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### Why Recovery Matters Even More in 2015

As the 21st century entered so did a new science for understanding and addressing America's problem with illicit substance use and addiction. In the previous century addiction was seen as one's fault or the inevitable outcome of bad decisions for which society also suffered. In response society, via very limited insurance, offered one or two supported treatment experiences before it through up its hands to public health, criminal justice or death to address the failures and societal consequences. Whole industries were born around the illness that more often retreated than addressing its root cause or its need for coordinated continuing care while providing relieving medical care, temporary stabilization and, in exasperation, more and more jails, intensive care units and – for the fortunate – long term rehabilitation. Early in the 20th century addiction treatment, albeit seen mostly through the eyes of alcoholism, designed a full array of well-intentioned but largely ineffective treatment approaches ranging from brain surgery, shock therapy (ECT), early alcohol laden replacement elixirs, to individual re-learning and/or mandated religious conversion with moral pledges as the then best attempt to de-spirit the spirited. Miraculously, amidst this constant attempts of science some – although far too few – still found recovery.

Later in the century a focus on the brain and what treatments seemed to scientifically work in the short term for the pathology led to initial successes but long term care remained generally absent. With still limited success, not surprisingly as the new century dawned scientists and practitioners began to ask again, "Are we understanding and addressing this illness properly?"

Many dedicated researchers, policy makers, clinicians and most of all those in recovery said "no" or more pointedly, "not based in my experience." Ironically when the failures of individual episodes of care were seen more longitudinally and the sense of futility passed the very clue that continuing care seemed more an answer than a failure emerged and the world of addiction understanding and treatment changed. A new scientific paradigm was born. Key studies led in this early re-defining of addiction. One by McLellan, Lewis, O'Brien, and Kleber courageously identified drug dependence as a *chronic* medical illness and while showing similar or better outcomes to other "chronic illnesses" if so approached, also asked what then would be the full implications of such understanding for treatment, insurance and ultimate outcomes with all individuals seeking help for addiction (JAMA, 2000). When other similar studies appeared, those dedicated to addiction at all levels began to scramble. Our treatment systems were built on an acute illness model and understanding that at best might combine time limited formal treatment with occasional "aftercare" and a distanced connectivity to Fellowships or peer support groups to meet the need for continuing care required by ALL chronic illnesses. Moreover, within the old acute model, the outcome of treatment was measured by the "completion of a treatment episode." Within a chronic understanding, illness recovery or illness reduction and self-management would become the new outcome – similar to other chronic illnesses.

Shifting then to those in recovery for answers in 2006 W. White and E. Kurtz described a variety of recovery experiences and how recovery seemed to be obtained therein (Int. Jr. of Self-Help and Self Care, 3). White also surveyed the literature at that time on this re-framed (chronic) understanding of “addiction recovery” and found that since 1997 more than 150 related articles had emerged in peer-reviewed journals related to addiction as chronic and recovery (Northeast ATTC, 2006). In 2007 a Betty Ford Institute Expert Panel, seeking to modernize the purpose of treatment from this perspective published the first consensus definition of recovery (JSAT, 33). Today that definition is used and elaborated upon by SAMHSA/CSAT in the U.S. and – with local and cultural modifications – worldwide in similar evolutionary efforts. In 2014 White returned to update his bibliography and found well over a 1500 related books and articles worldwide (see: [williamwhitepapers.org](http://williamwhitepapers.org)). A worldwide science was emerging. He also co-authored the first study identifying a common structure to the experience of recovery as evidenced across diverse pathways to it (Flaherty, Kurtz, White & Larson, *Alcoholism Treatment Quarterly*, 2014, 32). Indeed our view of addiction and the goals of treatment had changed prolifically since 2000. Still, one may fairly ask if our policies and clinical practice and treatment systems have kept up? What is the purpose of treatment today?

Today our treatment systems remain largely those built while addressing addiction via an acute (episodic) illness approach. Buildings and the systems supporting them are difficult to change. Providers and practice can adapt more easily. To reach the practice transformation needed given this history and the existing realities today within the community several key next steps seem needed:

1. A recognition that substance use and addiction are scientifically best understood and treated from the chronic disease model or understanding of care, i.e. while it may not be chronic for all, it is best addressed from that potentiality.
2. As with all chronic illnesses, strong prevention and early intervention integrated within general health care are the first and best steps to deterrence and sustained health and wellness – for the individual, family and community.
3. Treatment must be available along an available clinical continuum of care that recognizes the nature of the illness and the precise needed intervention – or the illness will become worse.
4. The individual’s “illness” defines the needed level of intervention and length of care. The return to one’s life, choices, health, citizenship and potential defines individual recovery.
5. All treatment should offer the possibility of recovery as defined for each individual.
6. Recovery should be defined for each person, family and community – with reportable measures.
7. Recovery is not universally alike nor the pathways to it found in any one approach to it.
8. There are phases to recovery and specifics to the management of recovery within each phase.
9. Recovery may be supported by acute care, co-occurring care and/or medications – all of which are *not* recovery in themselves - but may be critical aides to it.
10. Addiction can arise from prescribed or illicit drugs – depending on the person and use.

Given the numbers today needing care and the advancement of pharmaceutical and illicit drug use, to complete this new paradigm a highly trained and expanded workforce is needed. Each worker must think of his/her role along the chronic illness prevention-intervention-treatment and recovery continuum and apply themselves competently and effectively wherever along that illness trajectory they serve. The “illness” and its measureable “recovery” must be the driver of care - not a payment methodology, fee or revenue generation. To achieve this, all professional disciplines will need to know the nature of “addiction” and better collaborate peer to Ph.D. and M.D. across generalist and specialty care settings – including schools and law enforcement – to address the need of each individual for intervention or treatment that can lead to a real possibility to prevent the illness or to attain and sustain recovery from it. To succeed, each local community must be actively involved in this planning, subsequent action and evaluation – as with other chronic illnesses. Emerging models do exist in counties across the nation, large cities such as Philadelphia and states such as Connecticut, Michigan and most recently Ohio, to name a few.

Because of our re-understanding of addiction and the recovery focus today the world is closer to a *unified* scientific, experiential and community validated understanding and solution to addiction and recovery. 2015 can provide the next evolutionary step. Keeping a recovery focus and building recovery management and systems are not the easiest solution but the challenge to do so now matters more than ever - lest we lose the purpose of why we do what we do.

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