATTC region was in their interest in and development of ROSC. They were asked to report on needs of their states and what they – each ATTC – saw as best steps to further help the states to build RM and ROSC. This led to a plan within the ATTC Network to collaboratively assist in the development of RM and ROSC across the nation. In 2010, SAMHSA/CSAT, GLATTC, Northeast ATTC, and all the ATTCs partnered in developing the first "Training of Facilitators of ROSC" in Tampa, Florida. SAMHSA/CSAT and the ATTCs themselves found the funds for each ATTC region to send three trainees – one government, recovery and provider representative – to be trained on training for RM and ROSC upon return to their regions. This three day knowledge and skill building event created a national cadre of trainers in RM and ROSC. You were key there, Bill, and the central trainer along with Lonnetta Albright, Dr. Ijeoma Archara, and myself. The subsequent impact of the training to seed RM and ROSC locally cannot be overestimated.

At the same time, SAMHSA/CSAT was partnering with others such as Partners-for-Recovery and Faces and Voices of Recovery and leading states such as Connecticut, North Carolina, and Georgia and cities such as Philadelphia to document their RM and ROSC efforts. SAMHSA/CSAT also held key meetings on their own with national leaders to develop founding Principles and Objectives of Recovery and other focused aids and resources for specific populations, cost-offsets of ROSC, funding ROSC, outcomes, etc. NASADAD, the national body for state D/A directors, too asked states to identify recovery liaisons. At this same time, synergistically both independent (i.e., Betty Ford Institute) and government (i.e., SAMHSA) leaders began to articulate early definitions of recovery relevant for the time and current status of understanding. This was and remains a challenging but critical effort. Nonetheless, the new paradigm was indeed progressing. The ATTCs were the little engines who kept saying, "I think we can, I think we can."

One final thought. In some ways, my answers to the questions haven't really captured that RM and ROSC advancement was and is really a grassroots or bottom up driven event. Yes, our leaders and leading agencies played a critical role in providing organization and knowledge, but the true impetus and sustaining interest really originates with the individuals, families, and communities who are seeking a role and a solution to substance use and addiction. They're desperate to speak out and have a role, and local governments are hearing that more and more every day. This isn't a top down led initiative. It is an all for one and one for all collaboration and united solution – individual, family and community based – or as the scientists would say, "person centered" or, as I would say, "person driven."

Bill White: *What do you see as the most important changes in clinical practice that occur in the shift from acute care models of addiction treatment to models of sustained recovery management?*

Dr. Flaherty: There are many great happenings clinically and we're only in the infancy of this refined vision and applied recovery-focused care.

First was the establishment of a definition of "recovery." By beginning there, we found out how incongruent our efforts have been. We also re-established who our true "customer" is and what we need to do to best serve him or her. It's not about days in treatment but about attaining recovery. While still evolving, this effort is bringing more clarity each day to our purpose for being than any other single project over the past 50 years. The shift from the acute illness and episodic treatment model focus that measured outcomes at distinct levels of care is giving way in a more chronic understanding of the illness that sees person-centered outcomes and measures of attained and sustained recovery – individual, family and community – as a truer and more qualitative indicator of success. Clinical payment methodologies now have to catch up. The fee-for-service model isn't that applicable to funding illnesses that need continuums and continuing care. This, I believe, will change and better economies will be found in doing so.

Today, recovery management and recovery-oriented systems of care are mostly defined by the added value or an additive approach of connecting recovery supports and recovery support specialists and peers to treatment. Two systems are transforming their whole systems to recovery-focused care. From these studies in five states that use RM and ROSC – Vermont, Connecticut, Pennsylvania, Texas and California – reports documented this linkage improved clinical outcome and reduced overall costs. Other than the state reports, over 100 studies exist and more will be forthcoming on the value of a recovery focus to treatment. Internationally, in a study by Clair Boutillier and her colleagues reported in the *Journal of Psychiatric Services* (Dec. 2011), six countries – U.S., England, New Zealand, Scotland, Republic of Ireland and Demark – saw improvements in 16 areas of clinical practice when a recovery-oriented practice was used.

Following that publication, Mary Barber, MD, wrote in the March issue of that same journal that it was time for Psychiatry to proclaim the new recovery-focused model as the evolution of and "new medical model for psychiatry." For Barber, clinical practice had three recovery paths: 1) to cure the illness, 2) to help manage an illness, i.e., to manage the symptoms of an illness via long-term management by the doctor and patient, and 3) assisting the person to function at one's best despite ongoing symptoms of illness. For Barber, these clinical paths can all support recovery. While her model speaks more specifically to psychiatric practice, there are similar treatment-supported recovery paths to be defined in SU. Another clinical example is that of Aaron Beck, MD, a founder of cognitive-behavioral therapy, whose recent studies now suggest redefining CBT as CBT-R or CBT-Recovery, noting that the focus on the positive thinking of recovery can be the very pathway out of the negative thoughts and illness at hand. We spoke together on this topic at the 2012 American Psychological Association in Tampa, FL.

Beyond these examples, we should again point to the great work of SAMHSA to strengthen clinical practice via recovery-focused care. They have literally put their money where their mouth is. Since 2003, they have been awarding selected states Access to Recovery (ATR) grants that are generally three-year awards of about $7.6 million per year to build supportive services to individuals in care. These grants have a variety of uses to improve care and are producing significant improvement in outcomes based on recovery measures. They also the continued funding for the ATTCs and more recently the newer Bringing Recovery Supports to Scale-Technical Assistance Center Strategy (BRSS-TACS) and Recovery to Practice (RTP) Initiative.

BRSS-TACS was begun in 2011 and seeks to encourage the widespread adoption of recovery-oriented services and systems of care across the United States. It seeks to coordinate and document recovery and peer efforts and to build the guidance necessary to advance SAMHSA's Recovery Support Strategic Initiative. BRSS-TACS seeks to bridge MH and SU

recovery and in doing so, has the challenge to face the difference presented by each. The term ROSC, for example, is sometimes challenged by MH advocates as referring to a paternalistic "care" system that MH might better define simply as Recovery-oriented systems (ROS). Evolution is never easy!

The Recovery-to-Practice Initiative (RTP) began in 2009 and is housed at Yale University under the leadership of Larry Davidson, PhD. This 5-year federally funded center seeks to move the concept of recovery from policy and vision statements into practice. While initially focused on MH, it has recently expanded its scope to SU. It seeks to develop recovery-focused resources for all professionals with print, electronic materials, training, and technical assistance. To me, what is most exciting about the RTP initiative is that not only is it addressing the development of the traditional MH and SU workforce, such as professional MH and SU counselors, but that it is also speaking to the peers working with BRSS-TACS and the independent Guilds for the development of recovery-focused training within those disciplines. I am speaking here of new recovery-focused training being developed in MH- and SU-funded collaborations with the American Psychiatric Association, American Psychological Association, American Psychiatric Nurses Association, the Council of Social Work Education, the National Association of Peer Specialists, and the National Association of Drug and Alcohol Counselors. This is recovery unifying practice in action. This is great stuff, and it's only beginning. Clinical practice is only beginning to be shaped by other evidence-based practice and recovery-focused care. In the end, I believe the purpose of all care and treatment will be to at least offer the possibility of recovery – in whichever of the three pathways Mary Barber and others suggest – to attain and sustain that wellness and recovery.

Best of all, at a more grassroots level, communities and counties once understanding the opportunity of RM and ROSC are beginning to redesign their treatment systems around the principles of recovery and its objectives. I am working now with several who, like Philadelphia and Connecticut, are seeking to qualitatively transform their whole system to be an ROSC. They identify their key representatives from all related areas and draft a "Community Recovery Preamble" that sets the stage for what they want to develop – with their providers – in their community for their individuals and families. It is very exciting to see.

Bill White: *There has been a significant growth in peer-based addiction recovery support services in the U.S. What do you see as the current status and future of such services?*

Dr. Flaherty: Simply put, we won't achieve the goals of health care reform without peers. First the illness demands continuing care that most treatment agencies can't adequately provide as "aftercare." Second, the real lived experience of recovery – whether from mental illness or addiction – is often best conveyed by another person in recovery. Third, these newly defined roles are needed to make treatment more effective – it's the nature of the illness and the nature of treatment. Each has its role and boundaries. And lastly, for the cost, peers are likely to prove to be a valuable and cost-effective ancillary aid to true recovery. You have spoken, Bill, in your "Peer-based Addiction Recovery Support" monograph about the use of peers being really a centuries old adjunct to health care. Our current providers need not be threatened by them. With only 10% of those in need of care receiving it, there is more than enough challenging work for all. Peers do not seek to replace professional care but to strengthen it or be the support for recovery when professional treatment isn't needed. It's like a person who is healthfully managing their diabetes coaching a newcomer on those beneficial ways. Oh sure, much is to be

worked out: the roles of peers, who supervises them, their ethical and legal accountability, their training and potential credentialing, who will pay for them, etc. Still, as we speak, I know that 20 states now formally recognize peers in mental health and addiction treatment service settings and that another 22 are studying it. Ironically, the movement of peers into the workforce not only strengthens recovery but strengthens the professional counselor to grow its own profession – and value – from paraprofessional through PhD and MD as a specialty. This opens up a new specialty with a related professional career ladder for peers and others. I see it as a win-win-win.

State of RM & ROSC Implementation

Bill White: *How would you characterize the state of RM & ROSC implementation in 2013 at federal, state, and local levels?*

Dr. Flaherty: RM and ROSC are slowly continuing to grow. Parity, health care reform and the ACA, integrating care, a federal focus on earlier intervention, and generalized care combined with economic retrenchment have paralyzed our evolution by making providers be just grateful to "hold on" to what they've currently got. Fear can be paralyzing. As noted earlier, before the aforementioned forces, I visited 32 states who wanted to learn more and build RM and ROSC. Then the financial cuts and focus on earlier upstream interventions and integration came, and folks had to follow the money to survive. Ironically, nothing can be more cost-reduction and cost-effective than recovery and the prevention of mental illness and substance use. It's the revolving door of inadequate or repeated acute treatment that is breaking our budgets. Some might cynically say "that's by design." ROSC is very alive today in counties and communities who seek to participate in solving their SU problems. These communities are building treatment systems around recovery and the needed continuums of care to attain it. They are linking with their jails to reduce the community costs of incarceration via added recovery supports and connected treatment. The numbers are there: treatment saves $7 for every one spent over incarceration, and treatment is made even more effective and efficient when recovery supports are added. Community recovery centers are opening across America; colleges are offering drug/alcohol free roommates, dorms, and even whole colleges that specialize in recovering populations. These are only a few examples of our changing culture. Ultimately RM and ROSC, or some variation of it, will gain strength because it involves and empowers people at all levels to find solutions. This will impact all aspects of prevention, intervention, treatment, and recovery or, to use another language, help build individual, family and community resiliency, health, and wellness. It's the DNA of why we do what we do. It will survive and grow.

Bill White: *It is hard to discuss RM & ROSC without talking about the State of Connecticut and the City of Philadelphia. What makes CT and Philadelphia so significant?*

Dr. Flaherty: They were the forerunners and the first state and major city to actually apply and measure the impact of RM and ROSC. Without a formal science supporting the paradigm shift from an acute to a chronic model, these two pioneers were the foundation upon which RM and ROSC first took real world hold. Without them, RM and ROSC might have died an early death due to being more or less just constructs to be validated in a world of often self-sustaining science. Drs. Tom Kirk in Connecticut and Arthur Evans in Philadelphia are to be loudly acknowledged with great appreciation and respect for their courage and innovation – and the

good sense to evaluate it. You were key, Bill, in your advisory role, particularly in Philadelphia, as were so many others like Roland Lamb, Dr. Ijeoma Achara, Bev Haberle, just to name a few. All risk takers and trailblazers who shed light on what "could be" instead of only what "was." No Connecticut or Philadelphia, perhaps no RM and ROSC. Oddly, science is still slow to come to the challenge. That's why I call it an "evolution" of understanding because in true evolution, science is always a tardy partner. At times, life is what science comes to study.

Public Policy & Financing

Bill White: *Could you describe some of the more important of your involvements in the arenas of public policy and financing of addiction treatment and recovery support services and some of those who influenced this work?*

Dr. Flaherty: For me personally, the opportunity to work with the great people evolved from the individuals in my practice office and the influence of wonderful people in recovery like Charlie Bishop to the invested leaders in government and health care in general – from ONDCP down – were the greatest area of joy and validation. These are God's people – one and all.

Working with Tom McLellan and you, Bill, and others on the 2006 expert consensus panel and "Special Report" was a high point. In doing that, we gathered so many leaders and reshaped a then warring and divided field to build a Common Vision. We concluded the illness was better understood as more often chronic than acute, and we looked at how this understanding would change everything we were doing until then. Despite divergent views, no one left that discussion dead, but the world did change. Subsequently working on the implications of that shift for treatment and the mutually supportive ways that those in recovery and practitioners might better team for the shared interest of the person we commonly serve has been my passion ever since. For example, working with payers to see the absurdity of certain policies like "fail first" at lower levels of care or excessively restrictive lengths of care for an illness that couldn't even begin to be treated in the short ranged thinking offered. Look at the incarceration rates over the 1990s and early 2000s when such thinking prevailed. We just shifted the problem to the public system and in doing so paid much more to address it.

The Philadelphia Symposium on Recovery in 2008 was another personal highlight. There, those in recovery came back into the tent of treatment and science and we all saw the opportunity, and examples of it, of what could come from such aligned and collaborative effort. So much went on there, in the presentations and in the aisles. In the following year, the online video of that Symposium was viewed or downloaded at IRETA (www.ireta.org) over 13,000 times from around the world. China was the leading viewing country – outside of the U.S.

Beside those biggies, Bill, there were so many other more applied changes from the paradigm shift such as addressing recovery with the social security leaders so as to define ways to manage addiction recovery when it becomes an allowable disability; or building a new peer worker and working with SAMHSA and the Department of Labor to have the addictions workforce proclaimed a priority profession of need; working with NIDA and NIAAA to open offices on recovery. I worked for ten years to achieve parity and extensively to launch Drug Courts, helped rewrite how to best treat pregnant and addicted women and opioid addiction in general, and worked with ONDCP to end discriminative housing policies for those in recovery. I watched ONDCP Director Kerlikowske proclaim recovery as the vital role of policy at ONDCP in the Fall of 2011 in NYC. And let's not forget the work with the Betty Ford Institute to

architect an early but modern first definition of recovery that has gone worldwide in application. I had that same privilege to work on this with SAMHSA and CSAT in their efforts to build ROSC both through the ATTCs and external to the ATTCs. Looking back, joining with others like Lonnetta Albright to carry the message and possibility of this paradigm shift and recovery-focused care to the nation was a task you and others shared, Bill, but will be forever a remembered calling, treasure, and legacy. If I think of everyone I should express my gratitude to over those projects, we'd go on far too long with this interview but the gratitude would not end. I hope they know that.

Bill White: *RM & ROSC raise complex issues regarding the funding of addiction treatment both by governmental agencies, private insurance companies, and managed behavioral health organizations. Do you see a day when sustained recovery support will be reimbursed by organizations that today only pay for acute stabilization?*

Dr. Flaherty: Definitely – but not for a while. The cost of reducing the illness' actual costs has to be understood and accepted first and then recovery supports and continuing care will become a recognized procedure for maintaining wellness and keeping costs of acute and repetitive care down. Addiction treatment has a lot going on right now. For example, it is probably the single largest illness today in our country whose costs can be reduced, managed, and even prevented. Surprisingly, insurance and managed care see it as a relatively insignificant part of their concerns because they focus more on other more medical illnesses – many that are actual symptoms of addiction or abuse. COPD, hypertension, depression, diabetes, pain and other high cost societal illnesses, not to mention incarceration, court costs, children's protective services, disabilities etc. will all combine to confront our societal denial and force a facing of the truth. We are a society of addictions. Studies say alcohol and drug use alone costs this country $400+ billion dollars a year with about only 2% of the cost going to treatment. Both sides of that equation must change. Imagine what that savings could do for our national debt?

Sustaining recovery and being covered by insurance to do it, whether by professionals or peers in paid or voluntary roles, will become part of the "medical necessity" discussion of managed care and eventually be a covered procedure, I believe. 20 States are there now. The reimbursement is low but fair enough in most states to keep costs down and recovery support up. Faces and Voices of Recovery has been a leader with guidance on peers. We have a distinct opportunity now with health care reform to open our doors of knowledge wider and understand what best addresses the illness and its prevention, intervention, treatment, and recovery. Then we pay for what works, not for systems or practitioners seeking to sustain themselves or that don't work. Payment will be for performance, outcomes, and community satisfaction. When that day comes, I'm certain peer support will be paid for and organizationally supported.

Bill White: *How do you see evolving health care reforms affecting the future design and delivery of addiction treatment and recovery support services?*

Dr. Flaherty: Health care reform will use the biggest stick it has – payment – to improve quality and reduce costs. Health exchanges, Affordable Care Organizations, or medical homes will stand alongside treatment as usual and comparative analyses will begin. Costs will be capitated or, to say it differently, risk will be shared by all involved. To achieve the goals of addiction treatment and RSS, new payment methodologies will be advanced that pay for

performance and healthier outcomes, including recovery as it will be continuously defined for each person. Medical criteria will be adapted for each stage of the illness wherever it might appear, i.e., at the primary care physician (PCP) office, school, job, or specialized treatment facility. Building resiliency, wellness, and recovery will be included in the measures of success and for continued funding. Payment waivers from Medicaid and Medicare will be permitted to states and those holding financial liability so as to explore improving quality and being able to operate with the financial constraints and new payment methodologies designed to control costs, e.g., case rates. Addiction treatment will not be a single episode of care but a closer collaboration and continuum of care based on medical necessity and needs for each client to build person-centered recovery. Outcomes won't only be agency-based but will also be person- , family- and later community-based. Health care reform cracks the cosmic egg of historical health care and insurance, Bill. A new and better day is beginning if we let it.

Medication-assisted Treatment & Recovery

Bill White: *Could you describe your involvements to increase the recovery orientation of methadone maintenance and other forms of medication-assisted addiction treatment?*

Dr. Flaherty: One of the critical questions over time about recovery is how do medications fit or not fit into the recovery picture? This was not a simple issue nor did a present or scientific answer exist. At one time in the history of recovery, addicts seeking help were told certain medications weren't addictive and would help. Some of those medications were addictive and those seeking help were misled. Still, medications have and continue to play a critical part to support recovery in many. Over the past decade, with our expanded awareness of co-occurring disorders, nearly all have accepted that some medications can be helpful and key to supporting recovery.

The guidance used to be that medications that affected mood were not "ok." This left thousands of individuals outside of the recovery paradigm if they were on methadone, buprenorphine, or other agonist medications and even certain sedatives for genuine psychiatric illness. The new recovery paradigm brought a refocus on this by asking are these individuals on such medications in recovery and if so, how or what is the structure of that treatment that allows us to say so? At St. Francis, we offered methadone maintenance, and it was there I became convinced in its viability if properly managed and utilized for the best interests of the person, family, and community.

Methadone was by far the then largest prescribed medication for opioid addiction. Thousands had been helped by it, perhaps millions worldwide, and many advocates among their ranks begged to be recognized as being in recovery – while still on it. The most notable perhaps was an especially astute lawyer, Lisa Mojer-Torres, who devoted her life to defining those on methadone as being not only real human beings but individuals more than capable of being in and defined as being in recovery. Lisa was a saint. You and she combined, Bill, with the support of the Northeast ATTC/IRETA, GLATTC, Philadelphia DBHMRS and others to produce the seminal work, *Recovery-Oriented Methadone Maintenance* in 2010. It was a practice changing, mind-altering, gutsy work. I recall, as I'm sure you do, the many catcalls and heckles we all received from disapproving others. I also recall Dr. Westley Clark noting in the Foreword that this was the "new approach" for MM and an understanding that needed to be communicated; and later the Addiction Treatment Forum, the repository of the best-practice in methadone treatment,

referring to *Recovery-Oriented Methadone Maintenance* as being methadone's "coming of age." In it, not only the history and current practice were reviewed but the ways in which the recovery paradigm could then redefine and indeed recognize the value of methadone and its role to support recovery. It was the first to define Recovery-Oriented Methadone Maintenance.

Shortly afterwards, a relatively large community behavioral health management company in western Pennsylvania known as Southwest Behavioral Health and its Executive Director, David McAdoo, approached IRETA in the hopes of developing from the ROMM monograph actual guidelines that could be used in the 13 or so counties his company oversaw. IRETA reached out to national experts in both recovery and methadone and in state policies and formed an expert panel that worked with Dr. David Mee-Lee and the folks at the American Society on Addictive Medicine who produced the nationally accepted patient placement criteria. Those encompassing medically based criteria are divided into everything from phases and levels of care to optimal staffing patterns for each. Our expert panel, which included yourself, Lisa, Ira Marion, Walter Ginter and Jocelyn Sue Woods, Drs. Trusandra Taylor, Todd Mandell, Tony Stile, and Laura McNicholas among others took the time to design recovery guidelines for each level of the ASAM phases of care for methadone maintenance. Eric Hulsey of IRETA facilitated the process with me for IRETA. SWBH then took that document and began retraining all of its MM providers on it with the intent to contract on those guidelines and those measures in the very near future. It's been a slower than expected process, but it is evolution and one that will lead to a much wider knowledge of and acceptance for methadone as a medication capable of supporting recovery – not with being on methadone as an end in itself.

Still the issue of medication-supported treatment and recovery, Bill, is far from resolved. Truth be told, a recovery paradigm would seek a more clearly defined and generalizable pathway based on actual experience of the person, how and what medication is used, and how it can support recovery. When used as prescribed, it is medication. Recovery is possible. When used outside of as prescribed, it becomes a drug. This is a fine distinction but one to be further studied and integrated into the recovery approach. Another key factor is achieving "medical stabilization" on one's medication as the launching platform for recovery. Many questions remain but a structure of recovery and medication-supported treatment is emerging that will be more inclusive than exclusive and more uniform with all forms of recovery. It will be a guiding tool for such care lest medication distribution becomes an end in itself. SAMHSA is now focusing more also with its "Medication Assisted Treatment for the 21st Century – Community Education Kit." In the evolution of this area, medication-supported treatment or, as I prefer, medication-supported recovery, much has been advanced but much more is yet to come to light. Nonetheless the pathways to recovery are merging each day via common themes and goals. Medication is critical. Recovery has lots of room in its tent for those whose recovery is sustained by it.

Bill White: *Pennsylvania has witnessed both progressive developments in medication-assisted treatment and some of the most regressive efforts in the country to restrict access to and duration of medication-assisted treatment. How do you explain such contradictory developments?*

Dr. Flaherty: Scientific ignorance, poor knowledge, and fear. Old ways of thinking still lead many to see replacement medications such as methadone as a cop out on recovery. That just isn't so scientifically or experientially. Also poor education on how methadone – or the other replacement medications – work is a culprit. When we did the SWBH project spoken about

earlier, we learned that many citizens believed methadone was for six months – no more. Heck, in most cases, it can take that long to reach medication stabilization let alone completion of care. We had a lot of community education to do, but once we addressed the fears and the realities, folks felt duped by those who first told them about methadone and were angry. Once we got through that and those who successfully were helped by methadone spoke out, whether completely off or still in maintenance, the world changed for the community. If they could see its good – honestly – and its flaws, they had a better choice and could move with science and medical practice and those in the community in recovery who advocated for it. Success always breeds more success, not profit, not medication only, half-truths or quick solutions to complex problems. Worst was that in most cases, individuals seeking help for opiate dependence weren't being offered the full array of treatment possibilities for their illness. There is a full continuum of care for opioid dependence that goes from detox/rehab, to naltrexone to Buprenorphine to Methadone. Those treating opioid dependence should offer the full opioid cycle of care and whatever is most appropriate for each person – not just one, the fastest, or the most profitable. Addiction always is in a hurry. Patient options with clinical matching and recovery thinking need to balance the want with the need. Other issues remain for providers here, Bill. Those in recovery need to speak out; they can help safeguard the day. ROMM is the safeguard here lest we become part of fostering the problem we are seeking to solve.

Recovery Research

Bill White: You have been an outspoken advocate for increased investment in a science of recovery. Why do you see this as so important?

Dr. Flaherty: Without the science, we remain a movement. Movements don't last. This is evolution not a movement or fad. Evolution begs for a science to document and prove it. Our current science is of an illness that is supposed to be biopsychosocial in nature. Some would say biopsychosocial and spiritual in nature. In either case, we have the best biological science of the pathology in the world. We need now to be courageous and learn about the other parts and the inter-lay of all. We both work with countries and experts from all over the world who now use RM and ROSC. How many times have we read they're using it even though, and I quote here, "the evidence base for this lacks rigor." My goodness, the whole paradigm shifted from acute to chronic and from illness to wellness, and we haven't the science with us yet. I believe we have the best minds in the world at NIDA and NIAAA and NIH and HRSA (Health Resources and Services Administration) and so many other agencies and universities but they are afraid to move away from the brain as the focus lest they be seen as conducting soft science and be unfunded. Moreover, I believe they miss the very illness and its cure by defining it so organically and reductionistically. Think of the power of the brain's plasticity to change, of cells to reshape and grow or of the belief that one's personal narrative isn't just in managing pathology. If science truly seeks a cure, it is in the inter-lay of a whole person not only in the organic part of the answer. We need science or we won't evolve. The absence of evolution is status quo or extinction.

Bill White: *Do you think we will see NIDA and NIAAA support for a fully developed recovery research agenda in our lifetimes?*

Dr. Flaherty: Great question. Wow. Tell you what I honestly think. Gosh knows I'm going to get into trouble for saying it. They have the understanding of the pathology down to our genomes and individual probability for the illness. They do. Intergenerational probability, dopamine and hedonic states, mu-receptor actions, etc. It's unbelievable how great the science is and how fast it is growing. But they're seeking a pill for a pill – a sort of pharmacological Holy Grail or ultimate root cause. It won't happen unless we abandon consciousness. And if they don't produce a science of recovery, they will become extinct as failing in their ultimate societal duty. It's mankind's nature to find causes and cures. Finding cures in fact ends up strengthening the science with a better understanding of the illness. It also greatly strengthens and makes prevention more alive and applicable. Where is the science of prevention after 50 years? It's staring us in the face through building family and community recovery capital, that's where it is. Right in front of our very eyes. The Institutes have to become more relevant to daily life, and a recovery agenda does just that.

Perhaps not a full research agenda in our lifetime, Bill, but in our lifetime they will open to the inter-lay and recovery science or they will be changed by losing the very funding they fear they might lose by changing. That's evolution too. That is what I think.

Bill White: *You are now leading a study of prominent recovery pathways. Could you describe this study and what you hope to learn from it?*

Dr. Flaherty: About two years ago, somewhat in frustration with the science being so slow to come along, I enticed you and Ernie Kurtz, two longstanding heroes of mine, and a bright young graduate student, Ariel Larson, at Duquesne University in Pittsburgh trained in qualitative research, as am I, to launch a study of recovery across various pathways to it. I thought if we know about the structure of the illness, can we examine if there is a common structure to its recovery? I'm really the clinician member of the study, and you and Ernie are the absolute best in recovery understanding I know in the world. As a team, we have set out to qualitatively and quantitatively examine six distinct pathways of attained and sustained – for at least 5 years – recovery. With the oversight of the great folks at Chestnut Health Systems' Institutional Review Board (IRB), I now have personally completed interviews with each subject and transcribed them for the team's analyses. Each subject validated or changed the final transcription. We are now in the team analysis and write-up phase and hope to have a final paper for publication by the Fall of 2013.

What we hoped to learn is if there is a set of common themes to attained and sustained recovery, as found across actually lived distinct pathways to it. You might say we are seeking a structure of recovery and a glimpse of any variations in it that may be evident for individuals across the differing pathways to it. It's been a phenomenal process with very rich data and much to be analyzed. It's also been eye-opening to search the worldwide existing literature and find so many wonderful related studies. We hope to present some of that also. Lastly I know we hope to draw out the relevance of any findings both for those seeking recovery and for the practitioners offering treatment and scientists wishing to study it further.

Reflections on Service Integration

Bill White: *There has been a rush to integrate addiction treatment, mental health services, and primary health care. What do you see as the threats and opportunities within these integration initiatives?*

Dr. Flaherty: Conceptually I don't see a threat. Financially I do. Conceptually, we're just getting honest about the mammoth size of the problem in our population and to our society. Yes, if we want to reduce the volume of acute or specialized addiction treatment, we must go up stream and develop earlier screening and intervention and better ways to integrate with mental health and primary or generalist care. That's a sound concept. But we cannot do it by reducing the current vastly unmet needs of those needing specialty addiction treatment. In this sense, there definitely is a resource problem. Our past societal denial is catching up to us. Ok, so be it. Let's face the truth and address the illness wherever it may appear in the least restrictive and most cost efficient but effective manner. To do this with parity and early intervention and true integration of service – without the loss of already known illness and recovery knowledge – is the challenge, the threat, and the opportunity. Here again, Bill, as you have written, recovery can become the "unifying concept" for all at whatever level the illness appears for prevention, intervention, treatment, or recovery. It can, and that is what is now being applied in each community building recovery-oriented systems of care.

The full continuum of care is being greatly expanded today but we simply won't have the resources for all. It's too big of a problem with strong counterforces to the solution. In time, we will get there. In the generalist settings, we will vastly increase access via ACA (Affordable Care Act) and welfare expansion and we will need low-cost but experienced and knowledgeable practitioners to know the nature of the illness and its recovery from those settings. No short cuts to the knowledge others so painfully provided, even in generalist care. Referral then, as warranted, to specialist care with the greater amounts of accountability we spoke of earlier. All of this is strengthened by recovery supports or peer involvement at any level and for continuity of care, cost reduction and improved health, wellness, and recovery. We're certainly not there yet – or even close, but we're going there or so I believe. In time, we may reduce acute demand, but if populations continue to grow, that will be slow. You have to get back to doing what is best for each "star fish" to see the good and the possibility of these new initiatives as the extension of the continuum of care for addiction. We have to do that within the new funding mechanisms and limited resources we have while we address our ways of life that are at root a contributing cause. One star fish at a time.

Bill White: *You have expressed concern about the replacement of addiction-specific language within this new umbrella of behavioral health. Could you share this concern with our readers?*

Dr. Flaherty: Sure. How we language the illness is how we stigmatize those who have it. For example, while often chronic in nature, we don't have reoccurrences of the illness; we have "relapses" to it. When we do a toxicology screen, our results aren't positive but are "dirty" for what might be found. Those who come for help are often looked down on, especially in an ER or within a medical setting, and referred to as "addicts" or "junkies" when they are in reality persons with an addiction and human beings. Just look at our language and you can see much about how we stigmatize the person with the illness who then adopts that stigma as their self-identity. This is not healing medicine. In behavioral health specifically, we must be more precise and advocate for the person who comes to us with an often chronic and recurring illness. This

again is why recovery-focused care is so valuable as in it we can re-language the illness as only part of the person or a way of the person that isn't healthy. But it's not the whole person! In the new DSM-5, you need 3 months abstinence for early remission to be declared. That's a loaded statement if there ever was one. From where does it originate? Why 3 months? Why "early" remission? Why not recovery? When does recovery begin? Gosh, I see a long way to go here, Bill. The way we language the illness eventually becomes the illness and the person. We need to be more careful. We know and can do better. Enough said.

Bill White: *Do you envision a day when addiction treatment services will be available within all primary health care facilities?*

Dr. Flaherty: Yes I do. Not specialty or the more medically acute services but the services that can possibly be effective in those settings yes – if all the PCPs (primary care physicians) don't die from exhaustion first. There is an endangered group if there ever was one, the PCPs. So much is being expected of them now with no real change in status or priority or reimbursement. If we put too much on them too quickly or without other supports, health care reform won't succeed. That said, early screens such as SBIRT (screening, brief intervention and referral to treatment) for alcohol and other drug problems and others for depression, physical abuse, etc. will more than pay for themselves over time, but PCPs and nurses may be too costly to apply them. Again, less expensive health educators or behavioral health therapists can clinically and financially succeed with minimal oversight and positive growth for the practice. Brief addiction treatment at the PCP site has proven to be very effective with those in lower levels of medical severity or dependence. Those who need higher levels of care are referred to addiction specialty care programs. Ongoing care can and I believe will be provided in both generalist and specialty settings as related to overall health concerns and sustained recovery. Peers and clinicians will work together at both settings to relieve demand, lower cost, and sustain wellness and recovery. I see a kind of "anticipatory practice" emerging where all providers and practitioners and peers know what else should be looked for along the trajectory of maintained health and recovery, for example, compliance to meet other health needs, often related triggers to recurrence such as depression, trauma, or physical illness, etc. Anticipatory practice addresses the whole person, and we will need everyone in the picture to do it well.

I also see the other side of this, Bill. We need to put more primary health care (PC) and even day care in our specialty treatment programs if we are to be truly health and cost conscious. That is where the high-cost health care originates. While at St. Francis, we added PC and day care to our methadone program and blew the doors off the program with new women enrollees, so much so that we had to open a separate program for them and their children. So yes, to use ASAM criteria, I do see a "pre" level I care being offered in PC, but I also see more basic medical care being offered in Level I, II, and III specialty care and a much broader medical assessment and after care treatment from Level IV care.

Recent Transition Back to Clinical Practice

Bill White: *You have recently left your role as Executive Director of IRETA to return to clinical practice and consultation. What has it been like for you to return to greater time doing clinical work?*

Dr. Flaherty: It's been great. It gets a little nerve racking at times, but it's been great. I am so blessed to be able to do what I do and to work with the people I do whether in my clinical practice or outside of it. At this point in my life, I am finding more relevance and passion in being on the front lines of treatment and recovery. IRETA was wonderful and the transition from early prison work, St. Francis and everything about systems and policies but now it's about building recovery, RM, and ROSC and daily clinical practice that shows me time and again that it really does work. Besides working with one starfish at a time, I am actively helping a number of communities and counties to build RM and ROSC. I am seeing systems change right before my eyes. Recently, in Ohio, a community hospital was in an ROSC building community meeting with me, and I watched as they, despite a loss in revenue to do so, agreed with the community's desire to avoid the truncated and high cost care of the emergency room for a local referral center with SBIRT and other screens and recovery supports. It was so gratifying to see a community hospital agree to lose revenue in the short run for better client and community outcomes. I recall the hospital medical director stating openly, "I guess this is what we need to do if we are serious about bringing health care costs down." Similarly, in another example, a county jail and judges agreed to transfer a significant part of funds for their jails to outpatient community programs with recovery linkages. The cost savings from the jail was used to help expand outpatient and recovery services for the overall growth of service to the community. This too was courageous and was seen as much more possible because the community was doing it and those in recovery were at each step. This is health care reform. It's slow but so very meaningful and productive as we bring science and best practice to real life application.

Bill White: *Has this return to clinical work offered any fresh perspectives on RM and ROSC?*

Dr. Flaherty: None that I haven't already stated. At the end of the day, we all must ask ourselves "why" we do what we do? In the answer lies everything about who we are. RM and ROSC and good practice give me that daily. Doing it, I sleep well at night and arise with eagerness each day – even at 65. I only hope we continue to advance and don't lose our healing purpose in society for some Darwinian cost pacification of the problem such as "it's their choice to use, let them live it" or "give them what they want and control and profit from it." Addiction doesn't always grant a choice and no one should be seen as that expendable by health care or society. Recovery and wellness are the return to our best possible self and what is odd is that in its application, it works both for the person and the provider.

Closing Reflections

Bill White: *What do you feel best about when you reflect on your work promoting recovery research and increased recovery orientation of addiction treatment?*

Dr. Flaherty: The people I have met and been blessed to work with. No question. Each starfish. I have often felt like a miner going into a dark coal mine only to find nuggets of gold instead – if I kept working at it and had the courage to keep going beyond the last comfort zone. Also to keep my mind open knowing the more I got to see, the greater was the responsibility to learn more and use it. And then, when I became uncertain, which often happened, I would reach out to others in the mine that might be on a similar journey. No two journeys are ever the same but being with others was often so reassuring and encouraging even if in criticism. Don't be alone in

the unknown, but don't be afraid to go there. Someone is always close by. Lastly, my personal mantra was always to be quietly competent, i.e., more out of the limelight. By that, I believe never to do things for myself but for others and with others and as they succeeded, so then might I. In fact, I see actions as better prayers than words, Bill. More existential faith and hope is involved. It's a spiritual path this life. We're not perfect by any means and are really very fallible, but that doesn't preclude learning and progress from that fallibility, or as Ernie Kurtz would say, finding the spirituality in our imperfection.

Bill White: *Those of us who have had the pleasure of working with you often comment on your contagious optimism. How have you maintained such optimism for all of these years?*

Dr. Flaherty: It's that spirituality. It's hard not to be upbeat when finding that daily in your life's work. Of course, as you know, Bill, I'm a person who has suffered with bouts of depression and PTSD over the years so it might be mania! I don't think so though. That comes when you've gone too far. But then sometimes the pieces of life do fit, sometimes you do move the mountain instead of it beating you, sometimes another comes to share the challenge or just ask what they can do, it's all pretty exciting when you think about it. Is that optimism?

Bill White: *Do you have a priority list of things you want to accomplish in the years ahead?*

Dr. Flaherty: One starfish at a time. Refine myself and my focus. Give back and have the guts to accept. Keep working on building recovery-focused care and building it person by person, community by community. Leave my campsite better than I found it.

Bill White: *Dr. Flaherty, thank you for all that you do and for your enduring friendship.*

Dr. Flaherty: Thank you Bill. The privilege has been all mine.

Acknowledgement: Support for this interview series is provided by the Great Lakes Addiction Technology Transfer Center (ATTC) through a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT). The opinions expressed herein are the view of the authors and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA or CSAT.