Recovery-Based Care for Addiction: Lessons From the States

By: Matthew Gever
September 5, 2008

Introduction: What Is Recovery-Based Care?

Historically, a patient who left a substance abuse treatment program was sent on his or her way with a wish for the best and perhaps a referral to a mutual support group such as Alcoholics Anonymous. If the person relapsed, hopefully a program was available to provide care. Over time, researchers realized that this approach perpetuated a cycle of revolving into and out of treatment programs that could only be solved by significant system improvements.

Enter recovery-based care. Recovery-based care considers the substance abuse treatment and recovery system from a different perspective. It views effective treatment as part of a long-term, sustained commitment to helping individuals, families and communities recover from addiction and improve health and wellness. It also broadens the continuum of care by enhancing support for prevention, early intervention, treatment, continuing care and recovery. Treatment under a recovery-based approach incorporates quality-of-life elements by responding to addiction as a chronic rather than an acute care condition. To adopt recovery-based care requires engagement of multiple systems to: 1) provide support services, including education, housing, child care, financial planning, employment assistance, health care legal assistance; and 2) provide appropriate recovery-oriented services.

The primary goals of recovery-based care for addiction are to:

- Prevent addiction and intervene early with those who develop substance use problems;
- Support sustained recovery for those who are in recovery; and
- Improve the health and wellness of individuals, families and communities.

Recovery in Action

Connecticut

Connecticut pioneered the shift to state-level recovery-based care. The process began in the late 1990s and gained momentum in 1999 with the development of "Recovery Core Values." This joint effort involved the Connecticut Community for Addiction Recovery Inc. and Advocacy Unlimited Inc., two advocacy groups involved in mental health and

substance abuse. Following the merger of mental health and addiction services into a single state agency—the Connecticut Department of Mental Health and Addiction Services (DMHAS)—the two groups were asked in 1999 to envision the principles that should define the new DMHAS health care system. They identified 24, divided into four major categories:

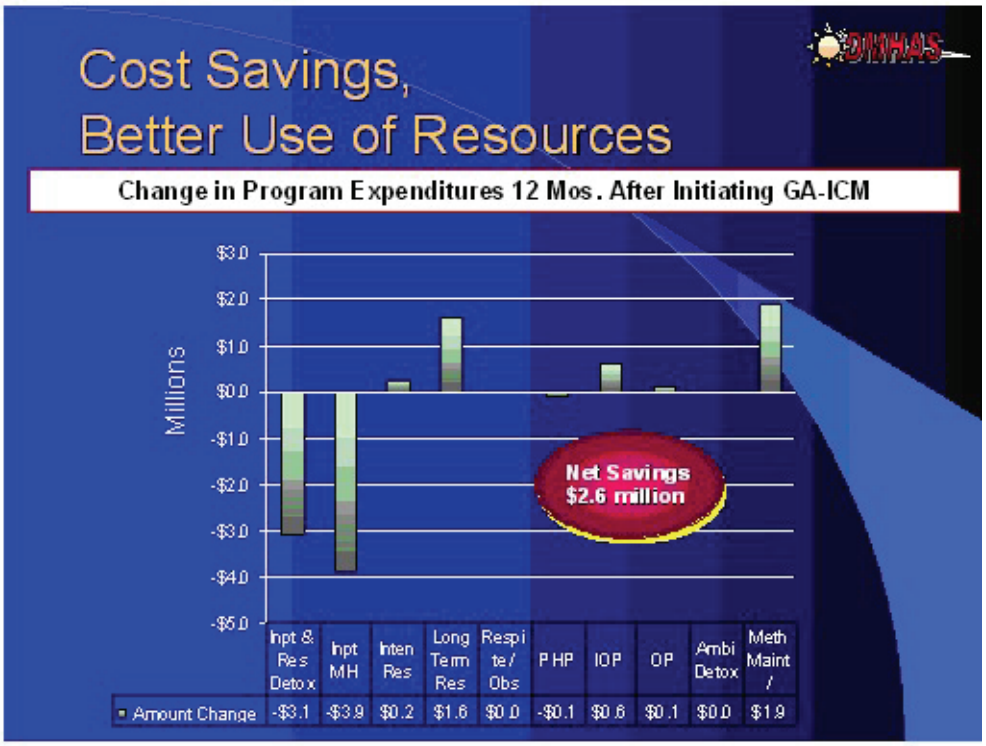
- Participation, where patients' choices are respected;
- Programming, including individually tailored and culturally competent care;
- Funding operations, where no results mean no income; and
- Direction, using recovery-based results measures and entire systems to support recovery.[1]

DMHAS then hosted a series of forums with major stakeholders in the addiction field, including patients, providers, family members, and private and nonprofit groups. This led to Policy Statement #83, signed by DMHAS Commissioner Thomas Kirk. The statement defines recovery as "… a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite, or within the limitations imposed by that condition."[2] Intended to guide all policy and planning efforts, it embeds the language, spirit and culture of recovery throughout the system of services.

To begin, the state instituted a series of initiatives under the General Assistance Behavioral Health Program (GA-BHP) to move people from inpatient care to less restrictive and less costly community-based care settings.[3] First under the program was the General Assistance Intensive Case Management Initiative. For this initiative, the state enlisted the services of an administrative services organization to help with claims processing. The organization was specifically charged with finding the highest users of acute care, defined as three or more admissions in a 90-day period. Patients who fit this pattern then were referred to a trained recovery specialist to develop a plan and help them move to community care.

Results have been positive. Patients who participate in the case management initiative are staying in treatment longer, leading to more time in what the agency calls "the recovery zone" and fewer readmissions to treatment. The number of admissions to inpatient care also has dropped by 56 percent since implementation began in 2002. Admissions were replaced by less costly outpatient services, resulting in net savings to the state of $2.6 million (see Figure 1).[4]

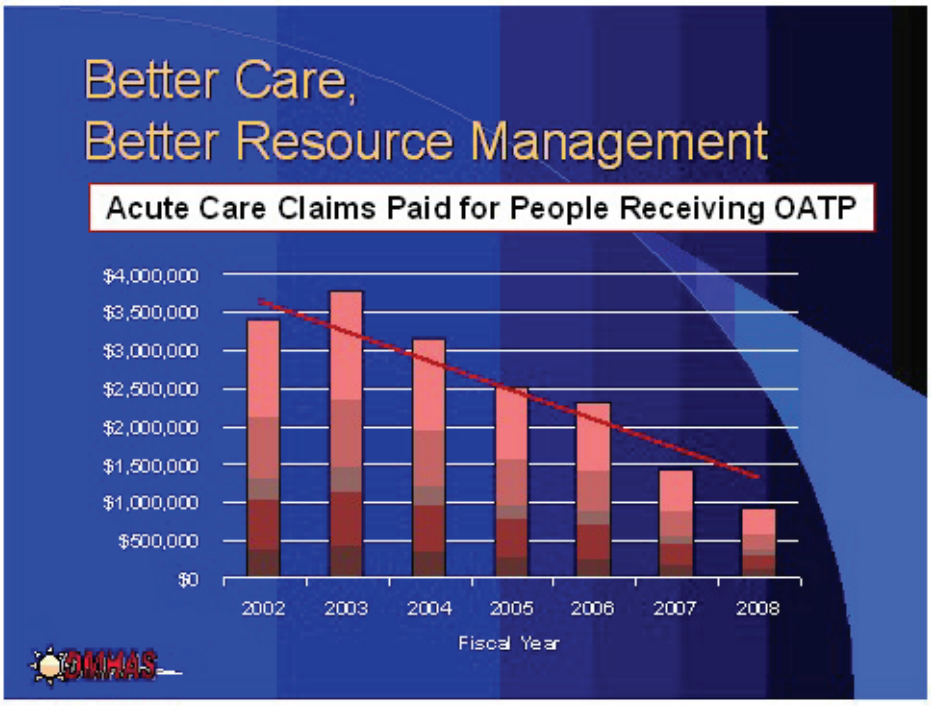
Figure 1. Change in Program Expenditures 12 Mos. After Initiating GA-ICM



Source: *Paul Dileo, "Facilitating Addiction Recovery using Healthcare Financing and Program Innovation" (Web Presentation to NCSL, July 18, 2008).*

The second initiative, the Opioid Agonist Treatment Protocol, provides treatment alternatives for those with opiate addiction. This initiative primarily targeted heroin users, who as a group are most frequently readmitted to residential treatment facilities. Participants were given priority for methadone maintenance therapy and were connected with recovery support services such as temporary housing. Housing, above all, was credited with helping opiate addicts remain longer in recovery and stay out of emergency rooms and acute care facilities.[5] Overall, the treatment protocol is responsible for a 20 percent reduction in the number of inpatient beds used since 2002; the state thus paid two-thirds less on treatment for this group in 2007 than it did in 2002 (see Figure 2).

Figure 2. Acute Care Claims Paid for People Receiving OATP

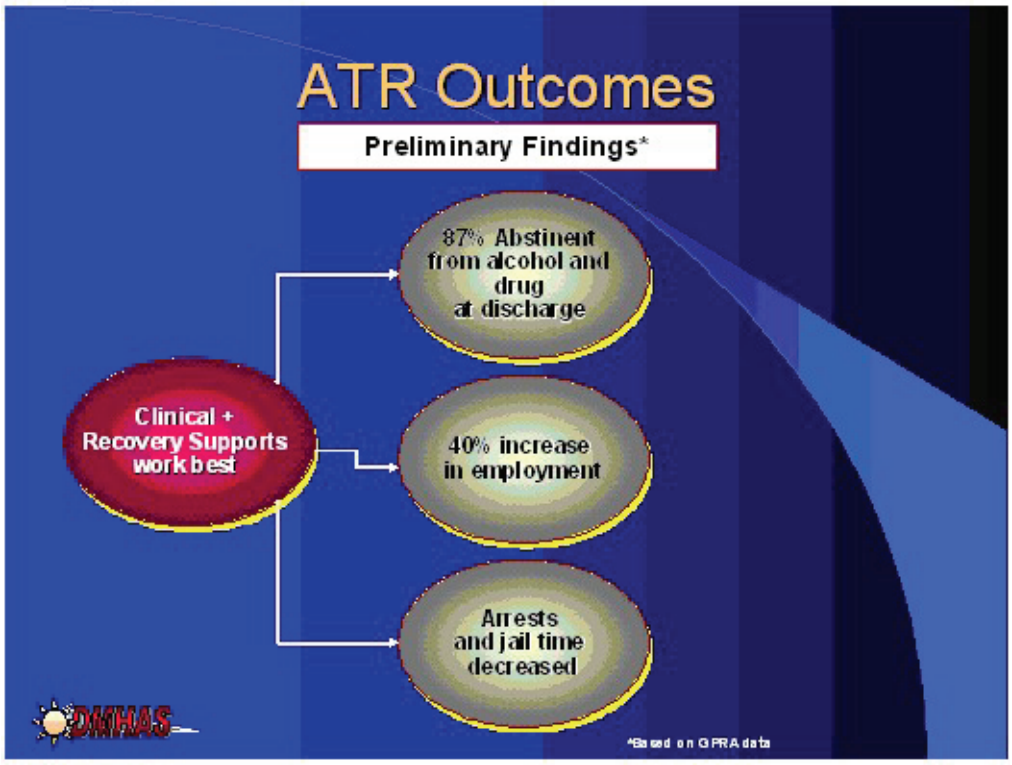


Source: *Paul Dileo, "Facilitating Addiction Recovery using Healthcare Financing and Program Innovation" (Web Presentation to NCSL, July 18, 2008).*

The third initiative focuses on those with co-occurring mental health and substance use disorders. The GA Alternatives to Hospitalization program screens emergency room patients who exhibit symptoms of a mental health condition, e.g., discusses or attempts suicide, and evidence of substance use. The goal is to determine how to intervene early with this group and refer them to appropriate treatment, rather than confine them to a psychiatric ward. In its first year, the program screened 614 patients and provided 299 with more appropriate care.[6] The state reinvested the savings from fewer emergency room admissions in two health centers that treat people with co-occurring disorders.

The Nutmeg State also was one of 14 states to receive a federal Access to Recovery grant to help cover nontraditional services. Two-thirds of this grant—$22.8 million over three years—paid for non-clinical services such as housing, transportation, vocational and educational services, faith-based services and peer counseling. Connecticut received a second award and is using it to pay for buprenorphine-enhanced services for patients with co-occurring disorders. Initial results for those covered by the most recent grant include increased abstinence, more instances of gainful employment and fewer arrests and jail time (see Figure 3).[7] The legislature plans to use state funds when the second grant ends.[8]

Figure 3. Access to Recovery: Preliminary Findings



Source: *Paul Dileo, "Facilitating Addiction Recovery using Healthcare Financing and Program Innovation" (Web Presentation to NCSL, July 18, 2008).*

Philadelphia

The City of Brotherly Love has long provided innovative treatment for people with alcohol and drug problems. In the late 18th century, Philadelphia doctors were among the first to consider alcoholism a chronic condition. More recently, the first professional addiction counselors began practice in the city. [9]

Early in the 21st century, Philadelphia redefined how treatment systems should operate. Local addiction professionals realized that every patient eventually leave the treatment system and return to the community, with varying levels of support—or none at all. This led the city to consider addiction as a chronic condition that requires a long-term approach to ease patients into a normal life.

The first step was to gather people in the recovery community to help city officials develop a comprehensive strategy. One lesson was that treatment services must address more than alcohol and drug use by including the underlying factors that may contribute to a person's alcohol or drug problem. A high proportion of substance users in Philadelphia, for example, have experienced some form of trauma, such as sexual, physical or emotional abuse, and use drugs or alcohol as a form of self-medication.[10] Officials realized the importance of treating both trauma and addiction for the patient to sustain recovery. The problem is exacerbated if few clinicians are trained to provide specific care for people with this background.

A similar problem exists for those with co-occurring substance use and mental health disorders; this group has one of the highest rates of readmission to treatment.[11] If a program addresses only substance use, it misses half of the equation. Patient age is another issue. A treatment program that is effective for people in their 30s may not be as effective for those in their 50s or 60s or for those in their late teens or 20s.

To address these and other concerns, the Philadelphia Department of Behavioral Health commissioned a series of workgroups to develop more effective practices for particular populations and situations. One working group searched scientific literature for evidence-based practices and the support structures to implement them. The workgroup developed a series of new programs designed for specific populations.[12] Another workgroup specifically considered methods to address trauma and its role in addiction and recovery. The department decided to open the workgroups to all departmental employees. As a result, the department learned that many employees had family or friends in recovery and, in turn, wanted to help shape and improve treatment and recovery services.[13]

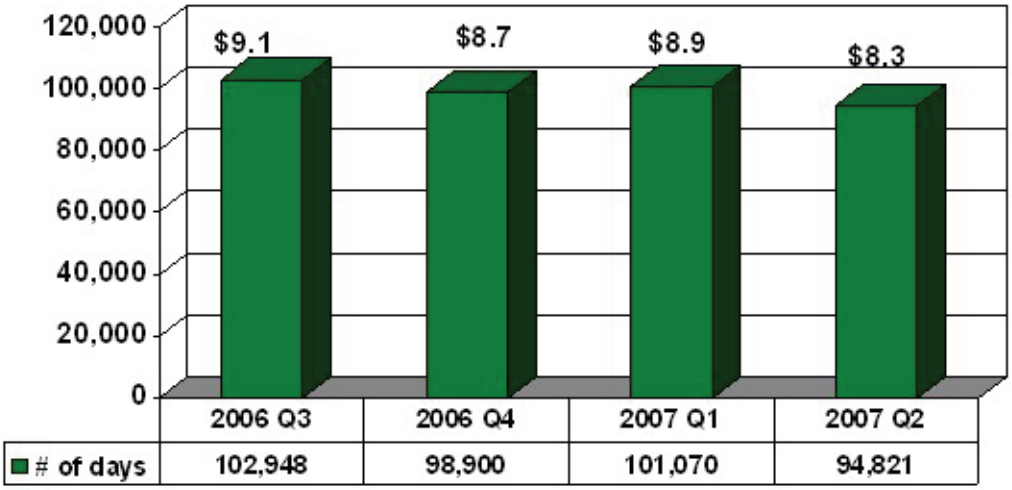
To develop post-treatment services, the city hired and trained about 200 peer specialists to work with those who have co-occurring mental health and substance use disorders. Peer specialists have a dual diagnosis, are in recovery, and want to help others.[14]

Another department strategy to connect patients with post-treatment services was to reach out to the Philadelphia faith community. In conversations with the recovery community and through literature searches, the agency found that spirituality can play an important role in patients' lives. Thus, the faith community can provide the impetus to seek help and provide support throughout the recovery process.

Peer specialists also helped the city reach out to communities that were underrepresented in treatment. This was especially the case among immigrant groups such as the Southeast Asian community, according to Dr. Arthur Evans, head of the department. Peer specialists serve an important function by helping with targeted outreach and providing culturally and linguistically sensitive programs.

The city funded these innovations by drawing from the cost offsets to other departments that realized benefits because fewer people needed their services. By working with county jails, for example, the department helped significantly reduce the number of days inmates spent behind bars and saved the jail system approximately $35 million in fiscal year 2007 (see Figure 4).

Figure 4. Prison Days Saved Through Forensic Intensive Recovery Program and Treatment Court, Showing the Value Saved, at $88 per Day ($ in millions, FY 2007)[15]



Source: *Arthur Evans, "System Transformation in Philadelphia: A Recovery Revolution," (Web presentation to NCSL, July 11, 2008).*

Other benefits include longer periods of sustained recovery, resulting in fewer readmissions to treatment, and improved quality of life for patients and their families. In a recovery-based system, many more individuals find jobs or enroll in higher education and thus move from being recipients of public services and funds to contributing taxpayers.

Oregon

Untreated substance abuse cases cost Oregon $5.93 billion in 2006.[16] This was due to a combination of increased health care costs, lost productivity, and expenditures for criminal justice and social welfare programs. These figures led the Beaver State to reconsider its current substance abuse treatment system.

Like Pennsylvania and Connecticut, Oregon began its transition to a recovery-oriented system by engaging people who already were in the recovery community or were still receiving services. In 2004, the state conducted a series of focus groups with people who were receiving services to discover what was working for them. Oregon officials learned people needed support services beyond treatment and detoxification.[17] In response, the legislature committed $14.1 million over the next three biennia to establish various recovery support services.

Part of the money will be used to establish data collection systems, which the state will use to measure effectiveness. In particular, officials want to know "… that transitions between levels of care are meaningful and how the clients feel about the services they received."[18] This currently involves county-level measures of engagement, retention, appropriate level of care, completion and reduced use.

Oregon also recognized the need to tailor services for certain populations. Parents with children in the welfare system now are eligible for new services such as peer mentoring and

increased subsidies for treatment if they are not eligible for Medicaid. The state also will build recovery centers throughout the state that include culturally specific services for African-American, Hispanic and Russian immigrant communities and for patients with co-occurring disorders. The state plans to develop drug-free housing options and will provide rental assistance for patients in the future.

In addition to appropriations, the legislature acted to ease the transition to a recovery-oriented system. It repealed the state's Uniform Accident and Sickness Policy Provision Law (UPPL), for example, which allowed insurers to deny a claim if a patient tested positive for alcohol or a controlled substance. The legislature also has added various addiction services and codes for Screening, Brief Intervention and Referral to Treatment to its Medicaid package.

Obstacles

States that seek to implement a recovery-oriented system of care face some obstacles that require various state and federal agencies to work together and to rethink goals and priorities. For example, Medicaid follows a medical model for reimbursement that funds only services deemed medically necessary. Although this includes many treatment and detoxification programs, it excludes some services—including, transportation subsidies and housing—that are critical to recovery but are not considered medical therapies. To develop recovery-based care, government agencies also will need to develop relationships with patients, the broader recovery community, and other non-governmental agencies and entities. The lessons learned in Connecticut, Philadelphia and Oregon demonstrate that innovation and flexibility are key to designing a recovery-based system and promoting long-term sustained recovery for people with addiction.

---

[1] Thomas Kirk, Phillip Valentine, and Ronald Fleming, "Connecticut: Innovation in Recovery-Oriented Systems of Care (ROSCs)," (presentation at NCSL health chairs meeting, Washington, D.C., June 20, 2008).
[2] Thomas Kirk, Commissioner's Policy Statement No. 83, Promoting a Recovery-Oriented Service System, Sept. 16, 2002, http://www.ct.gov/dmhas/cwp/view.asp?a=2907&q=334672, accessed Aug. 5, 2008.
[3] Senator Toni Harp, "State Support of Recovery-Oriented Care for Addiction: The Connecticut Experience," (Web presentation to NCSL, June 27, 2008).
[4] Paul Dileo, "Facilitating Addiction Recovery using Healthcare Financing and Program Innovation" (Web Presentation to NCSL, July 18, 2008).
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Toni Harp, "State Support of Recovery-Oriented Care for Addiction."
[9] William White, "A Recovery Revolution in Philadelphia," *Counselor* (Jan. 2, 2008).
[10] Arthur Evans, "System Transformation in Philadelphia: A Recovery Revolution," (Web presentation to NCSL, July 11, 2008).
[11] Arthur Evans, "System Transformation in Philadelphia."
[12] William White, *The Recovery-Focused Transformation of an Urban Behavioral Health Care System* (Chicago: Great Lakes Addiction Technology Transfer Center. DATE), 6.
[13] Arthur Evans, "System Transformation in Philadelphia."
[14] Ibid.
[15] Ibid.
[16] Robert Whelan, Alec Josephson, and Jake Holcombe, *The Economic Costs of Alcohol and Drug Abuse in Oregon in 2006* (Portland, Ore.: ECONorthwest, Jan. 14, 2008).
[17] Therese Hutchinson, "Building Recovery-Based Care in State Addiction Service Systems," (Web presentation to NCSL, July 18, 2008).

[18] Ibid.