Guiding Principles and Elements of Recovery-Oriented Systems of Care:

What do we know from the research?

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Table of Contents

1. Background

The concept of recovery lies at the core of the Substance Abuse and Mental Health Services Administration's (SAMHSA's) mission, and fostering the development of recovery-oriented systems of care and services is a Center for Substance Abuse Treatment (CSAT) priority. In support of that commitment, in 2005, SAMHSA's CSAT convened a National Summit on Recovery. Participants at the Summit represented a broad group of stakeholders, policymakers, advocates, consumers, clinicians, and administrators from diverse ethnic and professional backgrounds. Although the substance use problems and disorders treatment and recovery field has discussed and lived recovery for decades, the Summit represented the first broad-based national effort to reach a definition of recovery and a common understanding of the guiding principles of recovery and the elements of recovery-oriented systems of care.

Through a multistage process, key stakeholders formulated guiding principles of recovery and key elements of recovery-oriented systems of care. Summit participants then further refined the guiding principles and key elements in response to two questions: 1) What principles of recovery should guide the field in the future? and 2) What ideas could help make the field more recovery oriented?

A working definition of recovery, 12 guiding principles of recovery, and 17 elements of recovery-oriented systems of care emerged from the Summit process; these are subsequently defined in this paper and in the *National Summit on Recovery: Conference Report*.[1] These principles and elements can now provide a philosophical and conceptual framework to guide SAMHSA/CSAT and other stakeholder groups and offer a shared language for dialog.

Summit participants agreed on the following working definition of recovery:

> *Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life.*

The guiding principles that emerged from the Summit are broad and overarching. They are intended to give general direction to SAMHSA/CSAT and other stakeholder groups as the treatment and recovery field moves toward operationalizing recovery-oriented systems of care and developing core measures, promising approaches, and evidence-based practices. The principles also helped Summit participants define the recovery-oriented elements and guided recommendations for the field.

Following are the 12 guiding principles identified by participants (defined in this paper):

- There are many pathways to recovery.
- Recovery is self-directed and empowering.

- Recovery involves a personal recognition of the need for change and transformation.
- Recovery is holistic.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.
- Recovery emerges from hope and gratitude.
- Recovery involves a process of healing and self-redefinition.
- Recovery involves addressing discrimination and transcending shame and stigma.
- Recovery is supported by peers and allies.
- Recovery involves (re)joining and (re)building a life in the community.
- Recovery is a reality.

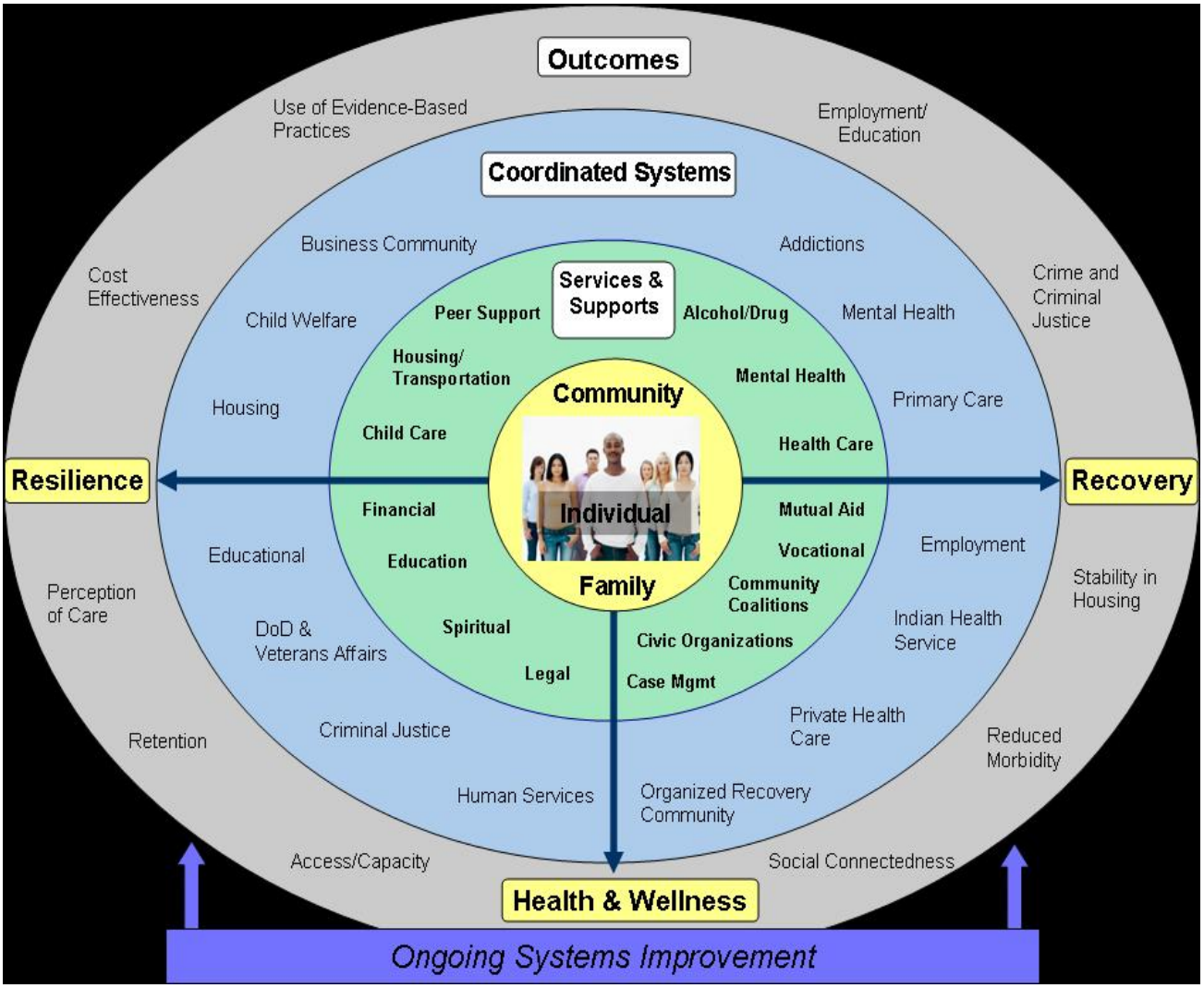
Participants at the Summit agreed that recovery-oriented systems of care are as complex and dynamic as the process of recovery itself. They are designed to support individuals seeking to overcome substance use problems and disorders across their lifespan. Participants at the Summit declared, "There will be no wrong door to recovery" and also recognized that recovery-oriented systems of care need to provide "genuine, free and independent choice" among an array of treatment and recovery support options. Services should optimally be provided in flexible, unbundled packages that evolve over time to meet the changing needs of recovering individuals. Individuals should also be able to access a comprehensive array of services that are fully coordinated to provide support to individuals throughout their unique journeys to sustained recovery.

Summit participants identified the following 17 elements of recovery-oriented systems of care and services (defined in this paper):

- Person-centered;
- Inclusive of family and other ally involvement;
- Individualized and comprehensive services across the lifespan;
- Systems anchored in the community;
- Continuity of care;
- Partnership-consultant relationships;
- Strength-based;
- Culturally responsive;
- Responsiveness to personal belief systems;
- Commitment to peer recovery support services;
- Inclusion of the voices and experiences of recovering individuals and their families;
- Integrated services;
- System-wide education and training;
- Ongoing monitoring and outreach;
- Outcomes driven;
- Research based; and
- Adequately and flexibly financed.

Work conducted after the Summit defined recovery-oriented systems of care as networks of organizations, agencies, and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders. Figure 1 illustrates the components of the recovery-oriented systems of care framework.

Figure 1: Conceptual Framework of a Recovery-Oriented System of Care



2. Purpose Statement

The purpose of this white paper is to review the research related to the 12 guiding principles of recovery and the 17 elements of recovery-oriented systems of care developed through the National Summit on Recovery. It also offers an appraisal of scientific literature discussing the recovery-oriented systems of care conceptual framework and literature on recovery-oriented service and systems implementation.

Policymakers, providers, practitioners, researchers, recovery support staff, and others interested in the concepts of recovery and recovery-oriented systems of care and services frequently seek data to inform policy development, planning, and program and systems development. This white paper has been prepared as a resource to those seeking information on the research related to recovery.

States, communities, and organizations across the nation are developing and implementing recovery-oriented services and systems. In this paper, they will find evidence that supports and validates services and systems improvements based on recovery-oriented approaches.

Finally, this paper establishes a baseline of existing research upon which the treatment and recovery field can continue to build an understanding of recovery and recovery-oriented systems of care. This paper also identifies areas in the recovery research where additional data are needed.

3. Methodology

Studies included in this paper were identified by searches of electronic bibliographic databases (PsychINFO, PubMed) as well as citations in published studies. Using keywords and established selection criteria related to the principles and systems elements, we conducted a computerized search of health, addictions, financial, and trade journals and newsletters. Many relevant studies were identified. This paper includes a review of research related to recovery-oriented systems of care and services for addiction published in peer-reviewed journals, books, and government publications within the past 20 years, with a focus on the last 10 years.

4. Research Supporting the Conceptual Framework of Recovery-Oriented Systems of Care

Recovery has been called the "organizing construct" for the addictions field.[2] Recently, a conceptual framework that describes and coordinates the delivery of care for individuals with substance use problems and disorders has begun to emerge. Recovery-oriented systems of care are networks of organizations, agencies, and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders. Although States and communities are implementing a variety of services and activities to create recovery-oriented systems, there is minimal research in peer-reviewed journals that examines the framework and the effectiveness and outcomes of this framework. Research is beginning to emerge within the mental health and addictions field related to the recovery-oriented systems of care framework, but the literature is scant. Systems of care research in the addictions field, although conducted within a treatment construct, provides helpful systems information. This section outlines research from the addictions and mental health fields supporting the recovery-oriented systems of care framework, supplemented by research on a systems of care approach within a treatment construct.

In a 2005 article in the *Psychiatric Rehabilitation Journal*, O'Connell, Tondora, Croog, Evans, and Davidson [3] conducted a comprehensive review of the literature on mental illness and addictions recovery that identified the elements of a recovery-oriented environment. According to the authors, a recovery-oriented environment is one that:

- Encourages individuality;
- Promotes accurate and positive portrayals of psychiatric disability while fighting discrimination;
- Focuses on strengths;
- Uses a language of hope and possibility;
- Offers a variety of options for treatment, rehabilitation, and support;
- Supports risk-taking, even when failure is a possibility;
- Actively involves service users, family members, and other natural supports in the development and implementation of programs and services;
- Encourages user participation in advocacy activities;
- Helps develop connections with communities; and
- Helps people develop valued social roles, interests and hobbies, and other meaningful activities.

Gagne, White, and Anthony in a 2007 article in the *Psychiatric Rehabilitation Journal* describe the recovery vision and the values of recovery-oriented care that intersect the addiction and mental health fields:[4]

- Recovery is a personal and individualized process of

growth that unfolds along a continuum, and there are multiple pathways to recovery.

- People in recovery are active agents of change in their lives and not passive recipients of services.
- People in recovery from mental illness and/or addiction disorders often note the important role of family and peer support in making the difference in their recovery.
- The values of recovery-oriented mental health and addictions systems are based on the recognition that each person is the agent of his or her own recovery and all services can be organized to support recovery. Person-centered services offer choice, honor each person's potential for growth, focus on a person's strengths, and attend to the overall health and wellness of a person with mental illness and/or addiction.

The authors conclude their discussion by presenting a synopsis of where the mental health and addictions fields concur on how to redesign the systems to assist people in their recovery from mental illness and/or addiction (some are extracted here). According to the authors, recovery should serve as the organizing construct for service provision and for systems improvement.

Additionally, to overcome the limitations of the current acute care model for delivering treatment services, it should be shifted to a community model, where recovery-oriented services are provided in communities, in specific environments of need, and be provided by professionals, family members, and peers. Services are structured to address the long-term and complex needs of people living with addiction and mental health issues. Moreover, to create and operate a recovery-oriented system it should include:

– Principles, e.g., multiple pathways to recovery, recovery is supported by peers, and recovery is non-linear;
– Values, e.g., person-centered services, client choice and, focus on health and wellness;
– Service strategies, e.g., treatment, post-treatment monitoring, early re-intervention, and community support; and
– Essential strategies, e.g., treatment, peer and community support, legal aid, basic support and family formation.[5]

Substance use problems and disorders are preventable and treatable chronic conditions. One aspect of providing recovery-oriented services is the shift from acute care methods to the broader adoption of chronic care strategies throughout the systems of care. Multiple articles have been published in which researchers provide a discussion of the chronic care conceptual framework and the effectiveness of addictions treatment.[6-27] Research in the addictions field uses the treatment system as its organizing construct. Within the recovery-oriented systems of care framework, although the treatment system is central, it is but one of multiple systems. To

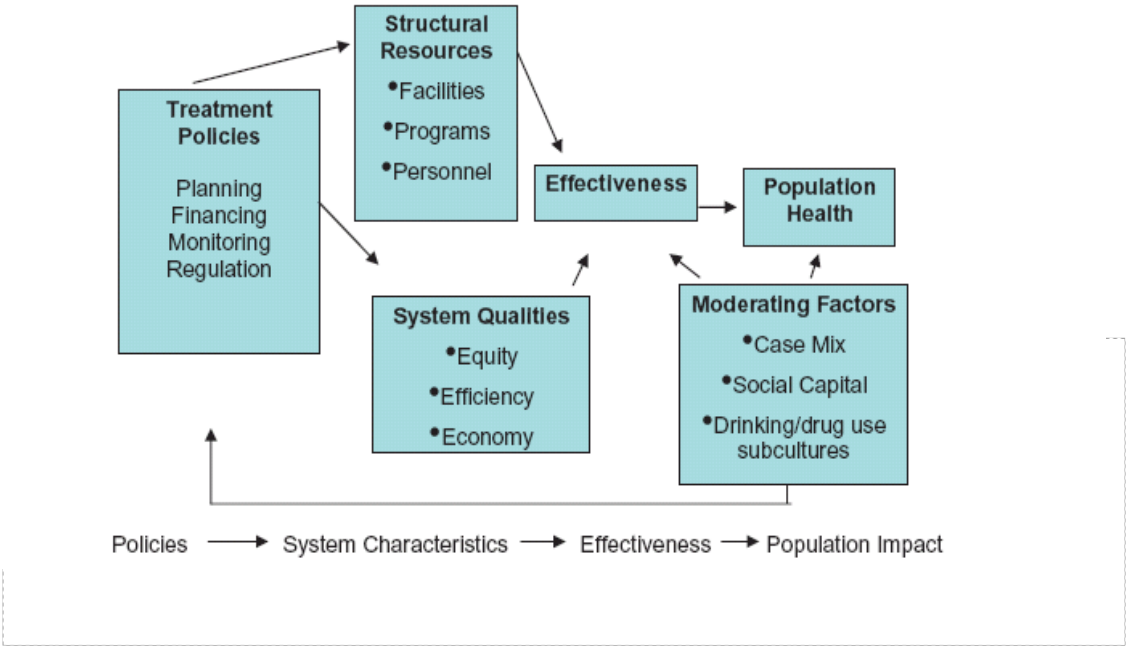
illustrate this point, research suggests that the service systems that support the initiation of recovery may be different from those that sustain recovery. [28-30]

The life course perspective on drug use is a conceptual framework for understanding drug use trajectories. This framework classifies varying drug use trajectories, identif[ies] critical events and factors contributing to the persistence or change in drug use, analytically order[s] events that occur during the lifespan, and determin[es] contributory relationships". [31, p.515] Hser, Longshore, and Anglin (2007), in presenting the life course perspective on drug use, discuss the evidence demonstrating the multiple service systems that drug users often come in contact with, including drug treatment, criminal justice, mental health, welfare, and primary health. They further state that the interactions with the varied social services system can "trigger turning points" for some individuals and aid in recovery. [32] Turning points are changes in an existing life pathway initiated earlier in one's life and can be positive (e.g., cohesive marriage, meaningful work) or negative (e.g., incarceration, heavy drinking or drug use). The authors' framework incorporates the "patterns or trajectories of drug use across individuals' lives and the ways in which the patterns are shaped by a broader historical context and social structures." [33,p.517]

Babor, Stenius, and Romelsjo (2008) describe elements of a public health approach and conceptual model for the delivery of services and the service systems for people with substance use problems and disorders. [34] The authors primarily focus on the importance of treatment as the organizing construct of the service systems. The model includes specialized services for alcohol and drug dependence as well as medical care and social welfare services that interact with and complement specialized alcohol and drug services. [35] The model also includes the mediators (treatment policies) and moderators contributing to successful outcomes.

The model (Figure 2) outlines the structural resources and qualities of alcohol and drug treatment systems and includes the policy determinants and the population impact of treatment systems. The policy determinants include authoritative decisions made by governmental agencies and legislative policies, regulatory and allocative policies, treatment policies, and system qualities.

Figure 2: Conceptual Model of Population Impact of Treatment Systems



In this model:[36]

- Treatment policies are authoritative decisions made by governmental agencies that affect the planning, financing, and monitoring of drug and alcohol services, as well as the development of a professional workforce to operate them.
- Regulatory and allocative policies are major determinants of the structural resources available to treat persons with substance use problems and disorders, including the number of facilities, the types of programs (e.g., detoxification, methadone maintenance, therapeutic communities), the settings where programs operate (e.g., hospitals, social service agencies, specialized drug and alcohol facilities) and the personnel who work there (e.g., drug and alcohol counselors, social workers, psychiatrists, psychologists).
- Treatment policies may also affect system qualities, specifying not only where services are located, but also how they are organized and integrated. System qualities include equity (the extent to which services are equally available and accessible to all population groups), efficiency (the most appropriate mix of services), and economy (the most cost-effective services).

As demonstrated by Babor et al., individuals receive alcohol and drug services from a variety of systems, including the specialized alcohol and drug service system; the medical, psychiatric, criminal justice, and social services systems; mutual aid groups; and voluntary organizations.[37] Individuals

also receive informal support provided by family and friends, churches and religious organizations, workplace programs, and impaired drivers programs. There are linkages and connections between these formal and informal systems and, depending on the structural resources and system qualities, these sectors will be more or less integrated with specialized treatment and will assume a greater or lesser amount of the responsibility for managing persons with substance use problems and disorders. The authors present an interesting conceptual framework for providing addictions treatment services from a systems perspective. [38] This framework can contribute to the development of the broader recovery-oriented systems of care framework that focuses on providing services throughout the continuum of care and promotes and sustains individual and community recovery.

Minkoff and Cline (2004) present four characteristics of the comprehensive, continuous, integrated systems of care model for organizing services for individuals with co-occurring psychiatric and substance use problems and disorders and the eight principles of treatment for this model. [39] The model's four characteristics are as follows:

1. *System level of change:* The model is implemented into the entire system of care, not only for individual programs or training initiatives.
2. *Efficient use of existing resources:* The model is implemented within the context of current service resources, but emphasizes strategies between each program's requirements and environments.
3. *Incorporation of best practices:* The model is recognized by SAMHSA as a best practice for implementation for those with co-occurring psychiatric and substance disorders.
4. *Integrated treatment philosophy:* The model utilizes a common language for both the mental health and addictions fields.

Minkoff and Cline outline the eight research- and consensus-derived principles that guide the implementation of the model of care and the approach for implementing the complex multilayered system model. [40] The implementation of the model includes the following steps, which the authors detail:

1. Integrated system planning process;
2. Formal consensus on the model;
3. Formal consensus on funding the model;
4. Identification of priority populations and locus of responsibility for each;
5. Development and implementation of program standards;
6. Structures for intersystem and interprogram care coordination;
7. Development and implementation of practice guidelines;
8. Facilitation of identification, welcoming, and accessibility;
9. Implementation of continuous integrated treatment;
10. Development of basic dual diagnosis–capable competencies for all clinicians;
11. Implementation of a system-wide training plan; and
12. Development of a plan for a comprehensive program array.

There is a sizable amount of literature on recovery as the focus of recovery-oriented systems of care in the mental health field. Starting in the early 1990s, the mental health field focused on the process of recovery to guide decisions related to the mental health system. A recovery mental health model puts the locus of control and decision-making in the hands of the person who has the mental health condition.[41-43] "Recovery is pushing systems, as well as providers, to see beyond the diagnostic and categorical services, to treating the individual consumer and his/her multiple needs. The [recovery] vision … is of an external system that reflects the internal reality of its consumers."[44,p.318]

Anthony (1993, 2000) describes the recovery vision and the community support system perspective that provided a framework and essential services of a recovery-oriented systems of care for mental health disorders.[45,46] The author's latest work outlines the relevant systems-level research that provides the foundation for his development of recovery system standard dimensions. The author delineates the essential services in recovery-oriented systems of care, including treatment, crisis intervention, case management, rehabilitation, rights protection, basic support, self-help, and wellness/prevention.[47] The standards incorporate the importance of recovery as the basis of the system and provide guidance and direction to reinforce the development of recovery-oriented systems of care. The standards are grouped by systems-level dimensions (for specific detail on the essential services and standards, please see Anthony, 2000):[48]

- Design
- Evaluation
- Leadership
- Management
- Integration
- Comprehensiveness
- Consumer involvement
- Cultural relevance
- Advocacy
- Training
- Funding
- Access

Jacobson and Curtis (2000) reviewed existing literature on the conceptualizations of recovery that are integrated within recovery-oriented systems of care for the mental health field:[49]

- Recovery is generally seen as a process. It does not represent a cure, but a state of being and becoming.
- The path to recovery is highly singular or unique; no two people will have identical paths or use the same benchmarks to measure their journeys.
- In contrast to the passivity of being a patient or a voiceless recipient of services, recovery is active and requires that an individual take personal responsibility for his or her own recovery, often in collaboration with friends, family, supporters, and professionals.
- A recovery orientation includes an emphasis on choice, a concept that encompasses support for autonomous action, the requirement that the individual have a range of

opportunities from which to choose and full information about those choices, and increasing personal responsibility for the consequences of choice.

- The emotional essence of recovery is hope, a promise that things can and do change, that today is not the way it will always be.
- A key theme is that of meaning, or the discovery of purpose and direction in one's life. The search for meaning is highly personal. For some people meaning may be reflected through work or social relationships. Others derive meaning from advocacy and political action. For others, the pursuit of meaning takes on strongly spiritual elements.

Finally, as discussed by Barton (1998), the three models for delivering care within a fragmented mental health system—the medical, rehabilitation, and community support system models—are responsible for the outcomes of care.[50] The recovery philosophy articulates the "process through which this occurs in partnership with the recovering consumer. From this perspective, the consumer-centered recovery philosophy is the umbrella over all models, disciplines, practices, and activities in the hospital and the community."[51] In this philosophy, system principles include:

- Empowerment of staff and consumers,
- Integration of the rehabilitation and medical model services across hospital and community settings,
- Provision of client-centered services,
- Validation of client choice,
- Generation of hope, and
- Collaboration and partnership, e.g., consumers, professionals, and disciplines.

5. Research Supporting the Principles of Recovery and Systems of Care Elements

Previous research efforts have outlined principles of effective addictions treatment. In 1999, the National Institute on Drug Abuse (NIDA) produced a research-based guide entitled *Principles of Drug Addiction Treatment.* It identified 13 principles that research has found to be associated with effective addictions treatment:[52]

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
4. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
9. Medical detoxification is only the first stage of addictions treatment and by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at the risk of infection.
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

NIDA's principles focus on the process of delivering effective treatment. The National Summit on Recovery's 12 principles of recovery provides guidelines on the process of and outcomes associated with recovery. The NIDA principles relate most closely to the following principles of recovery:

- There are many pathways to recovery. The pathway to recovery may include one or more episodes of psychosocial

and/or pharmacological treatment. For some, recovery involves neither treatment nor involvement with mutual aid groups. Recovery is a process of change that permits an individual to make healthy choices and improve the quality of his or her life.

- **Recovery is holistic.** Recovery is a process through which one gradually achieves greater balance of mind, body, and spirit in relation to other aspects of one's life, including family, work, and community.
- **Recovery exists on a continuum of improved health and wellness.** Recovery is not a linear process. It is based on continual growth and improved functioning.
- **Recovery involves a process of healing and self-redefinition.** Recovery is a holistic healing process in which one develops a positive and meaningful sense of identity.
- **Recovery is a reality.** It can, will, and does happen.

6. Research Supporting the Principles of Recovery

There are many pathways to recovery.

Individuals are unique with specific needs, strengths, goals, health attitudes, behaviors and expectations for recovery. Pathways to recovery are highly personal, and generally involve a redefinition of identity in the face of crisis or a process of progressive change. Furthermore, pathways are often social, grounded in cultural beliefs or traditions and involve informal community resources, which provide support for sobriety. The pathway to recovery may include one or more episodes of psychosocial and/or pharmacological treatment. For some, recovery involves neither treatment nor involvement with mutual aid groups. Recovery is a process of change that permits an individual to make healthy choices and improve the quality of his or her life.

Research has shown that there are a variety of methods that assist individuals in their process of recovery.[53,54] Some people recover naturally; others recover through treatment and/or the assistance of self-help and mutual aid groups.[55]

Natural recovery involves using one's own personal resources to resolve one's addictions without the use of treatment or involvement in a mutual aid or self-help group. It is believed to be the most common recovery pathway.[56-64]

In studies examining the existence and success of natural recovery, alcohol was the most studied substance, with heroin a distant second.[65] Research has shown that natural recovery is a viable and successful pathway for people with shorter and less severe substance use problems and disorders and for those with higher incomes and more stable social and occupational supports and resources.[66-72] Additionally, individuals who recover naturally typically have fewer interpersonal conflicts and rely less on avoidance coping.[73-75]

Granfield and Cloud (2001) attribute the success of natural recovery to an individual's social capital, which they define as "the benefits that accrue to an individual as a result of the network of personal contacts and associations that surround them."[76, p.1566] The "natural communities of friends, family members, and relatives, and the social capital available through these connections, contribute significantly" to recovery success.[77]

Longitudinal studies have repeatedly shown that substance use problems and disorders treatment is associated with major reductions in substance use, problems, and costs to society, and improved patient recovery.[78-85] Of individuals with chronic dependence who achieved sustained recovery, the majority did so after participating in treatment— cannabis (43 percent), cocaine (61 percent), alcohol (81 percent), and heroin (92 percent).[86,87] For some, treatment is part of the recovery process, while for others, they recover outside of the treatment system without the aid of treatment.

Participation in mutual aid groups has also been shown to be effective in supporting recovery.[88-98] Laudet, Savage, and Mahmood (2002) and Scott, Dennis, and Foss (2005) found that for many individuals in long-term recovery, recovery coaches, 12-step programs, spirituality, and social and community support are integral to sustaining recovery.[99,100] One of the most widely studied self-help/12-step groups is Alcoholics Anonymous (AA). Research has shown that patients who attend AA regularly experience better short-term alcohol-related outcomes than do patients who attend infrequently or irregularly.[101-103] Furthermore, ongoing participation in AA contributes to continued improvement of substance use disorder symptoms.[104-106]

Methadone is one of the most thoroughly studied pharmaceuticals in modern medicine. Methadone maintenance therapy (MMT) is one of the most widespread treatment approaches, with 179,000 individuals enrolled in MMT (out of an estimated 900,000 opiate-dependent persons in the United States) and 100,000 individuals receiving another form of treatment.[107] Methadone, combined with psychosocial support, leads to improved outcomes, such as decreased death rates, reduced transmission of sexually transmitted diseases, eliminated or reduced illicit opiate use, reduced criminal activity, enhanced productive behavior through employment and academic/vocational functioning, and improved global health and social functioning.[108]

Recovery is self-directed and empowering. *While the pathway to recovery may involve one or more periods of time when activities are directed or guided to a substantial degree by others, recovery is fundamentally a self-directed process. The person in recovery is the "agent of recovery" and has the authority to exercise choices and make decisions based on his or her recovery goals that have an impact on the process. The process of recovery leads individuals toward the highest level of autonomy of which they are capable. Through self-empowerment, individuals become optimistic about life goals.*

Doty, Kasper, and Litvak (1996) and Tilly and Wiener (2001a, 2001b), reporting on the results of initiatives in several States (California, Colorado, Kansas, Maine, Michigan, Oregon, Washington, and Wisconsin), demonstrated the effectiveness of consumer-directed services.[109-111] These evaluations show that clients who direct their own care express greater satisfaction over the services they choose. Moreover, participants in these State consumer-directed programs perceived that quality of care either improved as a result of consumer direction or at least did not suffer. An evaluation of an Arkansas consumer-directed care program found that individuals in the program were less likely than control subjects to have unmet needs, were at least as safe from adverse events and health problems, and were more likely to be satisfied with life.[112]

Research shows that a sense of self-efficacy is critical to successful self-management, where individuals direct and manage their own care of a variety of chronic illnesses. This is also the case in achieving improvements in health outcomes,[113-116] and self-management has been

shown to be an important component of recovery from substance use.[117]

Morgenstern, Labouvie, McCrady, Kahler, and Frey (1997) found that maintaining motivation and self-efficacy for abstinence and increasing active coping post treatment were predictive of more favorable outcomes.[118] Motivational interviewing (MI) has been shown to decrease substance use and improve outcomes.[119] MI is based on a partnership between the provider and the individual receiving services, and it acknowledges that individual's personal responsibility and freedom of choice.[120] It replaces the concept of "resistance" with that of "ambivalence." MI allows individuals to explore their own goals and take an active role in treatment,[121,122] thereby assisting individuals in changing their substance use behavior.[123] The clinician using MI assists the individual in clarifying personal goals, identifying discrepancies between the individual's current reality and his or her goals, and developing strategies to achieve those goals.[124,125]

Recovery involves a personal recognition of the need for change and transformation.

Individuals must accept that a problem exists and be willing to take steps to address it; these steps usually involve seeking help for a substance use disorder. The process of change can involve physical, emotional, intellectual and spiritual aspects of the person's life.

Research shows that the motivation to change drug-using behavior is a major contributing factor to a successful recovery process,[126-130] and the effect of motivation varies based on severity of an individual's substance use disorder.[131] Joe, Simpson, and Broome (1999) identified motivation as the best predictor of engagement and retention.[132] The substance-using individual must accept that he or she has a problem, make a conscious choice to change, and be willing and motivated to take action to change his or her behavior.[133]

Recovery is holistic.

Recovery is a process through which one gradually achieves greater balance of mind, body and spirit in relation to other aspects of one's life, including family, work and community.

Some literature demonstrates that the integration of the physical, emotional, and spiritual realms of an individual is influential in the quest for recovery.[134] Alternative (e.g., acupuncture) and traditional medicine approaches for substance use treatment and recovery programs promote a balance between mind, body, and spirit, and other aspects of an individual's life, and have been shown to be valuable in helping an individual achieve recovery.[135] For example, individuals who participated in a comprehensive, holistic, therapeutic community that offered many specialized services had sustained positive outcomes, including abstinence from drug and alcohol use 12 months post treatment.[136]

Recovery has cultural dimensions.

Each person's recovery process is unique and impacted by cultural beliefs and traditions. A person's cultural experience often shapes the recovery path that is right for him or her.

The literature demonstrates that an individual's culture plays a vital role in his/her life and

health status and that culture must be acknowledged, addressed, and effectively utilized in recovery.[137-141] Cross-cultural studies have demonstrated the importance of delivering culturally competent care.[142,143] Research shows that culturally competent care improves recovery and remission rates for minority populations who are at risk for relapse.[144-146]

Flores (2000), in his meta-analysis of research on implications of culture on clinical care, concludes that culture has significant implications on the patient-provider relationship and the delivery of efficacious care.[147] He further states that it is essential for providers to consider a patient's culture and linguistic issues; the failure to do so has been shown to result in inefficiencies and inequalities in patient care, such as "inaccurate histories, decreased satisfaction with care, nonadherence, poor continuity of care, less preventive screening, miscommunication," [148] which leads to repercussions in care delivery.

Traditional theories of counseling and treatment are reflective of the Western cultures. It is essential that providers develop awareness, knowledge, and skills appropriate to the client's culture.[149,150] This is particularly important when the counselor is working with individuals who do not share the counselor's racial or ethnic heritage.[151,152] Some scholars have argued that other aspects of culture, including sexual orientation, ethnicity, religion, and heritage, are also important.[153,154] Researchers believe that recovery rates of African-Americans, American Indians, and Asians are lower than other populations due to the failure of treatment providers and researchers to see race as a cultural rather than a physical phenomenon.[155-157]

Recovery exists on a continuum of improved health and wellness.

Recovery is not a linear process. It is based on continual growth and improved functioning. It may involve relapse and other setbacks, which are a natural part of the continuum but not inevitable outcomes. Wellness is the result of improved care and balance of mind, body and spirit. It is a product of the recovery process.

The literature consistently demonstrates that for many people, substance use problems and disorders are chronic conditions involving cycles of relapse and treatment readmissions over multiple years.[158-163] Scholars and researchers agree that recovery is a developmental and continuous process that varies from person to person.[164,165] Individuals continuously grow and improve their functioning throughout the recovery process. Additionally, individuals benefit from lessons learned throughout the process.[166]

Recovery emerges from hope and gratitude.

Individuals in or seeking recovery often gain hope from those who share their search for or experience of recovery. They see that people can and do overcome the obstacles that confront them and they cultivate gratitude for the opportunities that each day of recovery offers.

Several authors have written about growth beyond maintaining abstinence or

management of the problem, often describing theoretical frameworks and specific practices and techniques that help management of the problem and promote wider growth.[167-175] Irving, Seidner, Burling, Pagliarini, and Robbins-Sisco (1998) found that greater hope and increased goal-oriented thinking were positively correlated to length of time abstinent, quality of life, and self-efficacy.[176] Additionally, listening to peers share experiences about how they dealt successfully with drug-related problems gave individuals in recovery confidence in dealing with their own situations.[177]

In a qualitative study, Hewitt (2004) describes the posttraumatic growth that individuals experience after discontinuing alcohol and drug use.[178] His study expands a phenomenon reflected in the AA concept of gratitude:[179] recovering alcoholics often report viewing their alcoholism as a gift that brought them to a greater sense of wholeness, fulfillment, or self-actualization than they feel they would have achieved without having to confront the addiction. In his study, Hewitt found that many individuals marked a contrast between the "craziness" of their previous lives, which were devoted to drugs or alcohol, and the calmness, stability, and sanity that were more characteristic of their current post addiction lives.[180]

The importance of having hope and believing in the possibility of a renewed sense of self and purpose is an essential component of recovery;[181-187] this hope must be accompanied by a desire and motivation to recover.[188,189] Young and Ensing (1999) found that seeking out a source of hope and inspiration helps individuals desire change and foster motivation to embark on and/or sustain a process of change.[190]

Recovery involves a process of healing and self-redefinition.

Recovery is a holistic healing process in which one develops a positive and meaningful sense of identity.

McMillen, Howard, Nower, and Chung (2001) identified positive by-products of the struggle with substance use problems and disorders, including changes in life priorities and increases in self-efficacy, family closeness, closeness with others, spirituality, and compassion.[191] Many consumers view recovery as a process of discovering and fostering self-empowerment, learning self-redefinition, returning to basic functioning, and improving quality of life.[192]

Recovery involves addressing discrimination and transcending shame and stigma.

Recovery is a process by which people confront and strive to overcome stigma.

Stigma and discrimination have implications for an individual's ability to receive care and continue on the path of recovery.[193] Based on combined data from SAMHSA's 2004 and 2005 National Survey on Drug Use and Health (NSDUH), stigma was cited as the reason for not accessing treatment by 18.5 percent of persons who needed and sought treatment but did not receive it.[194]

Clinical practices may not be the most efficient way to reduce stigma, which is a major barrier to care, because the causes of stigma exist both within and outside of the health care

system.[195-197] Furthermore, societal stigma is viewed as one of the major barriers to recovery.[198]

While stigma is seen as a major barrier to accessing treatment, it also plays a role in affecting outcomes of treatment and access to services for individuals in recovery.[199-201] Link, Struening, Neese-Todd, Asmussen, and Phelan (2001) found that the stigma associated with mental illness puts people more at risk for low self-esteem.[202] According to the *Christian Science Monitor*, experts in treatment and recovery estimate that when recovering individuals are honest about their drug histories, they will be turned down for a job 75 percent of the time.[203] Additionally, a California survey found that 59 percent of employers surveyed said they would never hire anyone with a felony conviction.[204]

Recovery is supported by peers and allies.
A common denominator in the recovery process is the presence and involvement of people who contribute hope and support and suggest strategies and resources for change. Peers, as well as family members and other allies, form vital support networks for people in recovery. Providing service to others and experiencing mutual healing help create a community of support among those in recovery.

Evaluation data and research studies point to the benefits of peer-based recovery support services for consumers, individuals who provide the services, and the delivery system.[205-213] An individual's sustained recovery is often influenced by his or her social interactions.[214] Peers have been shown to be integral in facilitating abstinence and preventing relapse for individuals with substance use conditions.[215-220] Jason, Davis, Ferrari, and Bishop (2001) and Humphreys, Huebsch, Finney, and Moos (1999) found that processes of social support mediate the transition from recovery initiation to lifelong recovery maintenance;[221,222] furthermore, research shows that poor social supports detrimentally impact recovery and place individuals at risk for relapse.[223,224]

Mutual aid (or "self-help") groups have been shown to play a significant role in the process of recovery.[225-236] These peer-based support groups require no admission process or specified length of participation and are less formalized than other types of peer recovery services. The probability of stable remission rates has been shown to rise in concert with the number of recovery mutual aid groups attended in the first 3 years of recovery.[237] Additionally, active and continued participation in self-help groups has been shown to improve recovery outcomes.[238-246]

A longitudinal study of Oxford House recovery homes suggests that receiving abstinence support, guidance, and information from recovery home members committed to the goal of long-term sobriety enhances residents' abstinence and reduces the residents' probability of relapse.[247,248]

Recovery involves (re)joining and (re)building a life in the community.
Recovery involves a process of building or rebuilding what a person has lost or never had due to his or her condition and its consequences.

Recovery involves creating a life within the limitation imposed by that condition. Recovery is building or rebuilding healthy family, social and personal relationships. Those in recovery often achieve improvements in the quality of their life, such as obtaining education, employment and housing. They also increasingly become involved in constructive roles in the community through helping others, productive acts and other contributions.

The basic element in the process of recovery is the reclaiming of one's life in the community and the realization that one's self needs to be restored with a reawakening of old identities and establishment of new ones.[249] Individuals entering recovery must often work to reintegrate themselves with their families and communities,[250] while disengaging themselves from relationships, activities, and settings associated with their addictive behavior. By detaching oneself from the previous environment, an individual can find a satisfying job, non-substance-using friends, and networks of people who may be in recovery.[251-253] Personal resources,[254] positive influences of family,[255] and social and community support[256] have been shown to be critical factors in establishing and maintaining recovery. Granfield and Cloud (2001) posited that recovery capital, which are defined as resources that support people's recovery from substance use problems and disorders, and the inclusion of a strong social network of sober friends and family members, employment, education and a range of coping skills, improves an individual's capacity to successfully recover.[257,258]

Interventions that restructure the patient's life in the community, such as parole, methadone maintenance, and self-help groups, have also been associated with sustained abstinence.[259] As a part of one's recovery process and to incorporate oneself into an environment that supports their recovery, many individuals make fundamental changes to their personal, professional, and social network environments.[260-264]

Recovery is a reality.

It can, will, and does happen.

Many agree that recovery is a continuous, lifelong process.[265-267] Epidemiologic studies show that, on average, 58 percent of individuals with chronic substance dependence achieve sustained recovery.[268-271] Recovery rates for individuals with substance use problems and disorders differ by study and vary widely, from 30 percent,[272] 41 percent,[273] 48 percent,[274] 59 percent,[275] 63 percent,[276] to 72 percent.[277]

A national survey conducted on behalf of Faces and Voices of Recovery found that approximately half of individuals who self-identified as "in recovery" or "formally addicted to" alcohol and other drugs reported being in recovery more than 5 years, and 34 percent reported 10 years or more of stable recovery.[278]

7. Research Supporting the Systems of Care Elements

Person-centered

Recovery-oriented systems of care will be person-centered. Individuals will have a menu of stage-appropriate choices that fit their needs throughout the recovery process. Choices can include spiritual supports that fit with the individual's recovery needs.

A number of studies have shown that people become more committed to a course of treatment if they are allowed to choose between several alternatives rather than are forced to select a given option.[279] Patient choice of care is important to the individual patient and improves engagement with treatment and continuing care services.[280] Several studies have indicated that clients who were given a choice of treatment options showed greater acceptance of treatment and higher rates of recovery at follow-up.[281-286]

Researchers have reported that clients who had a choice of treatment had improved treatment processes and post treatment outcomes. Individuals who were provided with the option to choose their treatment services were more likely to work harder in treatment,[287] have more contact with their treatment program,[288] and better adhere to program requirements than individuals who were not given a choice of treatment.[289] Those who had treatment options were also less likely to drop out of treatment.[290]

Inclusive of family and other ally involvement

Recovery-oriented systems of care will acknowledge the important role that families and other allies can play. Family and other allies will be incorporated, when appropriate, in the recovery planning and support process. They can constitute a source of support to assist individuals in entering and maintaining recovery. Additionally, systems need to address the treatment, recovery and other support needs of families and other allies.

Research has demonstrated that involvement of concerned others can lead to improved outcomes in both alcohol[291-293] and drug[294] treatment. These connections may enhance individual's self-efficacy and reduce the probability of relapse.[295] In a review by McCrady (2004), it was shown that family and ally involvement in treatment was associated with more positive treatment outcomes in a variety of alcohol-dependent populations.[296]

Family and ally support and healthy and productive relationships nurture long-term recovery.[297] The family has been shown to be a key determinant of an individual's commitment and ability to achieve recovery.[298] An individual's family and other allies can be active participants, sources of strength, and resources in recovery and can

provide a central role in maintenance of recovery.[299-304]

The level of social support that an individual receives has been directly associated with engagement indicators and treatment completion.[305] Finney, Noyes, Coutts, and Moos (1998) found that recovery-oriented support may foster greater self-efficacy and longer abstinence.[306] The positive consequences linked to these associations may be the result of individuals acquiring effective coping strategies and greater support from other recovering individuals.[307-309] Furthermore, it has been shown that social support, particularly through interactions with individuals in similar situations, produces positive health implications.[310]

In a randomized controlled trial, it was shown that spouse involvement, regardless of the type and intensity of therapy utilized, was an effective intervention for enhancing compliance to disulfiram,[311] reducing total alcohol consumption[312-314] and maintaining treatment gains following discharge.[315] Higgins, Budney, Bickel, and Badger (1994) found that cocaine-abusing individuals participating in community reinforcement with a significant other had better outcomes than those who chose not to bring a significant other.[316]

Individualized and comprehensive services across the lifespan

Recovery-oriented systems of care will be individualized, comprehensive, stage-appropriate, and flexible. Systems will adapt to the needs of individuals, rather than requiring individuals to adapt to them. They will be designed to support recovery across the lifespan. The approach to substance use disorders will change from an acute-based model to one that manages chronic disorders over a lifetime.

Research has shown that access to and receipt of a comprehensive array of medical, psychological, and social services improves engagement, retention, and treatment outcomes.[317-320] For example, access to housing, employment, and legal systems has positively aided in the treatment of substance use problems and sustained abstinence.[321-323]

Studies find that when an individual's full array of needs (e.g., food, clothing, housing, transportation, medical care, childcare, and family, psychiatric, educational, and vocational concerns) are met, short- and long-term outcomes, including retention in treatment and reduction in substance use, are improved.[324-326] Additionally, if individuals' distinct needs are addressed, outcomes are improved.[327-330]

Similarly, individuals presenting to substance use problems and disorders treatment with comorbid psychiatric or medical conditions often have great difficulty sustaining recovery unless these conditions are fully assessed and addressed during treatment and continuing care.[331,332]

Recovery Across the Lifespan

Due to inherent differences, issues of gender, race, and age should be considered in the treatment and recovery process.[333-336] As individuals age, their health needs and social relationships evolve and their cognitive processes change.[337,338] Treatment approaches and social support mechanisms need to be developmentally appropriate,

taking into account the age of individuals.[339] Adolescent, adult, and elderly substance users differ in many ways and have unique issues and concerns that must be addressed through specific treatment and recovery planning.[340-344] At different stages in life, an individual's drug and alcohol use often stems from different causes and requires age-appropriate treatments.[345-350] Because of their unique developmental issues, adolescent, adult, and elderly users must be treated differently, with the variation taken into account in their treatment and recovery plans. Moreover, treatment approaches should address the nuances of each individual's experience, and their cognitive, emotional, physical, social, and moral development.[351,352]

Research shows that the types of substances that individuals misuse varies with age. Older adults, for example, more often misuse alcohol and prescription and over-the-counter drugs, while younger substance abusers more often use illicit drugs.[353-355] Adolescents are vulnerable due to their developmental stage, but multiple biological, psychological, and social changes associated with the aging process also make the elderly uniquely vulnerable to substance abuse problems.[356-359]

Natural recovery is most often seen in individuals with patterns of substance use that are moderate to mild or of short duration and is most often encountered among two age cohorts: 1) young adults whose use discontinues or is substantially reduced with maturation and assumption of adult role responsibilities, and 2) later-life adults who change behavior in response to the cumulative consequences of substance use.[360,361] (See also the discussion of natural recovery in Section 6.)

Systems anchored in the community

Recovery-oriented systems of care will be nested in the community for the purpose of enhancing the availability and support capacities of families, intimate social networks, community-based institutions and other people in recovery.

Research shows that social and community resources promote better recovery outcomes.[362] Healthy and productive environments are nurturing of recovery,[363,364] and the presence of strong social networks during and after treatment has been linked consistently to sustained reductions in substance use after treatment.[365-367] Strong social networks are particularly important as a counterbalance to the social pressures within high-drug-using networks and neighborhoods.[368-371]

To improve individuals' long-term stability, communities must provide necessary resources, such as housing, employment, and social support.[372-374] Comprehensive, easily accessible recovery support service programs located in high-need communities with staff functioning in multiple roles using culturally competent interventions have been shown to improve recovery outcomes for individuals with children.[375] Employment and stable housing have been found to improve self-esteem and support reintegration into mainstream society and thereby to support recovery.[376-381]

Community-based care systems provide opportunities for transitions between levels and types of care in a cost-effective manner and improve long-term health outcomes.[382,383] The Team for the Assessment of Psychiatric Services (TAPS) examined the health outcomes and quality of care for individuals who were discharged into the community after extended psychiatric hospitalizations.[384] Of 523 individuals still alive at the 5-year follow-up, 90 percent were still living in the community, and few individuals reported criminal justice system involvement or homelessness.[385]

Harrison (2001) and Knight, Simpson, and Hiller (1999) found that, among offenders reentering the community, participation in an in-prison treatment and in a post release, community-based aftercare program was associated with positive outcomes.[386,387]

Continuity of care

Recovery-oriented systems of care will offer a continuum of care, including pretreatment, treatment, continuing care and support throughout recovery. Individuals will have a full range of stage-appropriate services from which to choose at any point in the recovery process.

Continuity of care is particularly important in treating chronic and complex diseases where several providers may be involved in the provision of care.[388] Continuity of care is characterized by care from one doctor or team, coordinated through a common purpose and plan.[389] Furthermore, continuity of care is significantly related to positive treatment outcomes,[390] since continued attachment to treatment is consistently related to better outcomes.[391]

Continuing care includes services that are accessed post discharge from treatment and at a lower intensity. It provides sustained access to treatment and recovery services and promotes continued abstinence and recovery. Empirical research has demonstrated that continuing care contributes to improved treatment outcomes.[392,393] Gruber, Fleetwood, and Herring (2001) highlighted the efficacy and the positive effects of a continuing care program designed to assist the substance-affected family.[394] Continuing care has been shown to be effective in assisting individuals in starting and maintaining recovery.[395] The utilization of continuing care improves long-term recovery outcomes;[396,397] without continuing care, individuals are more likely to relapse.[398,399]

Linkage and retention in continuing care have been shown to improve long-term abstinence from a variety of substances.[400] Studies have shown that onsite medical consultation, team-based approaches, and facilitated referrals to primary care independently have a substantial positive impact on linkage to medical care and its quality for persons with mental and addictive disorders.[401,402] For example, participation in community services has been associated with engagement in outpatient treatment and better treatment outcomes.[403-413] Individuals who become more engaged in outpatient care in the community and self-help groups tend to experience better short-term abstinence outcomes.[414]

Transitional services are particularly important for correctional populations.[415,416] Substance use disorder treatment, when provided in

conjunction with credible sanctions against drug offenses, job training and placement, and advocacy services, has been shown to decrease recidivism rates and improve reentry from correctional institutions into the community for recovering drug offenders. [417] Completion of aftercare services by offenders has been shown to improve recovery outcomes. [418-420]

Partnership-consultant relationships

Recovery-oriented systems of care will be patterned after a partnership-consultant model that focuses more on collaboration and less on hierarchy. Systems will be designed so that individuals feel empowered to direct their own recovery.

Research shows that supportive therapeutic and trusting relationships enhance engagement and retention. [421-424] Early therapeutic alliances appear to be a consistent predictor of engagement and retention in treatment.[425] Providers must convey hope in their interactions with clients and develop individualized treatment or recovery plans that incorporate clients' goals and are designed to support increased patient/client autonomy.[426]

A partnership-consultant relationship is utilized to encourage patient self-management.[427] Patient self-management requires the clinician to utilize a "collaborative care model of practice in which the patient and clinician are equal partners, with equal expertise."[428] In the collaborative care model, the clinician brings medical expertise and "patients are experts in their own lives and in what concerns them and motivates and enables them to make changes in their lives,"[429] thereby creating a therapeutic alliance with patients as their principal caregivers.

A therapeutic alliance between providers and patients embraces a more empathetic approach where providers enhance their clients' involvement in service delivery and recovery.[430] Success of counseling is related to the quality of a working alliance and utilization of a patient-centered focus with therapist empathy, warmth, and genuineness.[431] A positive working alliance, reported by either the client or therapist, is a significant predictor of treatment participation and substance use behavior post treatment.[432,433] The association of a therapeutic relationship with positive outcomes is consistently reported, and there is a positive relationship between therapeutic alliances and outcomes. Moreover, "counselors who are confrontational or use confrontational interventions consistently" have worse outcomes.[434]

Studies confirming this have been performed across settings (residential, outpatient, continuing care, and office based) and approaches (medication-assisted, adolescent and family treatment).[435-439] Ilgen, Tiet, Finney, and Moos (2006) and Ilgen, McKellar, Moos, and Finney (2006) found that a positive therapeutic alliance counteracted the negative impact of low baseline self-efficacy and low motivation in some people.[440,441] Carten (1996) observed that the development of positive relationships, including jointly designed service contracts, shared planning, staff encouragement, nonjudgmental attitudes, and nonpunitive responses to relapse, improved success for mothers in recovery.[442]

Strength-based

Recovery-oriented systems of care will emphasize individual strengths, assets and resiliencies.

The strengths perspective emphasizes building on the client's assets, desires, abilities, and resources to assist the client in the recovery process.[443] Additionally, the strengths perspective demonstrates the importance and respect for the client's way of thinking and dealing with life situations. This perspective assumes that each individual has the capacity to draw from a variety of resources, skills, and motivations to focus on their strengths and create change in their lives.[444-447] Through examining the efficacy of combining intensive strengths-based case management services with an established program, Siegal and colleagues found that individuals who received strengths-based case management services had improved retention in treatment, lower reported drug and alcohol use, and better outcomes related to criminality and employment than those who did not receive the intervention.[448-450]

Culturally responsive

Recovery-oriented systems of care will be culturally sensitive, competent and responsive. There will be recognition that beliefs and customs are diverse and can impact the outcomes of recovery efforts. In addition, the cultures of those who support the recovering individual affect the recovery process.

Professional ethical guidelines and recently developed multicultural competencies for working with diverse populations suggest that the delivery of culturally competent services is integral to the delivery of quality and effective services.[451] Cultural competence has become a very important focus in the health services delivery field, as demonstrated by the U.S. Department of Health and Human Services, Office of Minority Health's standards project on Culturally and Linguistically Appropriate Services (CLAS).[452]

Ignoring culture can result in many negative consequences, including missed opportunities for screening, difficulties resulting from differing responses to medication, lack of clinician knowledge about alternative and traditional remedies, diagnostic errors resulting from miscommunication, and disruptions in services.[453-457] Minority Americans have different health experiences than nonminorities.[458] Moreover, nonminority Americans have different experiences from each other in the health care setting, even when they have similar medical conditions and insurance coverage.[459-466]

Gender- and culture-based approaches provide more effective substance abuse treatment for all individuals with substance use problems and disorders, particularly for African-Americans, Hispanics, and Asians and their families.[467-469] Longshore, Grills, and Annon (1999) found that individuals in a more culturally congruent intervention were more involved in counseling sessions, more willing to self-disclose, more motivated to seek help for drug use–associated problems, and more prepared for change.[470] Campbell and Alexander (2002) found that individuals treated in culturally competent substance abuse treatment practices had higher rates of specific medical and psychosocial services, such as medical exams and financial

services, but they concluded that the practices may not be uniformly effective in promoting utilization of all services.[471] Gender- and culture-specific care needs in relation to social structure, ethno-history, and cultural context have been shown to influence women's health and well-being as they move through recovery.[472]

Responsiveness to personal belief systems

Recovery-oriented systems of care will respect the spiritual, religious and/or secular beliefs of those they serve and provide linkages to an array of recovery options that are consistent with these beliefs.

Many researchers have documented the value of individuals' spiritual, religious, and secular beliefs in supporting recovery.[473-481] Religious involvement and spiritual (re)engagement appear to be correlated with and facilitate the process of recovery.[482-484]

Spirituality and faith, through their associations with cognitive processes, create more positive health outcomes, including optimistic life orientation, higher resilience to stress, lower levels of anxiety, and positive effective coping skills.[485] Evidence shows that spirituality and faith may facilitate the process of recovery[486-488] and promote improvements in long-term recovery.[489] Spirituality, religiousness, and life meaning "enhance coping, confer hope for the future, and provide a heightened sense of control, security, and stability; they offer support and strength to resist the opportunity to use substances, all of which are very much needed to initiate and maintain recovery."[490,p.15] Furthermore, many individuals in recovery cite strength acquired from religion and spirituality as main factors in contributing to their long-term recovery,[491,492] as a source of personal strength, and as a self-protection mechanism.[493]

Commitment to peer recovery support services

Recovery-oriented systems of care will include peer recovery support services. Individuals with personal experience of recovery will provide these valuable services.

Research on peer support / mutual support groups / recovering consumers as providers of alcohol and drug treatment services shows that the use of peer support is effective in helping individuals through recovery.[494-496] Evidence shows that seeing or visualizing those similar to oneself performing activities typically increases one's belief in one's own ability to perform those activities[497] and facilitates successful management of one's chronic illness.[498] Moreover, peer support has been identified in the Chronic Care Model as a method to support patients in their illness self-management.[499,500] Peer recovery support services "foster recovery in a relational, mutually-enhancing, and safe context."[501,p.171]

Involvement in mutual aid groups provides an opportunity for individuals to participate in drug- and alcohol-free activities as role models to others, rewards their own abstinence, and helps enhance individuals' personal and social resources.[502-504] Twelve-step involvement has been related to positive outcomes, including decreased substance use,[505-511] enhanced psychosocial adjustment,[512-514] and lower

health care costs.[515] Moreover, 12-step participation as a continuing care activity has been shown to be effective for long-term abstinence.[516 - 519] Self-help groups help sustain recovery[520- 523] and provide a community that strives to be drug-free with a structured mechanism for continuous abstinence or recovery.[524]

AA affiliation has been associated with self-efficacy and positive coping, which has been linked to better outcomes.[525,526] Rational Recovery, a self-help approach started by a clinical social worker in 1986, is intended for persons with all types of addictive disorders. It adopts cognitive approaches and has been shown to be successful in engaging substance users and promoting abstinence among members.[527]

For some dual diagnosis patients, 12-step interventions have been found to be more effective in decreasing alcohol use and increasing social interactions than self-management.[528] (For further information on self-management, please see discussion on page 16.)

Inclusion of the voices and experiences of recovering individuals and their families

The voices and experiences of people in recovery and their family members will contribute to the design and implementation of recovery-oriented systems of care. People in recovery and their family members will be included among decision-makers and have oversight responsibilities for service provision. Recovering individuals and family members will be prominently and authentically represented on advisory councils, boards, task forces and committees at the Federal, State and local levels.

Community involvement with public health planning and implementation has been shown to be integral to improving community health.[529,530] Additionally, with regard to improving public safety, the voices of consumers have played a large role in restructuring medical systems to better promote consumer, provider, and system safety.[531] In these movements worldwide, consumers have played key roles in defining the priorities, providing personal expertise, and reforming patient safety criteria of health care systems.[532] The patient safety movement is an excellent example of how partnerships among consumers and providers of care were instrumental in improving operational and systemic deficiencies.[533]

The rationale for seeking participation by consumers falls into three categories: 1) to improve services and decisions, 2) to gain legitimization and/or community compliance, and 3) to bring about social change with the redistribution of power or resources.[534] Furthermore, individuals with a "particular disease become more aggressive in voicing their desire not only for more response from government and the health care system, but also for more influence over policy decisions at the macro level and treatment decisions at the micro level…[for example,] by people with disabilities and their families and those initially affected by human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)."[535, p.216] Research shows that giving mental health consumers a significant

role in shaping services, policies, and research improves services.[536]

Some government agencies have mandated the involvement of affected populations in policy decisions through advisory groups and planning councils.[537] Little systematic research as to the effectiveness of the involvement of consumers on decision-making has been conducted.[538]

Integrated services

Recovery-oriented systems of care will coordinate and/or integrate efforts across service systems to achieve an integrated process that responds effectively to the individual's unique constellation of strengths, desires and needs.

Integrating care has been shown to optimize recovery outcomes and improve the cost-effectiveness of delivering services.[539-541] Collaboration between and integration across services systems and agencies has improved the probability of individual and family recovery.[542] Research has demonstrated the efficacy and effectiveness of providing onsite primary medical care and ancillary services in the addictions treatment setting[543-545] and integrating addictions services into other settings.[546,547]

Patients in an enhanced program that used case managers who coordinated and expedited the use of medical screening, housing assistance, parenting classes, and employment services had significantly fewer physical and mental health problems, better social functioning, and less substance use at 6 months after treatment than did individuals who were not in the enhanced program.[548,549]

Programs that are more effective with dually diagnosed individuals tend to have a combined treatment orientation; adopt a more tolerant and persuasive, rather than confrontational stance; use peer modeling in group psychotherapy; and provide continuity of care through assertive case management and after-care.[550-552] Additionally, individuals with co-occurring substance use problems and disorders and medical conditions have been shown to benefit from an integrated medical and substance abuse treatment program, with increased rates of abstinence, compared with individuals without co-occurring medical problems.[553,554]

Families and children at risk often present with a complex array of needs that require the provision and utilization of multiple services.[555,556] While effective delivery of health, child welfare, and educational services improves the lives of families who are able to access them, integration of the social services and health systems has been shown to further improve access to and provision of necessary services.[557-560]

System-wide education and training

Recovery-oriented systems of care will ensure that concepts of recovery and wellness are foundational elements of curricula, certification, licensure, accreditation and testing mechanisms. The workforce also requires continual training, at every level, to reinforce the tenets of recovery-oriented systems of care.

Educational interventions have been shown to improve physician performance and patient identification and outcomes of care.[561,562] A

meta-analysis of disease management, which incorporated case management, found that improved disease control was associated with education of providers.[563] Furthermore, Bukstein et al. (2005) found that continuing education is essential to providing care that is based on the latest clinical and service interventions.[564]

Ongoing monitoring and outreach

Recovery-oriented systems of care will provide ongoing monitoring and feedback with assertive outreach efforts to promote continual participation, re-motivation and reengagement.

Models of ongoing monitoring and early reintervention occupy a central role in the long-term management of chronic medical conditions.[565-568] Accumulating evidence suggests that many cases of substance use problems and disorders should be continually monitored and are best treated with "the same type and level of ongoing clinical support as other chronic illnesses."[569]

The evidence shows that it is necessary to continuously evaluate and maintain connections with individuals in recovery, and by doing so, individuals at risk for relapse can reenter treatment at an earlier point of relapse.[570] In general, about 50–60 percent of patients begin reusing within 6 months of treatment cessation; therefore, it is essential for ongoing monitoring and outreach to be conducted.[571-574] Individuals who are readmitted sooner after relapse have better short- and long-term abstinence, improved outcome measures for employment and criminality, and lower associated substance use problems.[575,576]

Outcomes driven

Recovery-oriented systems of care will be guided by recovery-based process and outcome measures. These measures will be developed in collaboration with individuals in recovery. Outcome measures will reflect the long-term global effects of the recovery process on the individual, family and community, not just remission of biomedical symptoms. Outcomes will be measurable and include benchmarks of quality-of-life changes.

There are several entities and projects focused on measuring substance use disorders process measures and outcomes. Examples include:

- Network for the Improvement of Addiction Treatment (NIATx; http://www.niatx.net), a partnership between the Robert Wood Johnson Foundation's Paths to Recovery program, the Center for Substance Abuse Treatment's Strengthening Treatment Access and Retention (STAR) program, NIDA, and a number of independent addictions treatment organizations, and
- Washington Circle (http://www.washingtoncircle.org), a policy group on performance measurement for care of substance use problems and disorders

These entities have independently developed process of care and performance measures aimed to improve treatment access and retention for individuals with substance use problems and disorders.

NIATx aims to improve access to treatment through its four process measures:

1. Average time from first request to first client treatment session;
2. "No Shows," which measures the number of patients who do not keep an appointment;
3. "Admissions," which counts the number of unduplicated client admissions by provider; and
4. "Continuation," which measures of the number of clients who stay engaged in treatment.

Washington Circle has and continues to develop performance measures in four domains of the process of care:

1. Prevention/Education
2. Recognition
3. Treatment
   a. Initiation of alcohol and other plan services
   b. Linkage of detoxification, alcohol, and other drug plans
   c. Treatment engagement
   d. Interventions for family members and significant others
4. Maintenance of treatment effects

Many large-scale longitudinal outcome studies have been conducted that examine various indicators of life changes, including substance use behavior, criminal behavior, education, employment, health, and social support. Examples of these data collection and outcome evaluation efforts include the Drug Abuse Treatment Outcome Study (DATOS) conducted by NIDA, the National Treatment Improvement Evaluation Study (NTIES) by SAMHSA, the Alcohol and Drug Services Study (ADSS) by SAMHSA, and the California Outcome Study using the California Drug and Alcohol Treatment Assessment (CALDATA) by the State of California. These data sets examine the impact of treatment and behavior change processes on quality of life outcomes.

Research based

Recovery-oriented systems of care will be informed by research. Additional research on individuals in recovery, recovery venues and the processes of recovery, including cultural and spiritual aspects, is essential. Research will be supplemented by the experiences of people in recovery.

This white paper is a critical first step in examining how the research relates to the principles of recovery and systems of care elements and identifies where additional research is needed.

Adequately and flexibly financed.

Recovery-oriented systems of care will be adequately financed to permit access to a full continuum of services, ranging from detoxification and treatment to continuing care and recovery support. In addition, funding will be sufficiently flexible to permit unbundling of services, enabling the establishment of a customized array of services that can evolve over time in support of an individual's recovery.

Pooling of funding may reduce problems associated with fragmented funding and separate service systems. Pooled funding also may improve service coordination within and between different organizations and networks and may work to expand access to and provision of services.[577] Additionally, States and service facilities can utilize creative financing mechanisms to provide and reimburse for recovery-oriented services. For example, Michigan's State agencies have organized multiple funding sources to provide integrated community mental health and primary medical care, and have improved access to these services.[578]

Voucher programs provide people seeking drug and alcohol treatment and recovery support services with a funding mechanism to pay for a range of unbundled community-based services. Many States, through the Access to Recovery grant program, have implemented voucher programs to improve Access to Recovery support services and promote patient choice in service provision.

8. Research Supporting the Implementation of Recovery-Oriented Services and Systems of Care

While many States (e.g., Connecticut, Georgia, Massachusetts, Michigan, New Jersey, New York, and Oregon) and cities (e.g., Philadelphia) are in the process of reforming their systems to implement recovery-oriented systems of care, there are few publications in peer-reviewed journals that describe the effectiveness of this systems change for individuals with substance use problems and disorders. However, there are several published articles in peer-reviewed journals that discuss the implementation and delivery of recovery-oriented services in the mental health system. This section discusses the available peer-reviewed literature focusing on the delivery of recovery-oriented services and the implementation of recovery-oriented systems of care in the addictions and mental health fields.

In 2000, the State of Connecticut embarked on transforming its system of publicly funded behavioral health care into a system that is recovery-oriented and culturally responsive. In 2002, Connecticut was the first State that incorporated recovery as the overarching aim of its publicly funded system of care.[579] The initiative targeted the statewide system of care as a whole instead of supplementing the existing system with recovery-oriented elements.[580] The Connecticut initiative involved several interrelated steps occurring over several years:

1. Developing core values and principles based on the input of people in recovery;
2. Establishing a conceptual framework based on this vision of recovery;
3. Building workforce competencies and skills through training, education, and consultation;
4. Changing programs and service structures;
5. Aligning fiscal and administrative policies in support of recovery; and
6. Monitoring, evaluating, and adjusting the efforts.

Two peer-reviewed articles describe the implementation efforts of the Connecticut system. A 2005 article in *Psychiatric Rehabilitation Journal* outlines the results of a recovery self-assessment implemented in Connecticut, which gauged perceptions of the degree to which programs implement recovery-oriented practices.[581] In this article, O'Connell et al. provide a statewide assessment of recovery-oriented practices in agencies. Results indicated that mental health professionals, persons in recovery, and family members "generally agreed that their agencies were providing services that are consistent with a recovery orientation."[582] A 2007 article in *Psychiatric Rehabilitation Journal* provides evaluative details on the implementation of the early stages of the initiative.[583] Two themes are discussed:

1. Recovery does not refer to any specific service, intervention, or support (which can be more or less recovery oriented) but to what people with psychiatric disabilities or addiction *do* themselves in order to manage their illness and/or get their lives back.
2. Recovery cannot be an "add-on" to existing services, supports, or systems. The focus of transformation needs to be on changing and realigning current policies, practices, procedures, services, and supports to be oriented toward, and effective in, promoting recovery.

In 2004, Philadelphia created the city's Department of Behavioral Health and Mental Retardation Services, which combined the Community Behavioral Health Office, the Office of Mental Health, and the Coordinating Office for Drug and Alcohol Abuse Programs into an integrated behavioral health care system.[584] The systems transformation in Philadelphia included numerous stakeholders in the process, including recovering people and their families, in developing a vision for the Philadelphia system. This vision and mission of Philadelphia was to create an integrated system that "promotes long-term recovery, resiliency, self-determination, and a meaningful life in the community," which shifted the values of the system from the "interventions of professional experts to the experience and needs of recovering individuals and their families."[585, p.36] Relationships between service practitioners, service consumers, the department, and local services providers shifted to partnerships based on mutual respect and collaborations. Additionally, "recovery representation" was emphasized at all levels of the system to "affirm that recovery is a living reality in the City of Philadelphia."[586] Practices of delivery services were changed to improve care delivery and focus on recovery. As discussed by White (2007) in his description of the recovery revolution in Philadelphia, in 10 service areas changes to the system occurred. These areas are the following: engagement, assessment, retention, role of client, service relationship, clinical care, service dose/duration, service delivery sites, post treatment checkups and support, and attitude toward readmission.[587]

Modification of Philadelphia Department of Behavioral Health and Mental Retardation Services Service System and Clinical Practice To Be More Recovery Oriented (White, 2007, pp. 36-27)

1. *Engagement*: Greater focus on early identification via outreach and community education; emphasis on removing personal and environmental obstacles to recovery; shift in responsibility for motivation to change from the client to service provider; loosening of admission criteria; renewed focus on the quality of the service relationship.
2. *Assessment*: Greater use of global and strength-based assessment instruments and interview protocol; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stages of recovery.
3. *Retention*: Increased focus on service retention and decreasing premature service disengagement; use of outreach workers, recovery coaches, and advocates to reduce rates of client disengagement and administrative discharge.
4. *Role of Client*: Shift toward philosophy of choice rather than prescription of pathways and styles of recovery; greater client authority and decision-making within the service relationship; emphasis on empowering clients to self-manage their own recoveries.
5. *Service Relationship*: Service relationships are less hierarchical with counselor serving more as ongoing recovery consultant than professional expert; more a stance of "How can I help you?" than "This is what you must do."
6. *Clinical Care*: Greater accountability for delivery of services that are evidence-based, gender-sensitive, culturally competent, and trauma informed; greater integration of professional counseling and peer-based recovery support services; considerable emphasis on understanding and modifying each client's recovery environment; use of formal recovery circles (recovery support network development).
7. *Service Dose/Duration*: Dose and duration of total services will increase while number and duration of acute care episodes will decline; emphasis shifts from crisis stabilization to ongoing recovery coaching; great value placed in continuity of contact in a primary recovery support relationship over time.
8. *Service Delivery Sites*: Emphasis on transfer of learning from institutional to natural environments; greater emphasis on home-based and neighborhood-based service delivery; greater use of community organization skills to build or help revitalize indigenous recovery supports where they are absent or weak.
9. *Post-treatment Checkups and Support*: Emphasis on recovery resource development (e.g., supporting alumni groups and expansion/diversification of local recovery support groups); assertive linkage to communities of recovery; face-to-face, telephone-based, or Internet-based post-treatment monitoring and support; stage-appropriate recovery education; and, when needed, early re-intervention.
10. *Attitude toward Re-admission*: Returning clients are welcomed (not shamed); emphasis on transmitting principles and strategies of chronic disease management; focus on enhancement of recovery maintenance skills rather than recycling through standard programs focused on recovery initiation; emphasis on enhancing peer-based recovery supports and minimizing need for high-intensity professional services.

Finally, Philadelphia worked with multiple constituents to plan and implement changes in funding and regulatory policies, which are critical to effectively implement and sustain the behavioral health system, and to focus its regulatory and policy reform on recovery. Philadelphia has focused on "providing regulatory relief (reducing duplicative and excessive regulatory requirements), generating more recovery-focused regulatory standards, shifting the focus of program monitoring from one of policing to one of consultation and support, generating new Request for Proposals for recovery-focused service initiatives, and exploring models for long-term funding of recovery support services."[588]

The State of Massachusetts, through its Departments of Mental Health and Public Health, designed a collaborative model to provide a comprehensive integrated service system for persons with co-occurring substance use problems and disorders and serious mental illness for the private and public sectors. Barreira, Espey, Fishbein, Moran, and Flannery (2000) describe the design phase of Massachusetts' integrated system and provide lessons learned and outcomes for developing the system, but the implementation of the initiative has not yet been published.[589] Specifically, the authors discuss utilizing a collaborative framework, which includes involving the key stakeholders, to foster change and buy-in for the system. The collaborative and consensus-building process builds on evidence-based practices and best practices, builds on organizational strengths, and is sensitive to barriers to change (e.g., differing philosophies, regulatory processes, clinical and administrative traditions and policies, resistance to change) and collaboration. Massachusetts also discovered that "providing a voice for stakeholders who are parties in designing change" and "developing consensus on a framework of care that all groups endorse" so funding resources are not seen as being taken from one system to another were critical for the collaborative process to succeed and the integrated framework to be implemented.[590]

Jacobson and Curtis, in a 2000 *Psychiatric Rehabilitation Journal* article, outline how the concept of recovery is being implemented in the policies and practices of several State mental health systems and review specific strategies that States, including Wisconsin, Ohio, Vermont, and Nebraska, are using to implement recovery principles into their mental health systems.[591] Most of the State systems reviewed begin their systems' transformation with the development of vision statements in consensus workgroups and task forces, renaming programs, and applying strategies for operationalizing recovery-oriented services. Both programmatic and administrative strategies are being adopted to implement recovery-oriented services; they include education, consumer and family involvement, support for consumer-operated services, emphasis on relapse prevention and management, incorporation of crisis planning and advance directives, implementing stigma reduction initiatives, innovations in contracting and financing mechanisms, definition and measurement of outcomes, and reviewing and revising key policies. In this article, while Jacobson and Curtis do not specifically review activities that occur across different service systems, they discuss the importance of

involving a variety of stakeholders in the systems-change effort and of recovery education initiatives and the destigmatization that is occurring across workers in different disciplinary backgrounds, consumers, family members, and administrators. They further state that the concept of recovery must look beyond the service provider and the mental health system.

In a 2004 article that outlines the complementary nature of evidence-based practices and recovery in a service system, Solomon and Stanhope describe the profound changes required at the systems level for the implementation of evidence-based practices and recovery-oriented services.[592] The authors trace the integration of a recovery orientation into the Ohio Department of Mental Health. In 1993, Ohio started the process to transform its system. The first step of the transformation was to have a dialog with providers, consumers, and family members to explore the mental health recovery process and prepare a report outlining the stages of the process. The stages were integrated into a framework for implementing recovery-oriented practices, which included clinical care, peer and family support, facilitation of employment, empowerment, stigma reduction, community involvement, access to resources, and education. By offering grants to localities, Ohio helped localities transform their mental health systems through establishing recovery centers and recovery management plans within agencies. "The Ohio recovery model is an example of tailoring a recovery vision to the specific needs of consumers and implementing change through financial incentives." [593, p.318] Other States, including California, Massachusetts, New York, and Washington, have written recovery principles within their State managed care contracts. These principles "require that organizations contract with providers who pursue recovery-oriented services, including consumer-operated services, and that consumers have an advisory role on managed care organization boards."[594, p.319]

9. Conclusion

This white paper examines the research that supports the principles of recovery and systems of care elements as defined by the National Summit on Recovery. The author identified findings in more than 375 studies that supported the framework, principles, elements, and implementation of recovery-oriented services and systems. This document is intended to serve as a starting point for further examination of recovery research. Additionally, it provides States, communities, and organizations that are developing and implementing recovery-oriented services and systems with evidence that supports services and systems improvements based on recovery-oriented approaches.

While many of the principles and systems elements are easily supported by existing literature in the addictions field, research supporting others was more difficult to find. In some circumstances, they were supported by literature outside of addictions research, primarily through the mental health and public health research fields. What follows is a brief synopsis of the research that was found to support the principles of recovery and systems of care elements and a listing of the fields from which the information was derived.

Extensive research has been conducted in the addictions field to support the following principles and systems elements:

- There are many pathways to recovery;
- Recovery exists on a continuum of improved health and wellness;
- Recovery is supported by peers and allies;
- Recovery is a reality;
- Inclusive of family and other ally involvement;
- Individualized and comprehensive services across the lifespan;
- Continuing care part of the continuity of care element;
- Partnership-consultant relationships;
- Responsiveness to personal belief systems;
- Commitment to peer recovery support services;
- Integrated services; and
- Ongoing monitoring and outreach.

The following principles and systems elements were supported by a modest amount of research from the addictions field:

- Recovery is self-directed and empowering;
- Recovery involves a personal recognition of the need for change and transformation;
- Recovery emerges from hope and gratitude;

- Recovery involves addressing discrimination and transcending shame and stigma;
- Recovery involves (re)joining and (re)building a life in the community;
- Systems anchored in the community;
- Strength-based; and
- Outcomes driven.

The following principles and systems elements were supported by limited addictions research, but were grounded in literature from the general public health and mental health fields:

- Recovery has cultural dimensions;
- Person-centered;
- Continuity of care;
- Culturally responsive;
- Inclusion of the voices and experiences of recovering individuals and their families; and
- System-wide education and training.

The following principles were supported by a minimal amount of research in the addictions, mental health, and public health research fields:

- Recovery is holistic;
- Recovery involves a process of healing and self-redefinition; and
- Adequately and flexibly financed.

In relation to the process- and outcomes-driven systems element, it should be noted that large-scale, longitudinal studies have been conducted that measure quality- of-life outcomes for individuals with substance use problems and disorders. However, this systems element points to the importance of examining long-term global effects of the recovery process on the individual, family, and community, while also studying the process of care and implementing continuous quality improvement mechanisms to improve treatment access and retention. Additionally, this element suggests that process and outcome measures should be developed in collaboration with individuals in recovery. Although the addictions research community includes some researchers in recovery, this element suggests broader inclusion of the voices of individuals in recovery in developing outcome measures.

Finally, this paper identifies areas where there are modest amounts of addictions research related to recovery. Limited literature on the conceptual framework of recovery-oriented systems of care exists, but even less research is available on the implementation and outcomes of recovery-oriented services and systems for those with substance use problems and disorders. By providing this baseline assessment and the associated gaps in the research, future research agendas can be better informed.

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