

This interview will be part of *Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-Oriented System of Care*, the second in a series of monographs on recovery management published by the Great Lakes Addiction Technology Transfer Center (ATTC).



Recovery as an Organizing Concept

An Interview with H. Westley Clark, MD, JD, MPH, CAS, FASAM
By William L. White, MA

INTRODUCTION

The effort to achieve a more recovery-focused system of care in the design and delivery of addiction treatment services has received considerable impetus from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). Through programs such as National Recovery Month, the Recovery Community Support Program (RCSP), Access to Recovery (ATR), and the Recovery Summit, to name just a few, CSAT has moved recovery to the conceptual center of its efforts to enhance the availability and quality of addiction treatment in the United States. I conducted the following interview with Dr. H. Westley Clark, Director of CSAT, January 12, 2007, on behalf of the Great Lakes Addiction Technology Transfer Center (GLATTC). The interview provides one of the most compelling statements to-date on this shift toward a recovery paradigm.

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GREAT LAKES ATTC: Dr. Clark, could you highlight your professional background and the circumstances that brought you to CSAT?

DR. CLARK: I'm a psychiatrist and addiction medicine specialist, and have worked in the addictions field off and on for the past 30 years. Before coming to CSAT in 1998, I had most recently worked for the Department of Veterans Affairs in San Francisco, serving vets with substance use disorders, psychiatric disorders such as Post-Traumatic Stress Disorder, and

medical disorders such as HIV. I also have a degree in Public Health and a degree in Law, which have increased my sensitivity to some of the policy issues germane to the substance abuse arena. My professional interests before coming to CSAT included such diverse areas as substance use among pregnant women, workplace drug testing, and working with substance use in the criminal justice system. I also worked as a senior policy advisor for the Robert Wood Johnson Foundation's Substance Abuse Policy Research Program.

GREAT LAKES ATTC: During your tenure at CSAT, recovery has emerged as a central organizing concept, both at SAMHSA and at CSAT. Could you describe the background of this shift in emphasis?

DR. CLARK: Recovery has been a key construct in the substance use disorder arena for some time. Recovery, as you know, is an integral construct of 12-step and other self-help programs. It became clear to me as a clinician that it is not simply acute intervention that helps a person. It's the ability to receive ongoing contact and support from others, either through professional support or through a community of recovering peers. Recovery is more than an abstinence from alcohol and drugs; it's about building a full, meaningful, and productive life in the community. Our treatment systems must reflect and help people achieve this broader understanding of recovery.

A few things happened at SAMHSA that facilitated the evolution of the recovery construct over the past five years. SAMHSA adopted recovery as its central vision. Our vision is a life in the community for everyone, and our mission is one of building resilience and facilitating recovery. CSAT, in turn, developed the vision of "Making the hope of recovery a reality...." Prior to 2002, we had a Recovery Community Support Program (RCSP) that organized people in recovery to advocate for themselves at the state and local community levels. We then translated that into a focus on peer-based recovery support activities within local communities. We made significant strides in building relationships in the community and expanding local recovery support services. The next major milestone was Access to Recovery, a Presidential initiative that provided a hundred million dollars a year for further expanding recovery support services provided by grassroots recovery community organizations and faith-based organizations. The new SAMHSA and CSAT missions and these two CSAT programs helped push recovery to the forefront of our activities at CSAT.

GREAT LAKES ATTC: CSAT's Recovery Month activities have grown exponentially in recent years. What do you see as their collective goal, and to what do you attribute such phenomenal growth?

DR. CLARK: Communities across the country have been concerned about the misuse of substances and the wide range of people affected by such misuse. National leaders and local community leaders recognize that we need the community benefits of recovery, and we need local communities to support people in recovery. And we want to provide a framework through which people in recovery can help others in need of recovery. That's what I've been promoting. We want support for those in recovery. We want people in every community to know that treatment works, that recovery is possible, and that long-term recovery is a reality. We want recognition for those in recovery, for their service providers, and for the efforts of local communities. Recovery Month provides such recognition through an ever-widening range of activities, including ballgames, picnics, pow wows, recovery celebration walks, and educational events. These events reward the hard work of people in recovery, their families, and the various organizations that have supported the recovery process. Seeing thousands of people in recovery gathered together reinforces the possibility and promises of recovery.

These events also provide a venue for organizing community response to new or resurging drug problems. A recent issue is methamphetamine. Large numbers of communities are seeing a drug that they hadn't seen before. In the beginning of the methamphetamine phenomenon, a number of people proclaimed that those affected were hopeless. What that meant for the community was that they would have to write off their sons and daughters. I think the community at large is loath to do that. Recovery Month offers an antidote to such pessimism by offering living proof of long-term recovery and its blessings to individuals, families, and communities.

GREAT LAKES ATTC: CSAT recently sponsored its first national Recovery Summit. What do you think was most significant about this event?

DR. CLARK: We are facilitating multiple discussions about recovery as a construct. We think that through the ATR and RCSP programs we can play a critical role in championing the impact of the holistic community-based system aiding recovery. The Recovery Summit helped articulate principles and guidelines that can guide our work. If we are going to foster recovery, we need to have a clear understanding of the range of recovery experiences and the elements that go into long-term recovery. We need the participation of the recovery community, the treatment community, and the research community to do that. I was quite happy with the Summit and our work to begin this dialogue across communities that often have little contact with one another.

GREAT LAKES ATTC: One of the most significant initiatives under your leadership at CSAT has been the Recovery Community Support Program. What do you think are some of the most significant contributions of the RCSP?

DR. CLARK: The RCSP program has demonstrated that people in recovery can in fact participate in offering assistance to other people who either are beginning the recovery process or need to have their long-term recovery efforts supported. The RCSP program is designed to help reduce stigma and barriers to service. We have two models. We have professionally facilitated recovery and peer-based recovery. Both models operate on the principle that the consumer can play a critical role in the recovery process. The peer support model offers several examples of services that are consumer driven and that can serve as important adjuncts to formal substance abuse treatment and prevention efforts. Peer-based recovery support services build on and extend the effects of acute intervention.

I think one of the things coming out of our ATR program is the understanding that the outcomes of acute intervention can be enhanced and sustained. We don't want to just describe the substance use disorder as a chronic relapsing disease and just leave it at that. What our peer support services, facilitated support services, and recovery model do is to stretch the effects of our interventions, while at the same time reducing the frequency of such acute episodes. We don't have to wait until a person completely relapses, with all the attendant problems with the family, the workplace, and the law. Recovery support services provide a vehicle to prevent relapse or to prevent lapses from progressing into full relapses. And we don't have to wait for people to hit bottom. What peer support efforts do is lift the bottom, so that individuals can find recovery before they've alienated their families, their employers, and the legal system.

GREAT LAKES ATTC: What do you envision in terms of the future of the RCSP program?

DR. CLARK: Well, as with all of our programs, we are tied to available funds. We are currently collecting performance data on the RCSP program, to make sure that we're achieving our goals and objectives. I'd like to continue to support the RCSP program, because it does represent the efforts of individuals in recovery. We would like to see if we can get the state agencies to acknowledge the utility of recovery support services as a part of their continua of care. We hope to demonstrate that peer-based recovery support services are more cost effective for individuals, families, and the community, and that they complement rather than compete with professionally directed treatment services. In fact, peer-based recovery support services enhance the impact of professional care by sustaining the effects of such care long after the intervention is completed. When I used to run a 28-day program, I would ask myself, "What happens on day 29?" Then, when I worked in an intensive outpatient program, I saw somebody 3 or 4 times a week, but I only saw them a few hours out of a 24-hour day. What did they do the rest of the time? You quickly learn—especially early in the process—that from a neuropsychological point of view, people are a lot more vulnerable in the early stages of recovery, after acute treatment. So I wanted something that would help me do my job. Recovery support services help me do my job, and they help the professional's patients build a life in recovery after the professional has helped initiate that recovery process.

GREAT LAKES ATTC: There have been recent calls to shift addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management. To what extent does this represent a fundamental change in the historical design of addiction treatment?

DR. CLARK: Substance use disorder treatment in the United States is being scrutinized from multiple perspectives, and the whole notion of sustained recovery management is consistent with the notion of disease management that you find elsewhere. The chronic disease model recognizes that there is no acute solution. You break your leg, you put a cast on it; it heals, and you go on with an otherwise unchanged life. You don't have a problem—unless, of course, you're into extreme sports. But if you've got asthma, you're going to have asthma off and on for awhile. If you've got diabetes, your diabetes is going to require different management strategies over a prolonged period of time, if not for the rest of your life. Some strategies are just diet and careful monitoring of what you eat. Other strategies include oral pills. Another strategy is insulin. These are different strategies, but they all require a fervent effort. Like long-term management of any other chronic disease, the substance use disorder recovery management strategy offers a framework for sustaining and actively managing recovery over a lifetime.

What recovery management does is allow you to differentiate and titrate the intervention. Not everybody needs an intervention at the same time or at the same level of intensity. Relapse is a common event early in the treatment and recovery process, and there are points of heightened vulnerability later in the recovery process. The recovery management model acknowledges this vulnerability but posits that relapse is not inevitable if the ongoing recovery process is actively managed.

We also have people with multiple problems, such as co-occurring depression or anxiety disorders. We've got complex medical issues, like HIV, Hepatitis, and AIDS. We've got other issues in the recovery process, like homelessness or involvement with the criminal justice system. So a recovery model says, "Okay, from the public's point of view, we have to deal with all of these complexities." We've got individuals who've been physically and sexually abused, or are victims of domestic violence or other kinds of violence and stress. So we need to have support for individuals depending on their unique situations, and that support must extend beyond the point of crisis stabilization. Beyond detox, beyond medical maintenance, what else happens in that person's life? We need to be doing aggressive post-treatment monitoring and

support—in part, because drug dealers are interested in having people buy their products, and they will be doing aggressive post-treatment monitoring and marketing.

Our data at the Substance Abuse and Mental Health Services Administration shows that 73 percent of the people who meet criteria for needing treatment for drugs perceive no need for treatment. Eighty-eight percent of people who meet criteria for needing treatment for alcohol use perceive no need for treatment. Now, they endorse all of these things, saying, “My life is adversely affected as a result of my alcohol or my drug use.” But these are people—73 percent, 88 percent—who are not seeking treatment. They see no need for treatment. So when we talk about recovery being a community phenomenon, my question is this: “How is it that a person on a self-administered test can endorse ‘I’m having problems with alcohol and drugs and with my job, my family, my health, the law, my life, but I don’t need treatment’?” In many cases it’s because their environment is saying, “You don’t need treatment,” whether it’s because of stigma, whether it’s because of denial for other reasons, whether it’s because there’s a conspiracy of silence. This person is already endorsing, “I’m having problems.” This isn’t somebody who’s just using alcohol casually, or occasionally using an illicit drug. These are people who endorse a sufficient severity of their substance use that treatment is warranted. So, if that’s the case, we need a recovery management strategy that helps promote the notion that the individual needs to be in recovery. The community needs to be in recovery. They need to work together on that.

GREAT LAKES ATTC: One of the things that is coming out of CSAT’s recovery support initiatives is a more assertive approach toward actually identifying and engaging these people and altering that perception.

DR. CLARK: Right. We also believe that the recovery process needs to be a part of an integrated health care delivery system—one in which substance use problems are perceived as health issues and not simply as a mental health issue or an issue of concern only to substance use disorder treatment practitioners. The message we are trying to promulgate throughout the whole health care delivery system is the value of brief intervention and referral to treatment. We are trying to help healthcare providers talk about substance use in nonjudgmental ways and intervene skillfully when they encounter substance-related problems. We are trying to get these practitioners to intervene early and to sustain their support, just as they would in response to hypertension, diabetes, or other chronic disorders.

GREAT LAKES ATTC: Do you envision a much closer integration of primary healthcare and addiction treatment in the future?

DR. CLARK: That is our hope. That is what our screening/brief intervention effort is trying to facilitate. The recovery process, as you know, is plagued with problems of compliance similar to those found with hypertension and diabetes. What we are doing is promoting a one-stop shop, meaning that the health centers would be authorized to provide early intervention. We don’t have to wait until the person crashes and burns and finally arrives at the doors of substance use disorder treatment, usually via the criminal justice system. By the time you get into the criminal justice system or the child welfare system as a result of drug use, you’ve usually got a long list of severe and complex problems. We believe that issues with alcohol and drugs adversely affect the person’s health and the person’s well-being, given that these problems have to manifest elsewhere. Early intervention will allow us to respond to these problems early and to begin to work with the person from a motivational point of view. The goal is to deal with these problems before they’re exacerbated to more severe levels.

GREAT LAKES ATTC: There are recovery-oriented systems transformations underway in states like Connecticut and in cities like Philadelphia. Do you see such efforts as the wave of the future?

DR. CLARK: Connecticut has done a brilliant job with the recovery model. Tom Kirk has a very good theoretical model, which could be widely replicated. I applaud the visionary efforts of Connecticut and Philadelphia and others who are leading this recovery-focused transformation of substance use disorder treatment. The field of substance use disorder treatment will have better outcomes as we move towards a recovery-oriented service system. What is emerging in these frontier efforts is the development of an integrated system that mobilizes both the formal and informal resources of a community toward the goal of widening the doorways of entry into recovery and providing the support needed for people to move from a community's problems to a community's assets.

GREAT LAKES ATTC: There is growing evidence that sustained post-treatment monitoring and support, assertive linkage to recovery communities, and early re-intervention enhance long-term recovery outcomes. Do you think such services will become standard practice in most addiction treatment programs?

DR. CLARK: The real question is how we define post-treatment monitoring. We need to be careful about characterizing post-treatment monitoring. We know that some people, particularly those with more severe problems, need ongoing support following primary treatment, and the evidence confirms that post-treatment recovery support services can help reduce relapse and facilitate early re-intervention. We could also use toxicology screening as feedback to an individual and an opportunity for early re-intervention. Post-treatment monitoring and support need to be recovery focused, with an emphasis on support as opposed to simply a policing function. That gets us back to recovery management. The question is, "Is the recovery management service that is monitoring the individual also supporting and helping the individual?" From assertive community treatment, we recognize that these are things that have to be put in place. Recovery support services will offer you the same dynamic and can be tailored to individual problem severity and recovery support needs. But the whole key is the experience that you are part of a community and the community cares about you. The community is supporting you. Monitoring sounds like an externally imposed mandate. What I'd like to see is recovery support services conceptualized as a voluntary phenomenon—something that is chosen because it is in the best interest of the individual.

GREAT LAKES ATTC: Several of the states and cities are committed to the development of ongoing recovery support services but are wrestling with the challenge of finding the best financing models to get these services into the field. "Do we enhance existing rates for inpatient and outpatient treatment that include recovery support services? Do we bill these as separate services?" Do you have any thoughts about future financing of post-treatment support services?

DR. CLARK: Part of a performance-driven system is looking at what we are getting from our existing system. That accountability becomes a key variable in what we're doing. As I pointed out, our delivery system addresses the needs of only a small minority of the individuals who need our services. If the majority of people who suffer from alcohol and drug problems presented for treatment, we would truly be overwhelmed. Our existing waiting list is miniscule compared to the potential demand. So the question for political leaders and those charged with managing behavioral health care systems is, "How do I determine service priorities?" You can look at recovery services in isolation, or you can ask what such services will mean to other costs

that substance use disorders impose on the community. What will these services mean to demands upon the mental health system, the child welfare and the criminal justice systems? If I collect one dollar for taxes, I can spend that dollar any number of ways. The savings that accrue within the criminal justice system and the child welfare system can be used to support the recovery of people who no longer demand the resources of those systems. We need to take the long view.

We're trying to get people to 5 years out. If I can get you to 5 years out in recovery, the chances of your getting to 10 years of recovery goes up dramatically. You see the potential. If you see the dollar as only the dollar from Medicare or the Block Grant, people will fight over that dollar. If you see the dollar as a whole dollar, a taxpayer's dollar, then people must ask how we can enhance recovery outcomes while minimizing demands for repeated episodes of high-cost services. If we can stabilize and support people in recovery, they won't need repeated episodes of such higher-cost interventions. What we pay for repeated episodes of detox and inpatient treatment will pay for a lot of post-treatment recovery support services. We will come to see the recovery support services as a good financial investment.

GREAT LAKES ATTC: What do you think are some of the most significant obstacles to treating severe alcohol and other drug problems in a manner similar to the management of other chronic illnesses?

DR. CLARK: As we begin to integrate substance use disorder treatment and primary health care, such parallels will become more obvious. What Tom McLellan and others are trying to do is to promote the parallels between other chronic health conditions and their treatment and substance use disorders and how they can best be treated. We're just beginning to understand the chronic care model in primary health care. What we will be doing in substance use disorder treatment is finding better ways to shorten and actively manage the prolonged course of many substance use disorders. Our message in Recovery Month to individuals, parents, friends, relatives, and employers is that these are solutions to these problems, and resources need to be mobilized to deal with these problems until they are brought under control. Our screening and brief interventions can help resolve these problems before someone crashes and burns. And with a recovery-oriented system of care, we can mobilize resources for those with the most severe and complex substance use disorders.

We want service providers to recognize that they have a sustained obligation to such clients, and that we have an obligation to use the best science and the best clinical strategies to promote long-term recovery.

GREAT LAKES ATTC: How is CSAT helping the treatment field make the transition toward more recovery-oriented systems of care? What do you see as the role of the ATTCs in helping the field through this historic transition?

DR. CLARK: CSAT recently hosted a Recovery Summit that brought together multiple stakeholders, including the major professional associations from the substance use disorder field, as well as leading substance use disorder researchers and key recovery community organizations. The focus was on how to use this new recovery orientation to enhance our research knowledge about recovery and how to improve the quality of substance use disorder treatment. We'll periodically consider whether we need additional recovery summits to guide our future efforts. We are continuing to work with visionaries like Tom Kirk in Connecticut to disseminate working models to other states and local communities. We have funded the Legal Action Center to document issues related to recovery barriers, social stigma, and confidentiality

issues in the delivery of recovery support services. One of our primary functions continues to be bringing together diverse stakeholders such as recovering individuals, family members, mutual aid organizations, system professionals, and those providing peer support services for policy review and systems planning. The systems transformation we envision goes two ways: the bottom to the top, and the top to the bottom. Our ATTCs are playing an important role in disseminating new information as it becomes available.

GREAT LAKES ATTC: Some of the organizations that CSAT has funded, such as White Bison, Inc., are integrating a recovery orientation with primary prevention activities. Do you think this growing recovery orientation will lead to a greater integration between treatment and prevention?

DR. CLARK: I think SAMHSA will increasingly move toward an integrated model that bridges and integrates primary prevention, early intervention, treatment, and recovery support services. The issue with early intervention is to bring evidence-based practices to bear on the human manifestations of our prevention failures—to reach those who didn't receive or heed our prevention messages. So rather than seeking a dichotomy between prevention and treatment, I think it is best to see these as a single continuum. A message common to all is that, once you start using, drug use is powerfully reinforcing and can quickly escalate out of control. With the strategies we develop and employ, we need to be able to reach people across this continuum of drug involvement—from people who have never used to people who are in long-term recovery, and all points in between. We need interventions that reach people who have diminished control over their decision-making. We know brains are in transition once drug use begins. We need to continue to make sure that the prevention and treatment interventions we employ are appropriate for each individual, family, and community.

GREAT LAKES ATTC: CSAT has done a wonderful job of reinforcing the idea that the recovery support services need to be nuanced across developmental age and gender and cultural context. That seems to be a very important contribution in what you've done the last several years.

DR. CLARK: Thank you. This is the product of a conscious and sustained effort on the part of many dedicated staff.