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**Citation:** White, W. (2009). Executive Summary: Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices. *Counselor*, 10(1), 24-32. Posted at [www.williamwhitepapers.com](http://www.williamwhitepapers.com)

## **Executive Summary: Recovery Management and Recovery-oriented Systems of Care: Scientific Rationale and Promising Practices**

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**Prologue by Arthur C. Evans, PhD Epilogue by Lonneta Albright and Michael Flaherty, PhD Introduction**

For the past decade, I have penned articles for *Counselor* that called for a fundamental redesign of addiction treatment. That redesign would extend treatment from an acute—an ever briefer--model of biopsychosocial stabilization to a model of long-term recovery management. Through the support of the Northeast Addiction Technology Transfer Center, the Great Lakes Addiction Technology Transfer Center and the Philadelphia Department of Behavioral Health and Mental Retardation Services, I have completed a review of the scientific evidence supporting this recoveryfocused transformation of addiction treatment and outlined the changes in clinical practice suggested by this research. The findings and recommendations are now available in a 138-page monograph that includes a prologue by Arthur C. Evans Jr., PhD, an epilogue by Lonneta Albright and Michael Flaherty, PhD, and more than 800 research citations. A free PDF of the monograph for downloading and hard copies for purchase are available at [www.ireta.org](http://www.ireta.org). The new monograph:

- defines and distinguishes acute care and recovery management models of addiction treatment,
- defines and distinguishes the terms recovery management and recovery-oriented systems of care,
- identifies recovery-focused performance measures (e.g., access, engagement, retention, service scope, service duration, linkage to communities of recovery, and post-treatment monitoring and support) that can be used to evaluate addiction treatment as a system of care and evaluate the performance of local organizations specializing in the treatment of severe alcohol and other drug (AOD) problems,

- presents findings from studies of addiction treatment and from national and state addiction treatment data collection systems related to the identified performance measures,
- highlights promising practices aimed at improving long-term recovery outcomes, and
- suggests measures that can be used to evaluate addiction treatment at both macro (system of care) and micro (individual program/unit/worker) levels of performance.

What follows is an executive summary of this monograph prepared for the readers of *Counselor*. I hope it will provide an opportunity to reflect on your own understanding of addiction treatment and recovery. I also hope it will stir sustained discussion and debate and spark new initiatives to widen the pathways to recovery for those individuals and families who are still suffering.

## **Executive Summary**

### **Chapter One Modern Addiction Treatment: Emergence and Evolution of an Acute Care Model**

- Addiction (severe alcohol and drug dependency) shares many of the defining characteristics of chronic primary illnesses, e.g., 2 diabetes mellitus, hypertension, and asthma.
- Characterizing addiction as a chronic illness does not mean that all AOD problems have a prolonged course requiring professional treatment, that full recovery is not possible, or that self-management responsibilities are in any way diminished.
- Although long characterized as a chronic disorder, addiction has been treated in an essentially acute care (AC) model of treatment.
- The AC model of addiction treatment is characterized by its crisislinked point of intervention, brief service duration, singular focus on symptom suppression (achievement of abstinence), professionally dominated decision-making, complete post-treatment termination of the service relationship, and expectation for full and permanent problem resolution following “graduation.”
- The development of the modern AC model of addiction treatment grew out of the medicalization, professionalization, and commercialization of addiction treatment and the subsequent growth of managed behavioral health care in the United States.

### **Chapter Two: The Momentum for Change**

- The AC model of specialized addiction treatment has measurable positive effects when compared to no intervention or alternative nonspecialized interventions, but these effects vary widely by program, counselor, and population served.
- A growing body of outcome data suggests that marketing of the AC model has oversold what individuals, families, and referral sources can expect from a single episode of brief, specialized treatment of severe AOD problems.
- Challenges to the AC model and calls for a more sustained recovery management (RM) model have come from multiple sources: a new grassroots recovery advocacy movement, disillusioned purchasers of care, research data on limitations of the AC model, positive evaluations of RM model components (e.g., recovery checkups), and from excitement generated by recent “recovery-oriented systems transformation” pilots, e.g., State of Connecticut and City of Philadelphia.
- “Recovery-oriented systems of care” (ROSC) are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and

families impacted by severe substance use disorders. The system in ROSC is not a local, state, or federal treatment agency but a macro level organization of a community, a state, or a nation.

- “Recovery management” (RM) is a philosophical framework for organizing addiction treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality of life enhancement for individuals and families affected by severe substance use disorders.

### **Chapter Three: Recovery-focused System Performance Measures**

- Interest is rapidly growing in the development of formal, systemslevel performance measures for addiction treatment.
- Recovery-focused performance measures include three dimensions of systems evaluation: 1) measures of infrastructure stability and adaptive capacity, 2) recovery-focused service process measures, and 3) long-term recovery outcome measures.
- Infrastructure stability and adaptive capacity reflect the capacity of an organization to undergo systems transformation processes (e.g., from an AC to an RM model of care) and the capacity of an organization to fulfill its commitment for continuity of contact and support over time to individuals and families seeking long-term recovery.
- Recovery-oriented service process measures are intermediary outcomes (e.g., early identification, engagement, service retention, etc.) that are linked to the final goal of long-term individual and family recovery.
- Long-term recovery outcomes measures represent the major fruits of recovery, defined here as the resolution of alcohol and other drug problems; the progressive achievement of global (physical, emotional, relational) health; and citizenship (elimination of threats to public safety; life meaning and purpose, self-development, social stability, and social contribution).
- Summary: Recovery-Focused System Performance Measures I. Infrastructure Strength and Adaptive Capacity A. Recovery Representation/Orientation B. Organizational Health and Stability C. Health and Stability of Administrative/Clinical Leadership D. Cultural/Political Status E. Capitalization, Funding Diversification F. Availability of Funding Streams for Sustained Support G. Financial Stewardship H. Institutional Relationships I. Workforce Composition and Stability J. Technological Capabilities K. Adaptive Capacity
- II. Recovery-focused Service Process Measures A. Treatment attraction and access B. Screening, assessment, and level of care placement C. Composition of the service team D. Service relationship (engagement, retention and discharge status) E. Service dose, scope, and quality F. Locus of service delivery / Influence on the post-treatment recovery environment G. Assertive linkage to communities of recovery H. Post-treatment monitoring, support, and early re-intervention
- III. Recovery Outcome Measures A. Pre-post treatment changes in: AOD use/consequences, Living environment, Physical health and health care costs, Emotional health, Family relationships and family health, Citizenship (legal status, education, employment, community participation, community service), and Quality of life (spirituality, life meaning, and purpose) B. Post-treatment Service/Support Utilization Patterns, Utilization of professional services, Utilization of indigenous recovery support institutions C. Changes in Family and Community Recovery Capital

## **Chapter Four: The Infrastructure of Addiction Treatment**

- Measurable elements of addiction treatment infrastructure required to fully implement a RM model include recovery orientation and representation, leadership stability, an esteemed status of addiction treatment as a cultural and community institution, capitalization and funding diversification, availability of funding streams for sustained recovery support, financial stewardship, organizational stability, workforce stability, technological capabilities, and adaptive capacity.
- Recovery advocates perceive a historical weakening of the recovery orientation of addiction treatment programs; in their view, addiction treatment has become detached from the larger and more enduring process of long-term recovery.
- The extension of the AC model of treatment to a RM model will require repositioning addiction treatment as a cultural institution and re-educating the public and policymakers about the nature of addiction and its treatment.
- The shrinking proportion of health care resources devoted to addiction treatment and the growing reliance on governmental funding for treatment will limit the resources, and demand effective stewardship of the resources, that can be mustered to support systems transformation efforts.
- The move to a RM model will require substantial changes in funding policies and mechanisms to facilitate the development of long-term recovery support services.
- Challenges to systems transformation efforts include the instability of addiction treatment organizations, the mass exodus of long-tenured leaders within the addiction treatment field, and the lack of systemwide programs of leadership development and succession planning.
- Assuring continuity of contact in long-term recovery support relationships will require reversal of the currently high annual turnover rate of the addiction treatment workforce.
- Efforts to create ROSC and to shift local treatment agencies toward a RM orientation will require tandem efforts to strengthen the national infrastructure of addiction treatment in the United States and the infrastructures of local addiction treatment service providers. Lacking such efforts, ROSC and RM will constitute only a new rhetoric and isolated pockets of innovation rather than a true transformation of the system of care.

## **Chapter Five: Who Receives Addiction Treatment? The Variability of AOD Problems and Their Patterns of Resolution**

- There are marked differences between AOD problems as seen in the larger community and those seen in specialty-sector addiction treatment settings.
- Those with AOD problems seen in clinical settings are marked by greater personal vulnerability; greater problem severity, complexity, and chronicity; and less recovery capital.
- Strategies of natural recovery, moderated resolution of AOD problems, and resolution of AOD problems through brief intervention that are quite viable in community populations have less utility with the clinical population now entering addiction treatment in the United States.
- The effective treatment of AOD problems requires a clear formalization and delineation of strategies distinguishing transient and less severe AOD problems from AOD problems of great severity, complexity, and chronicity.
- The most fundamental issue facing the field of addiction treatment is whether the field claims ownership of all AOD-related problems (and changes its treatment philosophies and service practices to fulfill that claim) or claims only a portion of AOD-related problems

(e.g., only substance use disorders or only substance dependence), leaving less severe AOD problems to other social institutions. Chapter Six Treatment Attraction and Access

- Only 10% of persons meeting criteria for a substance use disorder receive specialty sector addiction treatment in any year, and only 25% of persons meeting criteria for a substance use disorder will receive such specialized treatment in their lifetime.
- Multiple factors impede help-seeking for AOD problems: misperceptions of the severity of AOD problems; misjudgments regarding self-capabilities to resolve AOD problems, the cost of professional treatment, treatment-related social stigma, the lack of critical treatment supports such as transportation or day care, and resistance to complete abstinence as the only proffered treatment goal across levels of problem severity.
- The AC model voluntarily attracts only a small percentage of persons admitted to addiction treatment, with most persons entering treatment under external coercion at a late stage of problem development.
- High pre-treatment dropout rates (initial contact without service initiation—ranging from 25-50%) are linked to personal ambivalence, lack of geographical or financial access, waiting lists, and personal obstacles to participation.
- Promising practices related to increased attraction and access include social marketing of AOD problem resolution options and successes, assertive models of outreach, lowered thresholds of engagement, interim services for those on waiting lists, short-term case management to enhance engagement, regular check-ups for those resisting immediate service entry, telephone prompts through the early engagement process, family mobilization strategies, extended clinical hours, and delivery of services in non-stigmatized sites.

## **Chapter Seven: Screening, Assessment, and Level of Care Placement**

- Early screening and brief interventions for AOD problems are effective strategies of reaching persons with AOD problems who are involved in non-specialized community-based service settings, particularly primary health care settings.
- RM models of assessment differ from the AC models in key dimensions: assessment processes are global rather than categorical; define the individual, family, and community as the unit of assessment rather than just the individual; are asset-based rather than problem- or deficit-based; and constitute a continuing process rather than a point-in-time (intake) event.
- Where level of care decisions in the AC model focus primarily on problem severity and complexity, such decisions in the RM model are heavily influenced by the assessment of personal, family, and community recovery capital.
- Promising practices related to screening, assessment, and placement include AOD problem screening in primary care settings, internetbased screening services, use of standardized global assessment instruments, family-focused assessment protocol, and regular community-level recovery resource mapping.

## **Chapter Eight: Composition of the Service Team**

- The extension of AC models of addiction treatment to RM models involves increased involvement of medical, psychiatric, and other allied professionals and the development of peer-based recovery support services.
- There are a growing number of individuals and families with long, complex service careers within multiple systems who, despite the massive investment of dollars in crisis stabilization, exhibit minimal progress towards long-term recovery.

- RM models of care emphasize multi-agency models of intervention and embrace a larger goal of breaking intergenerational cycles of problem transmission, thus providing a framework for the integration of primary prevention, early intervention, treatment and long-term recovery support strategies.
- Promising practices that enhance service team composition include providing primary medical/psychiatric care in tandem with addiction treatment; the use of recovery coaches to provide continuity across levels of care; increased use of volunteers; and the creation of multiagency, multi-disciplinary service teams.

## **Chapter Nine: Service Relationship (Engagement and Retention)**

- Pre-treatment dropout rates in addiction treatment exceed 50% of those who initially call regarding services.
- Less than half of persons admitted to addiction treatment successfully complete treatment.
- The percentage of clients administratively discharged from addiction treatment, most for confirming their diagnosis (using alcohol or other drugs while in treatment), has ranged from 10-16% in recent years— between 200,000 and 320,000 individuals per year.
- Those persons who do not complete addiction treatment, both those who drop out and those who are extruded, include those who are in greatest need of such treatment.
- The service relationship in the transition for the AC model to the RM model shifts from that of professional expert to sustained recovery consultant.
- Promising practices in enhancing engagement and retention include the use of motivational interviewing, using senior staff to induct new enrollees into treatment, participation incentives, altering administrative discharge policies and practices, using a choice philosophy to expand the range of client decision-making, increasing the focus on therapeutic alliance in training and supervision, and monitoring engagement indicators by service unit and by individual counselors.

## **Chapter Ten: Service Dose, Scope, and Quality**

- Length of service contact is the best single predictor of post-treatment addiction recovery status.
- Length of time in treatment has decreased through the modern evolution of addiction treatment, rendering the service relationship within the AC model of treatment ever more transient.
- The majority of clients discharged from addiction treatment in the United States receive less than the 90 days of service contact (across levels of care) recommended by the National Institute on Drug Abuse.
- Expanding the scope of ancillary medical, psychiatric, and recovery support services in addiction treatment can elevate long-term recovery outcomes, but such service comprehensiveness is not the norm within the addiction treatment service sector.
- Progress is being made integrating evidence-based practices within mainstream addiction treatment, but treatment methods continue that are ineffective or potentially harmful.
- Promising practices related to the dose, scope, and quality of addiction treatment services include greater use of stepped care, more assertive linkage to recovery support groups and post-treatment recovery support institutions (e.g., recovery homes, recovery schools, and recovery ministries), co-location of medical/psychiatric/social services, increased emphasis on evidence-based treatments, increased monitoring of fidelity to preferred

service methods via clinical supervision, and increased communication between clinicians and researchers.

## **Chapter Eleven: Locus of Service Delivery Influence on Post-treatment Recovery Environment**

- Most addiction treatment services are institution-based; service providers have little contact with the natural environments of the individuals and families who consume their services.
- Post-treatment family and social environments play significant roles in the long-term recovery process.
- Recovery can potentially destabilize intimate and family relationships that have survived the wounds inflicted by addiction.
- Families can benefit from extended post-treatment monitoring and support.
- Clients deeply enmeshed in drug cultures face special challenges in transitioning from recovery initiation in institutional settings to recovery maintenance in their natural environments.
- Greater attention needs to be focused on the ecology of long-term recovery.
- Promising practices related to locus of service delivery and shaping the post-treatment recovery environment include assertive linkage to communities of recovery, home- and neighborhood-based services, abstinence-based social clubs, recovery support centers, development and/or use of recovery homes and recovery schools, use of indigenous healers and institutions (e.g., folk healers, recovery ministries), and use of consumer council and alumni association members to conduct street outreach and recovery coaching.

## **Chapter Twelve: Assertive Linkage to Communities of Recovery**

- Participation in recovery mutual aid groups can elevate long-term recovery outcomes for diverse populations.
- The effects of recovery mutual aid involvement reflect multiple mechanisms of change and vary by the number of meetings in early recovery, duration of participation, and intensity of participation.
- Combining addiction treatment and recovery mutual aid for persons with severe substance use disorders is more effective than either used alone.
- The positive effects of recovery mutual aid groups are compromised by weak linkage and a progressive attrition in participation over time.
- Half of all clients completing treatment do not participate in recovery support groups after discharge, and of those who do, 40-60% discontinue participation within a year of treatment discharge.
- Assertive linkage to a recovery support group is more effective than passive referral (verbal encouragement to attend), but the linkage process in most treatment programs is of the passive variety.
- Participation in other recovery community institutions (e.g., recovery homes, recovery schools, recovery industries, recovery support centers, recovery ministries/churches) may enhance long-term recovery, but evaluation of these other support institutions is at an early stage.
- Promising practices related to linkage to communities of recovery include enhanced institutional linkages between treatment institutions and communities of recovery, use of assertive linkage procedures, orientation and linkage to internet-based recovery support

groups, and expanding treatment philosophies to embrace diverse religious, spiritual, and secular pathways of recovery.

### **Chapter Thirteen Post-treatment Monitoring, Support, and Early Re-intervention**

- Post-treatment monitoring and support can significantly elevate long-term recovery outcomes.
- Only a small percentage (20-36%) of adolescents and adults completing addiction treatment receive post-treatment continuing care.
- RM models of continuing care are distinguished from AC models by several critical factors: Post-treatment monitoring and support is provided to all clients, not just those who successfully complete treatment; responsibility for continued contact is with the service staff rather than the client; saturated support is provided in the first 90 days following discharge from treatment; and “recovery check-ups” are provided for an extended period of time (up to five years).
- The timing and duration of post-treatment support exert a greater influence on long-term recovery outcomes than the total number of support contacts or the length of each support contact.
- The telephone and the internet constitute two underutilized media for post-treatment monitoring, support, and early re-intervention.
- Promising practices related to post-treatment monitoring and support include enhancements aimed at participation (behavioral contracts, prompts, escorts, financial incentives), removing barriers to participation, extending time-span of support via recovery check-ups, telephone- and internet-based systems of continuing care, and expanding the range of environments in which continuing care occurs, e.g., home- and work-based follow-up.

### **Chapter Fourteen: Post-treatment Recovery Outcomes**

- Reported treatment outcomes vary by definitions of key measures, e.g., abstinence, sobriety, recovery, lapse, relapse, and success.
- Post-treatment evaluations consistently report improved odds of sustained abstinence, reduced AOD consumption by those who use, a reduction in AOD-related problems, and reductions in crime and risk of HIV infection.
- The majority (over half) of people completing specialized addiction treatment in the United States resume some AOD use in the year following treatment.
- Post-treatment relapse rates are higher for men, adolescents, persons dependent on opiates, and persons with co-occurring substance use and psychiatric disorders.
- Between one-fourth and one-third of all clients discharged from addiction treatment will be readmitted to treatment within one year, and 50% will be readmitted within two to five years.
- The majority (64%) of those entering publicly funded treatment in the United States already have one or more prior admissions, including 22% with three to four prior admissions and 19% with five or more prior admissions.
- Clients discharged from addiction treatment have high post-treatment mortality rates—1.6 to 4.7 times greater than age-matched populations without substance use disorders.
- Stable recovery can be preceded by years of cycling in and out of sobriety experiments.
- Evaluations of specialized addiction treatment also reveal potential iatrogenic (harmful) effects of treatment.



- The potential for long-term recovery outcomes from substance use disorders is affirmed by population studies noting recovery rates of 50% or higher, but the process of achieving such recoveries is more complex than often portrayed.

## **Chapter Fifteen: A Closing Reflection: Recovery, Science, and Systems Transformation**

- Findings from scientific studies and systems performance data support extending the acute care model of intervention into severe AOD problems to a model of sustained recovery management.
- The findings support addiction treatment system redesign efforts focused on infrastructure enhancement; early intervention and improvements in service access and therapeutic engagement; improved systems of individual, family, and community assessment; broadening institutional and professional resources involved in service delivery; shifting the service relationship to a partnership model; elevating the scope, duration, and quality of services; assertively linking individuals and families to communities of recovery; providing post-treatment monitoring, support, and early re-intervention services for all clients/families for up to five years following completion of primary treatment; and the systematic collection of long-term, post-treatment recovery outcomes for all clients/families admitted to addiction treatment programs.
- Selected states, local communities, and addiction treatment institutions have already begun this recovery-focused systems transformation process.
- Model components of the recovery management model (e.g., assertive outreach, enhanced service access, evidence-based service ingredients, and recovery check-up pilots) are already in operation that could be refined for system-wide implementation.
- An existing model of intervention and long-term support that incorporates many dimensions of the recovery management model is the network of Physician Health Programs in the United States whose evaluations have revealed the highest long-term recovery rates reported in the scientific literature.
- It is time we proactively managed the prolonged course of addiction and recovery careers rather than focusing on self-encapsulated episodes of biopsychosocial stabilization.

**About the Author:** William L. White is a Senior Research Consultant at Chestnut Health Systems and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. He has worked full time in the addictions field since 1969.

**Note:** The monograph summarized here was prepared with the support of the Philadelphia Department of Behavioral Health and Mental Retardations Services, the Northeast Addiction Technology Transfer Center, and the Great Lakes Great Lakes Addiction Technology Transfer Center under a cooperative agreement from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). The opinions expressed herein are the views of the author and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA, or CSAT.