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POLICY STAKEHOLDER PERSPECTIVES ON ADDICTION RECOVERY IN THE ERA OF HEALTHCARE REFORM

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Dedicated to my family, to my community, and to people in recovery

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Chapter 1. Introduction

Overview

In recent years, people involved in addiction treatment service delivery have been increasingly talking about recovery. Advocacy groups representing people in recovery from alcohol and drug problems, addiction treatment providers, and government agencies are using recovery-oriented rhetoric in policymaking and service delivery. They are framing policy conversations around the adoption of recovery-oriented principles and values; they are including individuals who identify as people in recovery as partners in federal, state, and local policy decision-making and as service providers in their systems of care; and, they are considering the services and supports that clients need not only to be in remission from substance use disorders (SUDs) but also to achieve and maintain long-term recovery.

The purpose of this study is to better understand how policymaking stakeholders in the addiction service delivery system define recovery and describe its associated principles, policies, and services. First, we explore how people involved in the addiction service delivery system define recovery as an achievable goal for those living with SUDs and as an outcome for engagement in addiction treatment. Then, policymaking stakeholders conceptualize an idealized effective recovery-oriented system of care, or ROSC, including its essential scope of recovery services and supports. Finally, these stakeholders contextualize recovery-oriented policy and service adoption in light of recent and ongoing political and policymaking events, including the implementation of the Affordable Care Act (ACA), expansion of state Medicaid programs, and need to address the national opioid crisis.

Research Questions

This study is guided by two research questions: (1) How do policy stakeholders in the addiction service delivery system develop their definitions for addiction recovery and descriptions for a recovery-oriented system of care (ROSC) and its essential scope of services? (2) How have recovery-oriented policies and federal and state-level health policy reforms shaped the current addiction service delivery system and its ability to address the national opioid epidemic?

Motivations and Study Significance

I first encountered this proliferation of addiction recovery rhetoric in 2010 in Washington, DC, as I worked with federal and state-level government agency administrators in the addiction policy and service delivery domains. As a technical assistance provider and policy researcher with the National Association of State Alcohol and Drug Abuse Directors (NASADAD), I interacted with leadership at the Substance Abuse and Mental Health Services Administration (SAMHSA) and provided technical assistance to the single state agencies (SSAs) for addiction services, the state government entities responsible for the organization, funding, and delivery of local safety net addiction service. I grew to realize that federal and state stakeholders were preoccupied with the enactment of the ACA and the ambiguous details of this sweeping health policy's potential transformation of the addiction treatment service delivery system. Moreover, they were concerned with providing a continuum of prevention, treatment, and recovery support services and adopting recovery-oriented systems transformations through increased participation of people in recovery in their systems of care. Further, I also learned that there was an inconsistency in how stakeholders talked about recovery and implemented recovery-oriented policies and practices. States were choosing to define recovery and

conceptualize ROSC in different ways; they were selecting to implement different kinds of recovery support services in their service delivery systems; and, they were involving people in recovery, as service providers and as policy decision-makers, to varying extents. Overwhelmingly, stakeholders in the addiction service delivery field were describing the importance of recovery and recovery-oriented policy and practice. However, given the variation in definition and utilization of these concepts, I became interested in understanding how these various stakeholders came to develop their policies and practices around recovery.

Recovery is not a new concept to the addiction field. There is a longstanding tradition in the United States of individuals living with alcohol and drug problems finding and maintaining recovery through peer-based aid and participation in mutual aid groups, such as Alcoholics Anonymous. Arguably, what differentiates past understanding and use of the term "recovery" from its contemporary use is the increased and formalized role of people in long-term recovery in the service delivery system. People in recovery have a growing political voice as they have created national, state, and local grassroots advocacy organizations in order to vocalize their concerns and interests pertaining to the addiction service delivery system and other policy interests regarding their collective recovery and wellness. Additionally, people in recovery are volunteers and paid paraprofessionals within the addiction service delivery system who facilitate the recovery management process of others.

Given the broader context of the implementation of the ACA, including state expansion of Medicaid-funded addiction treatment, increased coverage of addiction treatment through commercial insurance, and reallocation of state block grant funds, there are opportunities to consider policy and systems shifts towards a ROSC that improves the accessibility and quality of services, particularly in light of the current national opioid epidemic. Historically, the addiction

service delivery system has focused on clinical treatment through the provision of acute episodes of care, which has been insufficient in ensuring positive and enduring outcomes of improved health and recovery for all individuals with alcohol and drug problems. According to many stakeholders within the addiction service delivery system, recovery-oriented systems transformation provides numerous opportunities for improvement to a system of care that has had its challenges with regards to service accessibility and effectiveness.

Study Approach

This study synthesizes the work conducted in two separate but complimentary research projects: (1) The National Drug Abuse Treatment System Survey (NDATSS) State Case Studies and (2) the Addiction Recovery Stakeholder Project. Both projects consisted of a series of semi-structured qualitative interviews with policy elites in the addiction field, ranging from government agency administrators; policy advocates, addiction treatment and recovery support service providers; recovery community organizations; and addiction policy researchers, evaluators, and trainers; among others.

The following chapters of this dissertation provide an overview of the historical and policy context for this study, methodological approach, and topically organized results and discussion.

Chapter 2 describes the background and context for this study. Specifically, I provide a historical overview of addiction treatment and recovery in the United States in order to contextualize contemporary policy reforms and service delivery shifts. In addition, I review the emerging research literature in addiction recovery policy and service delivery and identify the contributions of this study to the literature.

Chapter 3 is an overview of the study's methodological approach. This chapter describes the methods used in the two distinct projects that were considered in this study: The National Drug Abuse Treatment System Survey (NDATSS) State Case Studies and the Addiction Recovery Stakeholders Project. I explain the approach used to synthesize findings from these two projects as well as my approach in presenting findings, including choices related to use of language and participant descriptors.

Chapters 4 through 7 present the results of this study categorized by topic. Chapter 4 is an exploration of how policy stakeholders in the addiction service delivery system define addiction recovery and its related principles in their work. We consider who is involved in definition-making process and its implications for policymaking and practice. Chapter 5 explores how policy stakeholders conceptualize an ideal recovery-oriented service delivery system. We examine the elements of a ROSC and the perceived facilitators and barriers towards improved systems transformations. Chapter 6 describes the scope of recovery support services that policy stakeholders believe should be delivered in a ROSC, including which specific services and supports should be provided, who should deliver these, and in which settings. Further, we explore the policy considerations that must be addressed when people in long-term recovery, or peers, provide recovery support services. Chapter 7 contextualizes recent efforts to adopt recovery-oriented policies, principles, and services within the current addiction treatment and healthcare policy environment. Policy stakeholders describe how recovery-oriented policies and initiatives are consistent with and, in some cases, contradict, the health policy reforms of recent years, including reforms related to the ACA as well as efforts to address the opioid epidemic.

Finally, in Chapter 8, I review and synthesize the findings presented in this study and discuss the policy and practice implications for this work. I also consider the future direction of

national efforts to promote a recovery-oriented policy and research agenda in light of the perspective gained through this study.

Comparisons of Perspectives

In the subsequent chapters, I compare several policy stakeholder perspectives in order to shed light on commonalities and differences among policy actor types. My approach to comparing stakeholder perspectives across chapters and among themes emphasizes perspective differences relative to specific topics of discussion. In some instances, I spotlight the differences in perspective among those who are primarily embedded in the addiction *treatment* field against those in the addiction *recovery* field. In other cases, I consider the perspectives of all addiction service delivery system specialists—including addiction treatment and recovery stakeholders—and contrast these perspectives with other stakeholders in other sectors of healthcare such as primary care and healthcare financing.

This approach to stakeholder comparison is effective for identifying distinct policy actor perspectives but is imperfect for several reasons. Addiction policy elites have had longstanding careers in the field and several participants have held multiple roles in their careers informing their worldviews and perspectives on addiction policy and service delivery. For example, a stakeholder who might identify as a person in recovery and who has led a grassroots recovery community organization (RCO) might have previously had a position leading a state government agency overseeing addiction treatment services. Or, a policy actor who might currently represent a Medicaid managed care organization might have previously been an addiction treatment provider. This complicates the clear delineation among stakeholders. In order to address this, during participant interviews, I asked policy stakeholders to foreground particular perspectives

during certain points in the conversation and to clarify which perspective they were representing at particular points in time.

Presentation of Findings

The addiction field is vast, but, in identifying the national, state, and local policy actors who have been most influential in providing leadership in addiction treatment and recovery policy reforms, I have narrowed down a large number of individuals to a relatively small group of stakeholders who would be easy to identify in the real world. In order to protect the identities of stakeholders, I present findings in subsequent chapters in a manner that attempts to protect policy actor confidentiality while still providing adequate contextual description.

First, I refer to stakeholders using the singular pronoun "they" as to not reveal the sex and gender of participants, as this level of participant description would, in some cases, reveal the identity of certain stakeholders.

Second, I attribute interview passages to stakeholders based on their stakeholder type, such as "National Recovery Trainer," "SSA Administrator," or "RCO Leader." Acknowledging that these policy elites have had longstanding professional careers and that they may have served in various kinds of roles in their careers, I attribute just one or two roles as a consistent label for each participant throughout this text. Moreover, given that there are multiple participants of each stakeholder type interviewed throughout the study, I assign a number (e.g., National Trainer 1, National Trainer 2, etc.) to each stakeholder and consistently use this enumeration throughout the text.

Third, I omit details about participants' geographic origins, including their state or city as these descriptions would facilitate the ability to identity a participants. In cases where geographic

description and other contextual details would be useful for understanding findings, I provide some added description in this text.

Defining Terms and Concepts

This study is an exercise to better define and understand the terms and concepts used in the addiction service delivery system. For the purposes of this project, I present a series of definitions and descriptions for recovery, recovery-oriented systems of care, and recovery support services as points of reference for presenting policy stakeholder perspectives on these concepts and for critical analysis of these results. These definitions and descriptions are introduced at the beginning of each of the subsequent chapters covering these topics.

There are two terms that I believe are necessary to be defined at this point. First, I describe the interview participants in this study as "policy stakeholders." These stakeholders are members of the broadly defined policy community of addiction service delivery system specialists who are involved—both formally and informally—in the policy decision-making and implementation process, including, but not limited to government agency administrators, service providers and service provider association representatives, treatment policy and recovery advocacy community groups, and grassroots recovery community organization leaders, among others. From time to time, I interchange the term stakeholder with policy actor, policy elite, and other descriptors specifying their role within the service delivery system (e.g., government administrator, national recovery trainer, or advocate).

Second, I describe the process that stakeholders use to define and describe recovery as "conceptualization." This should not be mistaken for the process of conceptualization and operationalization used in social science research measurement development. Rather, conceptualization, in this case, refers to the process for which policy stakeholders develop

definitions and descriptions for addiction recovery in their work in the addiction service delivery system. What previously developed definitions and principles influence the definition they develop? What definitional elements are included or omitted? Who is involved or omitted in this decision-making process?

Last, like in many fields, the addiction service delivery system and health policy fields are filled with professional jargon, particularly acronyms. Appendix 1 is a glossary of acronyms that are frequently used in this study.

Chapter 2. Contextualizing Addiction Treatment and Recovery

Introduction

From a historical context, support for individuals with alcohol and drug problems in the United States has been delivered through three primary mechanisms: (1) family, kinship, and informal social networks; (2) peer-based recovery and mutual aid societies; and (3) professionally-directed addiction treatment (White, Kelly, & Roth, 2012, p. 297). These three mechanisms of support are not necessarily mutually exclusive, and the informal supports through family, kinship, and informal social networks are elements often directly addressed and integrated with peer-based and professionally directed interventions. Furthermore, punitive approaches to addressing alcohol and drug problems have, at times, come into favor, such as during the "War on Drugs" in the 1980s and early 1990s, which utilized the criminal justice system as a mechanism for addressing the crack and cocaine epidemic. This study, however, focuses mainly on the intersections between peer-based recovery and mutual aid with professionally-directed addiction treatment.

A great deal of the work done to capture the history of addiction treatment and recovery has been done by William White, an important thought leader in the New Recovery Addiction Movement and prolific historian and researcher in addiction recovery. His historical archive, *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* (2014) recounts in great detail the early history of addiction treatment and recovery in the United States.

In the addiction field, problem and intervention framing has evolved over time. This evolution is contextual to the societal problems and modes of assistance available and popular at certain points in American history. The historical context to follow is by no means a comprehensive historical account of addiction treatment and recovery but, rather, is intended to

provide a context to contemporary policy discourse related to addiction treatment, recovery, and healthcare policy.

The Importance of Problem Framing

Through the course of American history, one can observe the complexity of evolving and often competing perspectives on addiction problems and their solutions. Brickman et al. (1982) offer a useful framework for understanding the competing approaches to understanding health and social problems that focuses on attribution to the individual for the problem and the responsibility for the solution. Four models are described including: (1) the moral model, which squarely places responsibility on the individual for both problems and solutions; (2) the compensatory model, in which individuals are not responsible for problems, but are responsible for the solution, but are believed to need power; (3) the enlightenment model, where individuals are seen as responsible for their problems but are unwilling or unable to provide solutions and need discipline; and (4) the medical model, where individuals are not believed to be responsible for their problems or solutions, and are believed to need treatment (Brickman et al., 1982).

Table 1. Models of Helping and Coping for Addiction Problems*

Attribution to individual of responsibility for problem	Attribution to individual of responsibility for solution	
	High	Low
High	Recovery-Oriented Approach (Moral Model)	Criminal Justice Approach (Enlightenment Model)
Low	Alcoholics Anonymous (Compensatory Model)	Addiction Treatment (Medical Model)

*Theoretical framework adapted from Brickman et al., 1982

Within the context of addiction, the moral model aligns with the recovery-oriented approach, where individuals are responsible for their addiction problems as well as for obtaining and maintaining their own wellness and long-term recovery. The compensatory model aligns with the values of mutual aid groups such as Alcoholics Anonymous (AA), where are less responsible for their problems but are responsible for solutions, particularly with the aid of

another source of power. The enlightenment model aligns with criminal justice approaches to addressing drug problems, where there is the belief that those with drug problems are unable or unwilling to recovery and, thus, require punitive recourse. And, the medical model aligns with the approach of addiction treatment, where an individual is not responsible for the problem or solution and formalized treatment is deemed to be the appropriate intervention (Table 1).

The complexity of competing perspectives of drug problems and solutions extends into the realms of service delivery and policy. Considerable past research to understand social problems and their policy solutions has utilized Kingdon's policy framing approach that identifies multiple, aligning streams of "problems," "policies," and "politics" (Kingdon, 1995). Bacchi (2016) suggests that this approach is shortsighted, as it begins analysis at the "problem" which leaves limited opportunity to understand problem formulation. Rather, in a "What is problem represented to be?" (WPR approach) form of analysis, "'problems' do not sit outside policy processes waiting to be solved. Instead, they are produced as problems of particular kinds *within* policies and policy proposals. That is, every policy proposal contains within it an implicit representation of what the problem is represented to be" (Bacchi, 2016, p. 1).

Brickman et al. and Bacchi's frameworks are particularly useful in understanding the history of addiction treatment and recovery and present-day policy discourse related to the current addiction treatment and recovery service delivery system. Both historically and in the present-day, different policy stakeholders are addressing different kinds of service delivery and policy problems, including transforming a perceivably antiquated approach to treating SUDs, removing barriers to long-term recovery, improving the accessibility to and quality of behavioral healthcare, and addressing the national opioid epidemic, among others. These various service

delivery and policy problems are framed within the context of societal perspectives around an individual's responsibility for their alcohol and drug problems and solutions.

Early History of Treatment and Recovery in the United States

The history of addiction treatment and recovery in the United Sates is longstanding, complex, and begins with disparate approaches and interventions indicative of the culturally and politically relevant problems of the time. Early support for those suffering from alcohol use disorder came through alcohol mutual aid societies, which were provided as early as the 1750s to the early 1800s. Among Native American tribes, these mutual aid organizations were known as sobriety "Circles" (White, 2014).

The American Temperance Movement began in 1784 and was marked by Dr. Benjamin Rush's publication of *Inquiry into the Effects of Ardent Spirits on the Human Mind and Body.* The Temperance Movement signified a philosophical shift in American thinking about alcohol problems from accepting moderation in use towards a focus on abstinence. Prior to the Temperance Movement, drinkers were encouraged to practice moderation rather than to stop completely, or to switch from the consumption of distilled spirits to wine or beer. With past efforts to address alcohol use disorder through moderation failing, the goal became "prevent the creation of new drunkards and let the old drunkards die off" (White, 2014, p. 7).

Throughout the 19th Century, various temperance societies and reform clubs were being developed to address alcohol addiction across the country. The first "sober home" was developed in 1810, "inebriate asylums" had their beginnings in 1830, and alcohol mutual aid societies saw their beginnings in 1844 (White, 2014).

The Rise of Addiction Treatment in America

Although there had been little recognition of addiction as a health problem until the writings of Dr. Benjamin Rush in the 18th Century, the idea of having a physical space to treat those with alcohol and other drug problems is evidenced back to Ancient Civilizations, including Ancient Egypt (White, 2014, p. 31).

In the United States, the earliest treatment institutions developed in the latter 19th Century, including development of inebriate asylums. The American Association for the Cure of Inebriates was founded in 1870 (White, 2014). Early professionalization of addiction treatment also occurred in the 1870s with the movement towards professionalization among several addiction, public health, and charity-oriented organizations, including the National Conference of Social Work, the American Public Health Association, and National Prison Association, among others. The American Association for the Cure of Inebriates was developed in the same year and included the first efforts to develop professional tenets and a statement of principles that addiction was a curable disease. (White, 2014, p. 37).

By the 1890s, addiction treatment—particularly for alcohol—was a growing field, but an emerging shift in approach was underway. Inebriate asylums were increasingly viewed as unstable organizations built out of the passion of visionary individuals rather than out of a groundswell of public support (White, 2014, p. 39). These asylums and homes were built on unstable political and economic foundations, leading to their decline. Social and political forces that were once welcoming of the development of inebriate homes and asylums and other social institutions that valued personal isolation were dwindling in the early 1900s (White, 2014, p. 40-41).

AA was founded in 1935 and its principles and policies were developed in the text *Alcoholics Anonymous* in 1939 (Borkman, Kaskutas, & Owens, 2007; Kurtz, 2010; White, 2014). Arguably, no mutual aid movement for alcohol use disorder has reached more individuals, has achieved greater geographic dispersion, or has been more widely adapted, than the AA model (White, 2013).

The relationship between mutual-aid societies and professionally directed addiction treatment is a common theme and point of tension in the contemporary history of addiction treatment, critically shaped by the early history and interaction between AA and alcohol use disorder treatment programs (White, 2014). Early descriptions of addiction treatment are arguably less defined than early conceptualization of AA. As White describes, "while AA's boundaries are defined to a great degree by Twelve Steps and Twelve Traditions, the professional boundaries of what constitutes 'alcoholism' and 'alcoholism treatment' are much less clearly codified; they seem to be increasingly defined by professional and commercial interests, rather than by clinical science" (White, 2014, p. 228). In contrast, professionally directed addiction treatment takes place within a context of a business environment, are theoretically bound by the etiology of alcoholism and connect to specific intervention technologies, and are defined by a professionally governed relationship related back to a clinical diagnosis (White, 2014).

AA is influential in its early approaches to addressing alcohol use disorder as well as for its use in the treatment for other drug problems. Treatment and supports for alcohol use disorder had distinctly been provided in separate intervention approaches and systems of care, whereas other drugs had growth in distinct treatment and support programs later, in the 1950s and 1960s. Historically, narcotic addiction had been framed more so as criminal deviance than as a health

disorder and, thus, particularly within urban areas, issues of opioid use disorder were addressed through “narcotic courts” in the criminal justice system (White, 2014). From a medical and psychiatric context, the rise of medication-assisted treatment for opioid use disorder began with the use of methadone as a treatment in 1964. Moreover, religious interventions saw their rise in the 1950s and 1960s, as did the use of community-based supports.

Many approaches to treatment for alcohol and other drugs have been utilized and considered effective. Several of these programs originate from the AA tradition, including the Minnesota Model, California social programs model, and therapeutic communities.

The Minnesota Model was developed in the 1950s, adopted by the non-profit organization Hazelden Foundation, and then implemented nationwide. The Minnesota Model attempted to blend treatment from professional and nonprofessional staff using the principles of Alcoholics Anonymous (Anderson, McGovern, & Dupont, 1999). This model originated with an individualized treatment plan with expected family involvement over the course of a 28-day inpatient stay and has since evolved to include outpatient stay. The Minnesota Model is still widely used in addiction treatment, particularly in private-payer settings (Anderson, McGovern, & Dupont, 1999). This approach emphasizes the use of an interdisciplinary team of professionals. Peers are considered valued members of the team who can share their experiences of recovery with clients. (Borkman, Kaskutas, & Owens, 2007).

The California social model of recovery is believed to have arisen in the late 1940s and 1950s. Oral recollection from “old timers” describes the use of storefronts to develop recovery residences based on AA principles. These houses relied on AA and did not offer formal treatment. In California, the model transformed in the 1960s and 1970s into social programs that included publicly funded county alcohol treatment. Original social model programs were

community-based residential programs with nonclinical home-like settings based on peer support rather than treatment provided by a credentialed professional (Borkman, Kaskutas, & Owens, 2007).

Therapeutic communities developing in the 1960s and early 1970s were staffed by people in recovery in a therapeutic practice model known as Synanon, started by Chuck Dederich. Synanon borrowed many ideas from AA and its work focused on indigent populations often involved with the criminal justice system. Unlike AA, Synanon made no reference to God and rejected a spiritual approach. Therapeutic communities derived from Synanon evolved to value returning those in recovery to productive roles in society (rather than Synanon's focus on an enclosed system), acceptance of public funding (rather than solely private funds), and the integration of professionally trained staff and peers (rather than solely informally trained staff) (Borkman, Kaskutas, & Owens, 2007; White, 2014).

Many of the AA-based interventions of the past have been adapted and are used in contemporary addiction treatment, including those listed above, and has led to the evolution of the addiction treatment system. For example, social model programs that had previously relied primarily on non-professional staff has had to adopt licensed staff to handle dual diagnosis clients and case management paperwork as well as accept mandated clients (Borkman, Kaskutas, & Owens, 2007). Minnesota Models and therapeutic communities have become more diverse in their approach and have spread across the nation. The evolution of the addiction treatment system can also be attributed to other organizational and policy-oriented changes of recent decades. Commercial insurance began reimbursing for alcohol treatment in the 1960s and 1970s, becoming more common in subsequent decades.

In 1978, First Lady Betty Ford spoke out about her own personal recovery and in 1980, First Lady Nancy Reagan began the "Just Say No" campaign which suggested a return to the temperance movement. The development of the federally-funded Substance Abuse Prevention and Treatment (SAPT) block grant was created in 1982 and became one of the most important sources of public funding for addiction treatment up until the passage of the Affordable Care Act (ACA) in 2010. Subsequent iterations of self-help were developed in the 1980s including Cocaine Anonymous. The rise of women's specific addiction treatment also arose from 1982 to 1992 alongside those for other special populations from 1985 to 1990. The crack and cocaine epidemic arose in 1985 and the Reagan era "War on Drugs" began in 1987, signifying a shift from addiction treatment focus to incarceration (White, 2014).

Undoubtedly, the self-help and mutual aid tradition has been a heavily influential and, arguably, the values of self-help and AA are nearly impossible to disentangle from the professionally-driven addiction treatment system. However, it is important to understand how the clear organizational, financing, and delivery delineations have evolved and currently exist between what is considered mutual aid and what is considered clinical addiction treatment. As described above, early professionalization of addiction treatment begins in the late 1800s. Comparable to the professionalization of other helping professions, including social work, the addiction treatment field has evolved and patterned itself with other sectors of healthcare through a process of medicalization and professionalization that values the development of certification and accreditation processes and acute-care service delivery in regulated settings over peer-delivered and community-based supports (Leiby, 1978; Ehrenreich, 1958).

Addiction as a Chronic Disease

The addiction treatment community increasingly began viewing SUD as a chronic disease at the turn of the 21st Century under the thought leadership of Tom McLellan. Given its impact on social systems, SUDs had previously been viewed as a social problem, rather than a health problem. In comparing SUDs with other chronic diseases, genetic heritability, personal choice, and environmental factors all contribute to disease etiology and course among the illnesses examined. However, SUDs have historically been treated as an acute illness with few strategies for long-term disease management and monitoring (McLellan, Lewis, O'Brien, & Kleber, 2000).

Not all cases of SUD are chronic in nature—especially as those who meet the diagnostic criteria for SUD can recover completely—often finding natural recovery without engaging with the formal addiction treatment system or with other informal recovery services and supports. However, many who enter into addiction treatment often experience relapse on multiple occasions. For this reason, McLellan offers early argument of the need to provide continuing care to patients that goes beyond just successive doses of acute treatment, preferring a continuing care approach that is attractive to patients and recognizes the ongoing cooperation and partnership between patients and the service delivery system (McLellan, 1995). According to McLellan, "treatment practitioners often see complaints that a treatment is too time consuming, too intrusive or has too many side-effects as evidence for 'lack of motivation.'" (McLellan, 1995, p. 97).

If SUDs are most appropriately addressed as a chronic disorder, then this begs the question of how well has the system of care been evaluating the effectiveness of treatment? Rethinking how addiction treatment is provided also warrants a reevaluation of how addiction

histories are considered; how treatment and recovery support services are delivered; and how services are organized, financed, and evaluated (White, Boyle, & Loveland, 2002). All of these systemic changes can be encompassed in a transformation towards a recovery-oriented service delivery system.

New Recovery Advocacy Movement

In the past 15 years, addiction recovery has been increasingly used as an organizing framework for developing systems of care that are client-centered, accommodate multiple pathways to wellness (Berridge, 2012; El-Guebaly, 2007; White, 2005; White and Kelly, 2011), and deliver services that extend beyond acute episodes of treatment and towards chronic care through a growing range of ancillary and paraprofessionally-delivered services (White, Kelly, & Roth, 2012). Given this policy and systems shift towards what is often termed as a recovery-oriented system of care, or ROSC (Humphreys & McLellan, 2010; Humphreys & Lembke, 2013; Laudet & Humphreys, 2013; Laudet & Best, 2015), there are opportunities to consider how the addiction service delivery system organizes, funds, and delivers services and how to optimize service outcomes, particularly within the context of the implementation of the Affordable Care Act (ACA), enforcement of behavioral health parity through the Mental Health Parity and Addiction Equity Act, and reallocation of SAPT block grant funds.

In 2014, 21.5 million people in the U.S. aged 12 or older are estimated to have had a problem in the past year with an SUD including 17 million with past-year prevalence of an alcohol use disorder, 7.1 million with past-year prevalence of illicit drug use disorder, and 2.6 million with past-year prevalence of both alcohol and illicit drug use disorders. (SAMHSA, 2015a). Among the 17 million with an alcohol use disorder, only 7.6% received treatment while 2.5% perceived a need for treatment but did not receive it, leaving 89.9% without any treatment.

And among the 7.1 million with an illicit drug use disorder, only 14.6% received treatment while 5.6% had a perceived need for treatment but did not receive it meaning 79.9% did not receive treatment (SAMHSA, 2015b). There is clearly a need to address issues of access to services and support for individuals with SUDs, of which the specialty addiction treatment system is only meeting the needs of approximately 2.5 million individuals (SAMHSA, 2014). However, professionally directed addiction treatment is only one component of how individuals with alcohol and drug problems recover.

More recent conceptions of addiction recovery, as an organizing framework for addiction policies and services, have their roots in the history of peer-based recovery and mutual aid groups described above. However, recovery has only received revitalized attention in recent decades through national advocacy by those in recovery from alcohol and drug problems in what has been called the New Recovery Advocacy Movement by national recovery advocacy leaders (White, 2005). This advocacy, in many ways, has patterned itself after the social movement within the HIV/AIDS domain, where individuals living with HIV/AIDS have identified themselves as living with the stigmatized disease in order to mobilize and advocate for improved healthcare policies and services.

Since the late 1990s, the Substance Abuse and Mental Health Services Administration (SAMHSA) has been supporting recovery community organizations (RCOs) to develop leadership, promote local advocacy, and engage the community in public education about SUD treatment and recovery through the Recovery Community Service Program (Humphreys & Lembke, 2014). Since then, an array of other recovery-oriented policies, programs, and initiatives have been put in place, including, but not limited to, the inclusion of recovery as a goal within the Office of National Drug Control Policy's National Drug Control Strategy (Laudet

& Best, 2015); the Access to Recovery (ATR) federal grants to states for voucher-supported treatment and recovery support services; the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) federal initiative to provide technical assistance to community-based recovery organizations, service providers, and government agencies on the development of ROSC and promotion of peer-based services; and the creation of federal, state, and local government agency administrative roles primarily focused on promoting recovery.

Leadership in the New Recovery Advocacy Movement

Integral to the New Recovery Advocacy Movement is the mobilization and leadership of key figures in national advocacy; local grassroots communities; and in federal, state, and local government.

William White is a key figure in the recovery movement leading many efforts including the development of recovery-oriented concepts, research on recovery-oriented policies and services, and training and technical assistance provision. He has written several seminal works in the addiction recovery and treatment field, including *Slaying the Dragon: The History of Addiction Treatment and Recovery in America.* Arguably, much of the work to archive the New Recovery Advocacy Movement and conceptualize addiction recovery and its adjacent concepts including recovery management and ROSC would not have been started without his efforts.

Faces and Voices of Recovery (FAVOR), the national advocacy organization consisting of people in recovery from alcohol and drug problems, made early efforts to define recovery and to develop grassroots advocacy voices at federal, state, and local level. FAVOR's leadership and membership consists primarily of RCOs representing state and local grassroots communities. Leadership at FAVOR and among RCOs constituted the mobilized policy community that participated in early meetings to develop a recovery-oriented policy agenda and develop early

recovery-oriented policies and definitions. Among the numerous stakeholders involved in early decision-making are notable members of FAVOR's executive leadership, including Pat Taylor and Tom Hill, and the organization's RCO board members, including Phil Valentine of Connecticut Center for Addiction Recovery (CCAR), Bev Haberle of The Council of Southeast Pennsylvania, Neil Campbell of the Georgia Council on Substance Abuse, Andre Johnson of the Detroit Recovery Project, and Patty McCarthy Metcalf of Vermont Recovery Network, among many others.

Government agency level leadership at national, state, and local-level was imperative in making policy decisions to support the funding of recovery support services and other initiatives. In particular, Westley Clark was Director of the Center for Substance Abuse Treatment (CSAT) within the Substance Abuse and Mental Health Services Administration (SAMHSA). In 1998, Westley Clark, along with several of his senior managers at CSAT, initiated and funded the Recovery Community Service Program (RCSP) that convened members of the recovery community together to develop a recovery-oriented policy agenda and early iterations of recovery-oriented definitions and principles.

Approximately a decade later, under the Obama Administration, SAMHSA's policy agenda shifted towards integrated behavioral health efforts meant to combine mental health and addiction-focused policies, funding, and service initiatives. Pamela Hyde, SAMHSA's Administrator, impacted addiction recovery efforts because CSAT's recovery-oriented initiatives were now overseen by a broader SAMHSA initiative which was led by the Director of the Center of Mental Health Services. This move led to national recovery-oriented initiatives, including policy-change efforts, technical assistance initiatives, and recovery support service delivery being inclusive of both addiction and mental health-related recovery specialists.

Additionally, at state and local government level, government agency leadership in the state of Connecticut Department of Mental Health and Addiction Services and at the Philadelphia Department of Behavioral Health and Intellectual Disability Services are touted for their governmental leadership on ROSC transformations. In particular, Connecticut's leadership under Tom Kirk is exemplary and innovative. Commissioner Tom Kirk's Deputy Commissioner, Arthur Evans, went on to serve as Commissioner in Philadelphia and oversee its ROSC transformation.

Emerging Scholarship on Recovery

There is a limited but growing body of scholarly research being done to understand how addiction recovery is defined and used as an organizing construct for the addiction service delivery system (Hser & Anglin, 2011; White & Kelly, 2011). Previous efforts have been made to develop working definitions for addiction recovery and ROSC (El-Guebaly 2012; Laudet 2007; White 2007), including standardization efforts by the federal government (SAMHSA, 2012), state governments (Bersamira & Harwood, 2011), and other institutions (Betty Ford Institute Consensus Panel, 2007). In some instances, including SAMHSA's federal definition, recovery is defined as a construct for both substance use and mental health disorders, which speaks to the federal agency's policy initiative to integrate SUD and mental health systems and services under a common "behavioral health" umbrella. Regardless, there is much variation across definitions which are not necessarily connected with evidence-based outcomes. And further, even less has been done to understand how recovery-oriented service outcomes should be measured and aligned personal definitions for recovery (Andresen et al., 2010).

How recovery is defined has implications for how people in recovery are identified and counted, which is an important epidemiological, health services, and policy consideration. There

have been recent empirical efforts to better understand how individuals with SUDs define recovery for themselves (Kaskutas et al., 2014; Kaskutas, Witbrodt, & Grella, 2015; Witborodt, Kaskutas, & Grella, 2015).

When prompted with the question, "Did you used to have a problem with alcohol or drugs but no longer do?", approximately 9.1% of the U.S. population is estimated to be in recovery with 46% self-identifying as being "in recovery" of which 54% reported using an assisted pathway to achieve recovery. Among those using an assisted pathway, 45% used mutual aid such as AA, 28% engaged in formal addiction treatment, 22% used recovery support services, and 6% used recovery support centers (Kelly, Bergman, Hoeppner, Vilsaint, & White, 2017). More than half (54%) of those in recovery did not identify with that terminology suggesting the sustained stigma of affiliating with one's alcohol and drug problems and the recovery label. This has consequences for future prevalence-counting and community advocacy efforts which are often intended to secure resources, including service funding.

Compared with the number of efforts made to define addiction recovery, even fewer working definitions and conceptions of ROSC have been developed. The most commonly used definition comes from SAMHSA, which defines a recovery-oriented system of care as "a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems" (SAMHSA, 2010). And even less research has been done to understand service delivery transformations towards ROSC and the necessary elements of ROSC transformation that ensure improvements in community and individual outcomes. Case studies have been conducted to better understand the systems transformation efforts undertaken in the

state of Connecticut (Kirk, 2011) and county of Philadelphia (Achara, Evans, & King, 2011), but little has been done to identify the key elements of transformation that made these systems changes successful.

There has been substantial research done to understand SUDs and the processes of change, including relapse (Connors et al., 2001) and recovery and improvement (DiClemente, 2003). Further, researchers in the field have done substantial work to understand informal helping structures and methods such as through mutual aid groups (Kaskutas & Subbaraman, 2011), peer-delivered social support (White, 2009), and the importance of experiential knowledge in treatment (Borkman, 1976). Scholars and addiction treatment practitioners have also focused on how to improve client outcomes through the focus on long-term wellness. For example, rather than focusing on reducing or eliminating substance use, researchers are promoting time spent on activities that are enjoyable and rewarding to clients and ensuring there are incentives in the system to maintain and achieve long-term recovery (McKay, 2017).

Only a few studies have been conducted to understand the subjective definition of recovery for service consumers and persons in long-term recovery (Laudet, 2007; Kaskutas et al., 2014). Laudet (2007) attempted to understand whether, according to people in recovery, total abstinence from alcohol and drugs is required to achieve recovery and whether recovery is defined solely within the context of addiction or other factors. Laudet's research found that most respondents (n=289) defined recovery as requiring total abstinence from alcohol and drugs but that recovery's scope goes beyond addiction-related needs. In the more recent "What is Recovery?" study, Kaskutas et al. (2014) queried respondents who identified as being in recovery, recovered, in medication-assisted recovery, or as having a problem with alcohol or drugs (but no longer do) (n=9,341) to better understand which elements of recovery (among 34)

mattered most. The six most endorsed factors included elements of "essential recovery" including *being honest with myself, handling negative feelings without using drugs or alcohol, being able to being able to enjoy life without drinking or using drugs like I used to* and elements of "enriched recovery" including *process of growth and development, reacting to life's ups and downs in a more balanced way than I used to, taking responsibility for the things I can change*. Moreover, there were numerous other factors of recovery that were identified by a smaller but still large proportion of respondents, shedding light on the diversity of recovery definitions among persons in recovery (Kaskutas, et al., 2014).

These studies serve as starting points to my research questions as they provide understanding for how service consumers define addiction recovery. My research, however, would contribute and expand from this area by improving understanding of how definitions for addiction recovery and conceptualizations of ROSC, and its scope of services, are defined by other policy stakeholders in the addiction service delivery field, including government administrators, funders, service providers, and advocates. Understanding these congruencies and dissimilarities is important for two reasons. First, political elites are the decision-makers for how addiction services are organized, funded, and delivered and, thus, it is important to take into account how they are considering and implementing recovery-oriented principles and policies, particularly in the changing healthcare landscape. Second, there is evidence that service matching to a client's needs, which aligns with the values of a client-centered ROSC, are an effective strategy for client outcomes, including increased retention and reducing post-treatment relapse (Marsh, Cao, Guerrero, & Shin, 2009; Smith & Marsh, 2002; McLellan et al., 1997; Friedmann et al., 2003; McLellan & Weisner, 2000). When considering ROSC's scope of services, it is necessary to consider how people in long-term recovery—as current and former

service consumers and policy advocates in the addiction field—define the scope of services that are included within an effective system of care to ensure that there is congruence.

This study contributes to a broader understanding of how health and social service outcomes are impacted by conceptions of recovery and wellness. By learning more about how addiction recovery is defined and ROSC and its scope of essential services are conceptualized, we can better understand the implications of policy implementation and service delivery as they relate to individual recovery. This is particularly relevant to consider given the systems transformations that are occurring as a result of the ACA and other health policy reforms.

Health Policy Reform and the National Opioid Epidemic

Given the recent policy shifts towards ROSC (Berridge, 2012; Humphreys & McLellan, 2010; Humphreys & Lembke, 2013; Laudet & Best, 2015), opportunities for service funding and implementation through the ACA and Medicaid expansion, and the openness to fund and administer programs and services beyond clinical treatment services (White et al., 2012), there are opportunities to consider how we fund and deliver recovery support services in the United States and how to optimize service outcomes. In particular, the ACA has expanded the number of insured individuals, increasing the demand for health care, including addiction services (Buck, 2011; Mark et al., 2014). In addition, increased Medicaid reimbursement in the addiction system and the reallocation of SAPT block grant funds can potentially be used to finance recovery-oriented services (Buck, 2011; Stewart & Horgan, 2011).

In the context of the national opioid epidemic drawing attention to the addition treatment system and the major policy reforms underway as a result of the ACA and other reforms, the *United States Surgeon General's Report on Substance Use, Addiction, and Health* (2016) is hoped to have a major impact on addiction treatment comparable to that of the 1964 Surgeon

General's report on smoking. Notably, an entire chapter of the report was devoted to addiction recovery, including an exploration of the many elements necessary for defining recovery and an overview of the research regarding recovery prevalence and the efficacy of mutual aid and other recovery supports services.

Conclusion

The history of addiction treatment and recovery in the United States is vast and complex. The overview offered above is intended to provide understanding of key historical events and contemporary policies and systems characteristics that contextualize the present-day service delivery system and policies. Notably, there are three key themes to keep in mind as we move forward in understanding stakeholder perspectives in subsequent chapters. First, the pattern of shifts and transformations in ideology and service delivery have occurred several times over the course of history, including shifts from attitudes of moderation to temperance, from addressing addiction as a social condition to treating it as a medical condition, from addiction treatment focus on alcohol use disorder to an integrated approach to addressing alcohol and drug problems, and from focusing on peer-based recovery and mutual aid to professionally-driven interventions, among other transitions. Second, although there are several kinds of services and supports that individuals can utilize to achieve and sustain recovery, including informal support from family and friends, peer-based recovery and mutual aid, and professionally-driven addiction treatment, these seemingly separate forms of support are interrelated and have built off one another in the history of addiction treatment and recovery support. Third, although it is difficult to disentangle the impact and role of peer-based support from formal addiction treatment, the addiction service delivery system has undertaken its own process of medicalization and professionalization that resembles other sectors of healthcare. This formalization favors the adoption of licensing and

accreditation processes and values the role of education and training over the value of lived experience and peer-delivered and community-based supports.

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Chapter 3. Methodological Approach

Data for this study was collected from two separate but complimentary projects: (1) The National Drug Abuse Treatment System Survey (NDATSS) State Case Studies and (2) the Addiction Recovery Stakeholder Project. Both projects consisted of a series of semi-structured interviews with policy elites in the addiction field, ranging from government agency administrators; policy advocates, addiction treatment and recovery support service providers; recovery community organizations; and addiction policy researchers, evaluators, and trainers; among others. Semi-structured interviews consist of a series of open-ended questions with a loose structure that guide initial exploration of a defined area; within each interview the conversation may diverge to pursue an idea in more detail (Britten, 2016). In order to enhance elite interview validity and reliability, careful attention was paid "to question formats and wording, sampling, and the process of data collection and analysis" (Beamer, 2002).

There are several commonalities between the two projects with respect to the methodological approaches taken in sample selection, participant recruitment, data collection, and data analysis. However, there are also important distinctions in methods as the objectives of the two projects were different. Below, I describe the methodological approaches to sample selection and participant recruitment, interview guide formation, data collection, and preliminary analysis for each project separately. Thereafter, I describe the synthesized approach used in theme analysis and describe how findings are presented in subsequent chapters.

NDATSS State Case Studies

The National Drug Abuse Treatment System Survey (NDATSS) project is a National Institute on Drug Abuse (NIDA)-funded, multi-wave national study of addiction treatment services and policies consisting of surveys with addiction treatment providers and state

government agencies responsible for administration, funding, organization, and delivery of addiction prevention, treatment, and recovery support services. The purpose of the NDATSS States Case Studies is to understand states' policy priorities with respect to addiction treatment, and the process and extent of state policy planning and implementation related to the Affordable Care Act (ACA) and other federal and state-level policy reforms.

Given my role as project coordinator for the NDATSS State Case Studies, I had direct involvement in sample selection and interview guide development and led data collection and analysis efforts. Through this capacity, I was able to integrate questions and concepts pertaining to addiction recovery and recovery-oriented systems and services into the project's interview guide.

Sample selection and participant recruitment

State selection

Eight states were selected for the NDATSS State Case Studies to provide a deeper understanding of addiction treatment and ACA policy reform implementation in a range of states. Using purposive sampling, state selection was based on four criteria including: (1) high salience of addiction issues as measured by national media coverage and state political attention to addiction-related issues; (2) inclusion of both Medicaid expansion and non-expansion states; (3) variation in state-run and federally-facilitated health insurance exchanges; and (4) regional variation. First, we identified states with high salience of drug and alcohol issues as measured by national media and state political attention. We drew from four national newspapers with high readership: *The New York Times, USA Today, The Wall Street Journal,* and *The Washington Post*. In these newspapers, we identified national-level articles' coverage of state-specific alcohol and drug problems from 2013 to 2014. States were ranked based on the extent of media attention

they garnered, with states receiving greater coverage being more likely to be chosen as a case site. Next, governors' State of the State addresses were reviewed for explicit mention of alcohol and drug problems, including the opioid epidemic. In states with incoming governors, Inaugural Addresses were reviewed in lieu of State of the State addresses. Second, we identified states based on whether or not a state had expanded Medicaid. We wanted to ensure that at least half of our sample states had chosen to expand their Medicaid program. Third, we wanted to have a mix of states that established their own state insurance exchanges and ones that opted to use the federally-facilitated platform. Fourth, acknowledging the influence of geographic variation in response to policy, selected states represented all regions in the United States. States were ranked based the combination of the abovementioned criteria with California, Colorado, Florida, Georgia, Kentucky, New Hampshire, New York, and Ohio selected for case study analysis.

Stakeholder recruitment

To capture a comprehensive understanding of states' responses to health policy reform, our recruitment strategy targeted a range of stakeholders in each state using a non-probabilistic snowball sampling approach to understand the perspectives of a variety of policy actors (Weiss, 1994). Elite interviews target stakeholders directly involved in the policymaking process in order to better understand goal conflicts, technical disputes, and take into account the role of multiple actors within the policy community (Beamer, 2002; Sabatier & Weible, 2007). Although this approach can contribute to sampling bias, as it may reduce the diversity of perspectives obtained due to sampling within individuals' professional networks, this approach facilitates capturing the perspective of elites who have been most involved in the policymaking process, which is the primary objective for the project.

Elite interviews were conducted with stakeholders from: state government agencies representing the single state authority (SSA) for addiction services, state Medicaid agency, and commercial insurance agency; regional and county behavioral health authorities; addiction treatment providers and provider state associations; prevention and recovery support service organizations; Medicaid managed care organizations (MCOs) and MCO state associations; state Qualified Health Plans (QHPs) and QHP state associations; policy advocacy organizations; recovery advocacy organizations; and researchers and evaluators. In all eight states, stakeholders from the SSA and Medicaid government agencies, addiction treatment providers or provider state associations, and MCO plans or plan state associations were interviewed. Other types of elites were interviewed depending on whether they were identified by other interview participants as being active participants in the state's addiction policy planning and implementation process. Recruitment was conducted to the point of knowledge saturation, where redundant ideas and themes arose from conversations pertaining to each state (Morse, 1995; Padgett, 2008) (See Table 2).

Recruitment outreach was conducted by the project coordinator with assistance provided by The University of Chicago Survey Lab. Recruitment began via email contact with states' Single State Agency (SSA) directors, who were identified through a publicly available directory and using the study team's professional contacts. Given the breadth of work and other professional experience of the study team, which has enabled far-reaching connections with stakeholders in addiction services, policy, research, and advocacy, we were able to recruit across a very wide network of individuals, which was an important consideration that outweighed the risks to sampling bias for this recruitment approach.

Table 2. NDATSS State Stakeholder Types	
State Government	Single State Agency (SSA) for Addiction Services*
	Medicaid State Agency*
	Commercial Insurance State Agency
	State Legislator
	Drug Policy Office
	Evaluators/Researchers
Regional/County	Local Behavioral Health Authority and State Association^
Insurance Plans	Medicaid Managed Care Organization
	Qualified Health Plan
Service Providers	Treatment Providers and State Provider Association*
	Prevention Coalitions
	Recovery Support Service Providers
Advocacy	Drug Policy Advocacy Group
	State Associations for Addiction Treatment
	Recovery Community Organizations

*Stakeholder type interviewed in all 8 states

^Stakeholder type interviewed in all states where administration level existed

In cases where prospective participants did not respond to the initial email contact within a week, recruitment staff sent up to four additional follow-up emails in subsequent weeks. Additionally, after two email attempts, recruitment staff also attempted to make telephone contact. Prospective participants generally expressed interest and availability to participate in an interview and, in a few cases, they suggested we reach out to other colleagues in the same or comparable organizations to participate in an interview in their place. At the end of each completed interview, participants were also asked if they could refer the study team to other relevant individuals (i.e., someone who met the stakeholder criteria) who could speak on the topics of interest and would be willing to be interviewed for the study. From July 2016 to November 2017, 65 telephone interviews were conducted with 83 unique stakeholders, approximately 10 stakeholders per state.

Participant social identity

Participants' sociodemographic characteristics were not collected as part of the NDATSS State Case Study project as the primary area of interest in sample selection was in identifying policy stakeholders with direct participation in the addiction system's policymaking process. Through participant background research as part of the sample selection and recruitment process, however, one can infer that these policy elites were predominantly white, educated, and had many years of professional experience in the addiction field as they were typically senior-level managers in their respective roles. At times during interviews, participants disclosed information about their own demographic and socioeconomic background. These details are described in the findings presented in subsequent chapters when relevant to the presented results.

Interview guide development

The NDATSS State Case Studies interview guide was developed and refined through a series of pilot interviews with the first state. The interview guide covered the following domains: state and organizational-level policy priorities related to addiction treatment and the opioid epidemic; state Medicaid policy priorities, waivers, and amendments; MCO plan coverage of addiction treatment; commercial insurance policy priorities related to addiction treatment; QHP coverage of addiction treatment; behavioral health parity enforcement; primary and behavioral health services integration; data systems and reporting policies; and addiction recovery-oriented policies and services. As the 2016 presidential election and leadership change occurred during the process of data collection, participants interviewed after the election were also provided the opportunity to discuss implications of potential ACA repeal and replacement. All stakeholders were asked the same introductory questions in each domain with some topics receiving more

attention based on the participant's position and area of involvement and expertise (see Appendix 2 for NDATSS State Case Studies Interview Guide).

Given the diverse backgrounds of the policy elites interviewed in the study, ensuring interview guide question validity can be a difficult problem. To enhance the question validity, convergent and discriminant validity needs to be addressed (Beamer, 2002). Convergent validity concerns whether a policy stakeholder has consistent attitudes towards the same construct in multiple areas. In the development of the interview guides, we enhance convergent validity by asking about multiple topics in different ways. For example, an interview participant whose work focuses on addiction treatment might indicate that they prioritize establishing a recovery-oriented practice. We would then subsequently ask about the stakeholder's commitment to spending limited resources on recovery support services and employing non-clinical paraprofessionals with lived experiences as recovery coaches to ensure the stakeholder was not just paying lip service about prioritizing a recovery-oriented practice because it is the preferred normative response in the current behavioral health environment. Discriminant validity is achieved by posing questions that help eliminate other possibilities for interpretation besides the topic of interest. For example, a policy stakeholder may indicate objection to admitting clients utilizing medication treatment such as methadone into recovery housing. We would want to ask subsequent questions about attitudes related to medication treatment to determine whether this perspective was due to stigma towards harm reduction approaches or if this interpretation could be attributed to other factors (Beamer, 2002).

Data collection

Stakeholder interviews

Semi-structured interviews were conducted via telephone and audio-recorded with each interview lasting approximately one hour (ranging from 40 to 75 minutes). All interviews were conducted by the project coordinator who was accompanied by study co-investigators, who were designated to interviews by state. Prior to the start of each interview, verbal informed consent was obtained from participants.

Interview data was complemented by supporting documents such as provider initiatives, policy memos, research and evaluation reports, and government and organizational website information reviewed prior to stakeholder interviews or provided to the study team following the interview. All study protocols and procedures were approved by the study team's respective Institutional Review Boards.

Preliminary data coding and analysis

All interviews were transcribed verbatim by a professional transcription company and reviewed by the project coordinator for accuracy. Qualitative coding and analysis were conducted using Dedoose online software. Using an initial template coding scheme based on the topics covered in the interview guide, each transcript was first independently reviewed and coded by at least two study team members in order to provide an overall structure for sorting the data and to facilitate a subsequent refined coding process. Each transcript was coded by at least two of the co-investigators, first coding each transcript individually and then comparing to ensure the same codes were applied to corresponding texts and to discuss discrepancies in order to establish consensus. This study draws from all the text coded as, "recovery," which was applied to any transcript text in which addiction recovery, recovery-oriented systems of care, recovery support

and services, ancillary services, peers and recovery coaches, and other adjacent topics were mentioned. These passages were coded in a second cycle to refine salient themes and identify differences in perspective across states and stakeholder types.

Concurrent with the data collection and coding process, analytic and theoretical memos were developed by the study team as a method of interpretation. Through memo writing, "researchers gain analytic distance from data and create an intellectual space for documenting their analysis" (Charmaz, Thornberg, & Keane, 2018, p. 429).

The Addiction Recovery Stakeholder Project

Data for the Addiction Recovery Stakeholder Project were collected with the intention of supplementing knowledge gained about addiction treatment policies, addiction treatment services, and ACA implementation through the NDATSS State Case Studies by targeting policy stakeholders specifically involved in addiction recovery policymaking, advocacy, and service delivery.

Sample selection and participant recruitment

A non-probabilistic snowball sampling approach was used in order to capture a range of perspectives within the addiction recovery system that may have been involved in national, state, and local-level efforts to transform the addiction service delivery system towards a recovery-oriented system of care (ROSC), mobilize addiction recovery advocacy efforts, and deliver recovery support services (Weiss, 1994). As with the NDATSS State Case Studies, the risks to sampling bias with this approach relates to individuals identifying other participants within their own professional networks; these risks are outweighed by the benefits of being able to identify the policy elites most involved in the policymaking process. Elite interviews are used to target addiction recovery stakeholders directly involved in the policymaking process in order to better

understand goal conflicts, technical disputes, and take into account the role of multiple actors within the policy community (Beamer, 2002; Sabatier & Weible, 2007).

Interviews were conducted with stakeholders from: federal government agency stakeholders who, at the time of the interview were either currently or previously affiliated with the Office of National Drug Control Policy (ONDCP) and the Substance Abuse and Mental Health Services Administration (SAMHSA); national training and technical assistance providers; national and state-level recovery advocacy organizations; national behavioral health provider associations; single state authorities (SSAs) for addiction services; county behavioral health authorities; local recovery community organization (RCO) leadership; recovery support service providers; and policy and program evaluators and researchers (See Table 3).

These interview participants are distinct from those selected for the NDATSS State Case Studies project in several key areas. First, many of these participants' work is focused primarily within the realm of addiction recovery policy, service delivery, or advocacy; these policy actors are those who had been instrumental in their participation in early national meetings around the New Recovery Advocacy Movement and in consensus groups convened by SAMSHSA and other organizations to shape recovery definitions, principles, and policies. Second, among policy actors whose work was not primarily in the realm of addiction recovery, their work in addiction treatment policy, service delivery, and advocacy were influential given their adoption of recovery-oriented principles and values.

Table 3. Addiction Recovery Stakeholder Types	
National Level	Substance Abuse and Mental Health Services Administration (SAMHSA)
	Office of National Drug Control Policy (ONDCP)
	National Recovery Advocacy Organization
	National Treatment Provider Association
	National Training and Technical Assistance Provider
	Program and Policy Researcher/Evaluator
State/County Level	Single State Authority (SSA) for Addiction Services
	County Behavioral Health Authority
	Recovery Advocacy Organization
	Behavioral Health Services Network
Local Level	Recovery Community Organization (RCO)
	Recovery Support Service Provider

Some stakeholders' past and current experiences allowed for representation of multiple perspectives given their longstanding careers and vast experiences. For example, one participant identified as an addiction treatment provider but eventually became a longstanding director for a single state agency (SSA) for addiction services. Another stakeholder, who identified as a person in long-term recovery, also identified as a recovery policy advocate but had previous experience working as SAMHSA senior-level director, currently representing addiction treatment agencies at a national association.

Recruitment outreach was conducted by the lead researcher via email communication. Identifying and recruiting the policy stakeholders who, from a historical perspective of the addiction recovery field, have been involved in critical events of the New Recovery Advocacy Movement, including key federal and state meetings identified by stakeholders, allows for insights that would not be achieved through another sampling approach. In cases where prospective participants did not respond to the initial email contact within a week, up to four additional follow-up emails were sent in subsequent weeks. Prospective participants generally

expressed interest and availability to participate in an interview. In one case, a prospective stakeholder indicated being out of the country and unavailable for participation but recommended other policy actors that might be able to provide a comparable perspective. At the end of each completed interview, participating stakeholders were also asked if they would recommend speaking with other relevant policy stakeholders who could speak on the topics of interest and be willing to be interviewed for the study. Recruitment was conducted to the point of knowledge saturation, where redundant ideas and themes arose from conversations (Morse, 1995; Padgett, 2008). From April 2017 to February 2018, 21 interviews were conducted with 24 unique stakeholders.

Participant social identity

As with the NDATSS State Case Studies project, participants' sociodemographic characteristics were not collected as part of this project as the primary area of interest in sample selection was in identifying policy stakeholders with direct participation in addiction recovery policymaking, service delivery, and advocacy. Through participant background research as part of the sample selection and recruitment process, however, one can infer that these policy elites were educated and had many years of professional experience in the addiction field. At times during interviews—particularly with stakeholders representing advocacy organizations and recovery community organizations—participants disclosed information about their own demographic and socioeconomic background, including race/ethnicity, gender, and self-disclosure of recovery status. These details are described in the findings when available and relevant to the presented results.

Interview guide development

The Addiction Recovery Stakeholder Project interview guide was developed prior to data collection but refined after the first interview to take into account participant comprehension of interview guide questions. The interview guide covered the following domains: individual and organizational background; exploring definitions for addiction recovery; conceptualizing a recovery-oriented system of care; recovery supports and services, including peer-delivered services; recovery data and measurement; recovery and health policy reform; and the historical context of the addiction recovery advocacy movement. All stakeholders were asked the same introductory questions in each domain with some topics receiving more attention based on the stakeholder's position and area of involvement and expertise (see Appendix 3 for Addiction Recovery Stakeholders Interview Guide).

Given the diverse backgrounds and experiences of policy elites interviewed in this study, interview guide question validity was enhanced by addressing convergent and discriminant validity (Beamer, 2002), as was done with the NDATSS State Case Studies.

Data collection

Stakeholder interviews

All semi-structured interviews were conducted by the lead researcher and lasted approximately one hour (ranging from 55 to 80 minutes). Twenty of the interviews were conducted via telephone while one was conducted in-person as the participant resided in the Chicago area. Prior to the start of each interview, stakeholders were contacted via email and provided informed consent information as well as examples of addiction recovery definitions which were referenced during interviews. Verbal informed consent was obtained at the beginning of each interview.

Interview data was complemented by supporting documents such as provider initiatives, policy memos, research and evaluation reports, and government and organizational website information. This data was reviewed prior to the stakeholder interview or provided to the lead researcher following the stakeholder interview. All study protocols and procedures were approved by The University of Chicago Institutional Review Board.

Preliminary data coding and analysis

All interviews were transcribed verbatim by a professional transcription company and reviewed by the interviewer for accuracy. Qualitative coding and analysis were conducted using Dedoose online software. Using an initial template coding scheme based on the topics covered in the interview guide, each transcript was coded by the lead researcher with consultation from colleagues at the Applied Qualitative Research Seminar.

This study draws from all the text from the Addiction Recovery Stakeholders Project with data for each subsequent chapter being extracted from particular codes (described below in Combining Project Data: A Synthesized Analysis).

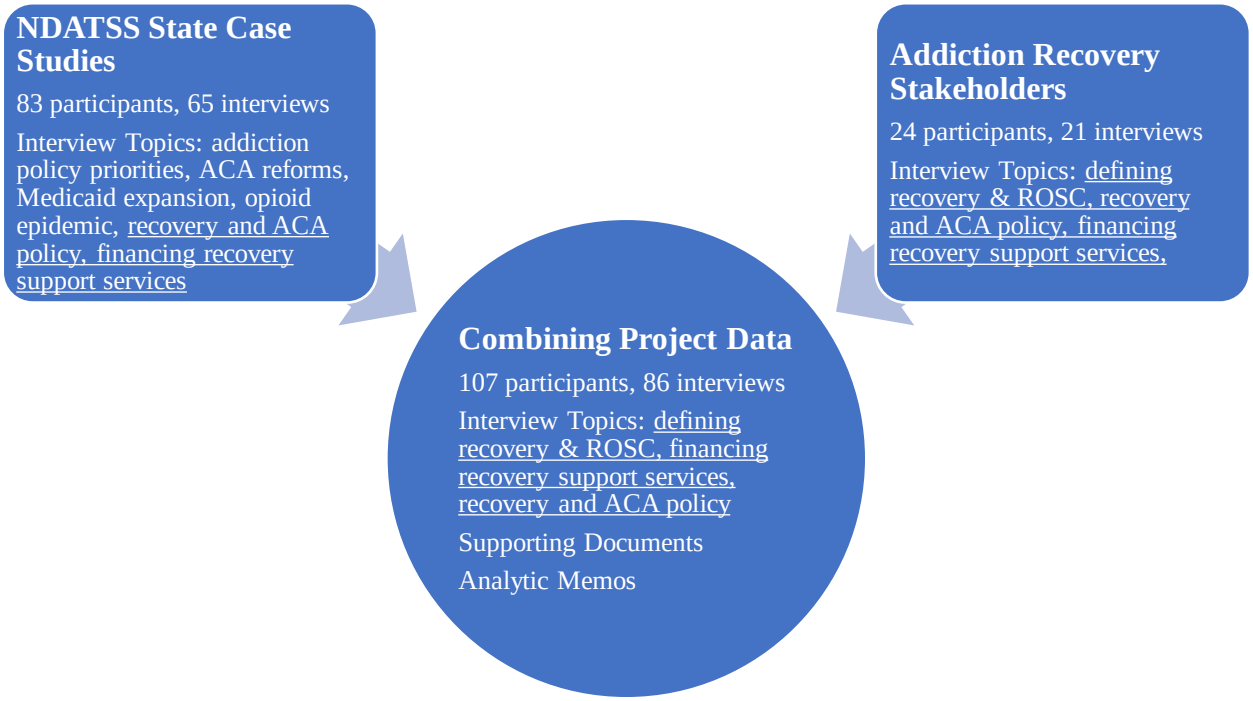
Concurrent with the data collection and coding process, analytic and theoretical memos were developed by the lead researcher as a method of interpretation. Through memo writing, "researchers gain analytic distance from data and create an intellectual space for documenting their analysis" (Charmaz, Thornberg, & Keane, 2018, p. 429).

Combining Project Data: A Synthesized Analysis

Data from the NDATSS State Case Studies and Addiction Recovery Stakeholder Project are synthesized for this study (see Figure 1). In total, the perspectives of 107 unique stakeholders from 86 interviews are considered. Conversations with the NDATSS State Case Study research team and with colleagues from the Applied Qualitative Research Seminar facilitated the process

of conceptually synthesizing findings from these complimentary projects while the iterative process of data collection and ongoing data analysis of interview transcripts and supporting documents through the development of analytic memos further refined the organization of analysis.

Figure 1. Combining NDATSS State Case Studies and Addiction Recovery Stakeholders Project Data



Throughout the data collection and analysis process, the entirety of NDATSS State Case Study and Addiction Recovery Stakeholder Project data were broadly considered in order to understand how specific analytic codes and greater themes related to one another. However, subsequent analysis examined targeted interview topics and themes that were most salient to the research questions posed by this study.

Chapter 4, particularly, examines how stakeholders in the addiction service delivery system define addiction recovery based on Addiction Recovery Stakeholder Project text coded as "defining recovery." These passages include conversations related to how stakeholders

developed their definitions for recovery as well as specific details about the dimensions of recovery that might be mentioned, including recovery domains such as abstinence and sobriety, health and wellness, and citizenship, among other adjacent concepts.

In Chapter 5, stakeholder conceptualization of recovery-oriented systems of care (ROSC) focuses on Addiction Recovery Stakeholder Project text coded as "ROSC." These passages included conversations pertaining to the elements needed in order to transform an addiction system into a ROSC as well as conversations about policy facilitators and barriers towards developing ROSC.

In Chapter 6, findings pertaining to recovery supports services is examined by looking at the Addiction Recovery stakeholder Project text coded as "recovery support services" and "peers" and NDATSS State Case Studies project data coded as "recovery" that focused more specifically on recovery support services and peers. Moreover, conversations about the policy facilitators and barriers to financing and delivering recovery support services are considered.

In Chapter 7, stakeholder comments of how addiction recovery policies, within the context of health policy reform, shape the current addiction service delivery system are considered by examining NDATSS State Case Studies text coded as "recovery" and Addiction Recovery Stakeholder Project text coded as "ACA." These passages shed light on how, if at all, addiction recovery principles, policies, and services are being considered in light of broader federal and state level policy reforms related to the ACA, Medicaid expansion, and other policy transformations, such as current attention on the national opioid epidemic.

The passages examined in subsequent chapters are extracted from interview transcripts during the first cycle of thematic coding. From these extracted passages, a second cycle of coding is conducted to identify deeper themes within the data and similarities/differences in

perspectives across stakeholder types using an axial coding approach (Saldana, 2013). Analytic memos were developed by the lead researcher to reflect upon data interpretation and theme development.

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Chapter 4. Policy Stakeholder Perspectives on Addiction Recovery

Introduction

Definitions for addiction recovery serve several roles. For those directly impacted by substance use disorders (SUDs), including service delivery clients, individuals in recovery, and their family members and loved ones, recovery can represent a meaningful, achievable goal for addiction treatment and long-term wellness. Recovery can also serve as a collective banner under which individuals in recovery and their allies can advocate for improved services and reduced stigma, particularly as it relates to engagement in adjacent healthcare, criminal justice, and other systems, and in efforts to find meaningful employment and improved personal connections. For policy stakeholders in the addiction service delivery system, definitions for recovery can drive policy and systems transformations, impact the scope of services delivered and have impacts on how service outcomes are evaluated.

Since the emergence of the New Recovery Advocacy Movement, several definitions for recovery have been developed and adopted by the elites directly involved in policy decision-making and implementation. In this chapter, I describe conversations with these stakeholders and explore how they conceptualize definitions for recovery in their work. In these conversations, we explore the tradeoffs of including or omitting certain elements within a recovery definition and discuss the process for developing these definitions, including the cultural and political factors that may have shaped the decision-making process.

For the purposes of this project, I describe the process of definition and policy development as a process of "conceptualization." This should not be mistaken for the process of conceptualization and operationalization used in social science research measurement

development. Rather, conceptualization refers to the process for which policy stakeholders develop definitions for addiction recovery in their work in the addiction service delivery system.

The findings in this chapter explore the question, how do policy stakeholders in the addiction service delivery system define recovery in their work? Through this exploration, stakeholders describe the process for which they developed their definitions as well as potential implications for these choices.

As described in Chapter 2, scholars in this field have previously attempted to better understand how people in recovery from alcohol and drug problems define recovery for themselves, including the most essential elements of recovery (Laudet, 2017; Kaskutas et al., 2015). It remains largely unknown, however, how policy elites such as federal, state, and local government administrators, funders, service providers, and policy advocates, among others, develop their definitions for recovery. The choices and actions of these policy stakeholders have practical implications for the organization and funding of addiction services and the evaluation of client outcomes.

Methods

Chapter 3 offers a comprehensive description of the methodological approach to sampling selection, interview guide development, data collection, and coding and analysis. Data presented in this chapter comes from interviews from both the NDATSS State Case Studies and the Addiction Recovery Stakeholders Project.

NDATSS State Case Studies stakeholders were asked how addiction recovery concepts, policies, and services connected with their work in the addiction treatment realm. Depending upon the extent that a stakeholder specified that their work focused on recovery policies and services, follow-up questions related to policy development and recovery definition development

were posed. Findings presented in this chapter derive from transcript data initially coded as "recovery."

Prior to interviews for the Addiction Recovery Stakeholder Project, participants were sent preparatory documents via email including working definitions for recovery concepts that are frequently used in the field. Stakeholders were notified that the definitions—from the Betty Ford Institute and the Substance Abuse and Mental Health Services Administration (SAMHSA)—would serve as starting points for conversations. Findings presented in this chapter derive from transcript data initially coded as "recovery definitions."

Results

Conversations with policy stakeholders about definitions for recovery revolved largely around three types of definitions and descriptions: (1) definitions that included abstinence or sobriety as a key indicator for recovery, (2) definitions that omit mention of abstinence or sobriety, (3) and definitions that describe recovery as self-defined. As mentioned above, conversations were primed by providing stakeholders with two recovery definitions from the Betty Ford Institute (where sobriety is included as a key indicator of recovery) and SAMHSA (where sobriety is omitted).

Some elites openly aligned their work with one or both of these definitions while others criticized these definitions for their inclusion or omission of particular elements. Moreover, in considering the prevalence of those who previously but no longer have problems with alcohol or drugs, a fourth definition emerged from these conversations that is worth consideration, particularly given the stigmatizing nature of addiction and, subsequently, the self-identified label of recovery. Other stakeholders, including those who provide recovery-oriented training and technical assistance, noted that they do not identify or align themselves with a particular

definition in the work they do, and, rather than focus on the context of the definitions themselves, place greater emphasis on the community-driven process of conceptual development. Finally, in targeting a wide variety of policy stakeholders involved in addiction service delivery including those whose work primarily relates to addiction treatment and healthcare financing, notably, some stakeholders had limited understanding of concepts related to addiction recovery and described these concepts as beyond their scope of work.

How is addiction recovery defined?

Betty Ford Institute Consensus Panel definition

In 2007, the Betty Ford Institute convened policymakers, addiction treatment experts, and people in long-term recovery from alcohol and drug problems to discuss issues pertaining to addiction treatment and to develop a consensus definition for recovery from SUDs. The Consensus Panel developed the following definition: recovery "from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship" (Betty Ford Institute Consensus Panel, 2007). The group of experts convened to develop this definition, consisting primarily of experts in the addiction treatment and recovery fields, highlighted in their definition the importance of sobriety, individual health, and citizenship as necessary life domains for achieving recovery.

A stakeholder, who is a national trainer and researcher on addiction recovery, provides insight on the Betty Ford Institute consensus definition and how the elements it introduces beyond health distinguishes SUDs from other health disorders:

> *When you have Betty Ford Institute talk about sobriety enhancements of global health and citizenship, we don't talk about citizenship in terms of cancer because we don't know of anything that's been really damaged from cancer in terms of the person-community*

relationship, per se. But with addiction that's frequently the case. – National Recovery Trainer and Researcher 1

This stakeholder is suggesting that addiction recovery is different from other health disorders because of the damage done in other life domains including one's ability to be a valued participant in the community. Implicit in this stakeholder's comment is that the Betty Ford Institute definition include areas or domains that are damaging to an individual, including substance use, health detriment, and having a deficit of positive participation or damaged relationship with society.

The same stakeholder continues the conversation by disclosing having had direct involvement on the Consensus Panel. They explain the Panel's rationale in developing the consensus definition that extended beyond a focus on disease pathology and remission and situated itself more so on improving life functioning:

Remission is a process of subtraction. If you think of it that way… we're subtracting but also in the process of adding these additional elements that didn't exist before hand. So, you could actually have somebody come out of recovery in better shape than they were before the onset of the disorder – National Recovery Trainer and Researcher 1

In comparing recovery with remission, this stakeholder situates recovery as a process of adding benefit and value to an individual rather than focusing primarily on the pathology of SUD and orienting the outcome on remission from the disorder.

In considering the process for which these stakeholders developed this definition for recovery, another national recovery trainer who participated on the Consensus Panel describes the process for which these stakeholders developed the definition and the rationale behind its development:

> *We spent a week in the Betty Ford Center and a group of us came up with that initial definition and the reason we did so was because until that time there had not been a conceptual definition for what recovery is and we all saw [its] importance… You have to know what the goal is if you're going to design the treatment system… We didn't have a consensus agreement and a bunch of really good leaders spent that week coming up with it. – National Recovery Trainer 2*

This stakeholder notes that this particular definition for recovery was developed with the purpose of using it as a goal for redesigning the addiction treatment system. The stakeholder notes that they believe that there was a lack of a consensus definition previously and an underlying assumption that "a bunch of really good leaders" who were convened were the correct individuals to develop such a definition.

SAMHSA's working definition

Five years later, the Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency responsible for the funding and coordination of addiction prevention, treatment, and recovery support services across the country convened a group of stakeholders to develop an updated definition for recovery—notably their third and current iteration of a working definition. SAMHSA's working definition for recovery is as follows: recovery is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2012). Under the Obama Administration, SAMHSA had a newly appointed Administrator who favored policies and initiatives that integrated addiction and mental health initiatives, policies, and services under the umbrella of "behavioral health." SAMHSA's consensus panel included several stakeholders in addiction treatment and recovery, but also included mental health service delivery and

advocacy stakeholders. Unlike the Betty Ford Institute definition, SAMHSA's current working definition omits sobriety as an integral recovery element and favors describing the recovery as process-driven, self-directed and targeted towards improved health and wellness.

In describing SAMHSA's efforts to convene policy stakeholders together to develop a national definition for recovery, a federal government administrator explains how the definition for recovery is rooted in the Alcoholics Anonymous 12-step tradition, but intentionally moves beyond the focus on abstinence:

> *The definition is of course influenced by 12-step programs. They were the first ones that attempted to characterize recovery as a social construct, not just abstinence. Because as you see in all of the definitions, abstinence is just a starter. And we also have to recognize that medication-assisted treatment could play a critical role… So, the concept of abstinence had to be broadened to allow for that. By looking at these life indicators and function, you're able to come up with a definition that recognizes abstinence, while important in some cases… it does not define recovery, in part because it deals with chronic relapsing disease. – Federal Government Administrator 1*

This federal government administrator acknowledges the relevance of the mutual aid movement's role in shaping recovery for individuals but also stresses the emphasis on "health and wellness, liv[ing] a self-directed life, and striv[ing] to reach their full potential" to be just as, if not more, important than abstinence. This stakeholder also notes the chronic nature of addiction as a reason to deemphasize the relevance of abstinence in the definition, given relapse is a common pitfall in SUD.

The federal government administrator continues by explaining the relevance of other contributing factors to relapse:

> *When you deal with chronic relapsing disease, you have to look at contributing factors… to relapses, like psychiatric problem, trauma, poverty, unemployment, domestic violence, domestic discord, lack of effective parenting in a household, all of those psychosocial variables, which essentially constitutes psychological stress within a person's life. Those things operate to highlight how a person copes or does not cope, depending on what's going on in their lives. – Federal Government Administrator 1*

In considering the factors that lead to an individual's relapse, this stakeholder is shedding light on the elements that both contribute to SUD as well as challenge one's ability to achieve recovery. These factors extend beyond alcohol and drug use and relate to other life domains that, from this stakeholders' perspective, can and should be addressed. Issues pertaining to mental health and social well-being all connect back to the "health and wellness" and one's ability to "reach their full potential."

In comparing the Betty Ford Institute and SAMHSA definitions for recovery, a second federal agency administrator explains their preference for the SAMHSA working definition over other definitions given its emphasis on addiction as a chronic disease and description of recovery as an ongoing process:

> *I think that it's really important to understand it as a process. A process that is not synonymous with abstinence but for many requires abstinence for it to reach any kind of fruition. By abstinence, I don't mean not taking medication for a substance use disorder. – Federal Agency Administrator 2*

This stakeholder makes clear that in their perspective, the use of medication therapies for addiction treatment, such as methadone or buprenorphine for the treatment of opioid use disorder, are not considered actions of relapse, which is a frequently held perspective self-help

and mutual aid culture, where some feel that using medications as treatment is "replacing one addiction with another."

Given the project's focus on understanding the perspective of elites in the addiction service delivery system directly involved with policy decision-making and implementation, I talked with several stakeholders who disclosed that they were directly involved in the development of these consensus definitions. During these conversations, I also prompted stakeholders to also describe what recovery is *not.* In trying to better understand the process for which stakeholders came together to develop these definitions, one policy stakeholder who was involved in the development of SAMHSA's working definition explains how the group neglected to have this specific conversation:

> *It was a one-day meeting, it was face-to-face, and no, there were not any discussions about what recovery wasn't. Which is very astute because this definition could fit anybody. That was the concern some of us had about leaving out any notion of disorder or disability, or even condition. Partly because it's sort of dishonest, but practically speaking, it also leaves [Medicaid] and private insurance companies off the hook, because if it's not a disorder, then nobody has to pay for the care. – Behavioral Health Services Researcher 1*

This behavioral health researcher expresses concerns about SAMHSA's definition particularly because its lack of explicit mention of SUD or reference to abstinence leaves vague the problem or disorder for which one is recovering. This definitional vagueness has potential consequences for policies and service delivery decisions.

Furthermore, this behavioral health researcher's direct involvement in consensus definition development and admitted dissatisfaction with the definition developed suggests that

not all stakeholders directly involved may be content with or agree with the final product. This is an important consideration as it might be the assumption of some that participation in stakeholder definition development equates with agreement with outcome of this process.

As mentioned above, SAMHSA's current working definition is the federal agency's third iteration of a definition. Although not discussed in detail with stakeholders, a few elites made reference to SAMHSA's first working definition for recovery and noted that it resembled the Betty Ford Institute's definition more closely than the current definition as abstinence was directly addressed. Definitions can change and evolve and policy stakeholders who participate in developing definitions through workgroup processes such as the Betty Ford Institute's and SAMHSA's may not agree entirely with the product at the time of initial development and they may also disagree with these definitions in the present-day, particularly as perspectives about addiction recovery and its principles may also evolve over time.

Addiction recovery grassroots definition

Conversations with policy stakeholders about recovery definitions revealed that stakeholders frequently agreed with one definition while rejecting the elements, approach, or purpose of another. One stakeholder, on the other hand, rejected both the Betty Ford Institute and SAMHSA definitions for recovery with open hostility. This stakeholder, a recovery community organization (RCO) leader, disapproves of the limitations of defining sobriety in recovery through in the Betty Ford Institute definition and highlights the vagueness of SAMHSA's working definition is intended to be applicable to both addiction and mental health recovery communities:

Those two are crap… The first one is for Betty Ford, uses the word sobriety, which really talks about abstinence in a lot of ways, abstinence from alcohol in particular. The

SAMHSA definition is just so broad and generic… They try to put both addiction and mental illness and recovery into the same boat… I don't think it works well, especially when you get such a vague definition. – RCO Leader 1

This RCO leader's sentiment about the Betty Ford Institute definition echoes the perspective of several other stakeholders. Their observation about SAMHSA's definition's vagueness stemming from attempting to frame recovery around mental illness and SUDs is an important consideration that connects back to SAMHSA leadership's agenda to integrate these systems under the banner of behavioral health. In rejecting both these definitions, this RCO leader, along with several other stakeholders whose work was situated more so in the grassroots recovery advocacy and the New Recovery Advocacy Movement made mention of another definition: "You're in recovery if you say you are."

A national recovery trainer, who identifies as a person in recovery and has had previous experience as an RCO leader, emphasizes the power of being able to define one's own recovery:

There's a SAMHSA definition and a Betty Ford definition and there's other definitions. The one definition that works the best for me is the one that says, "You get to define recovery however you think that recovery works for you." That's revolutionary. Why in the devil are we the ones who tell them what recovery is? – National Recovery Trainer 3

After explaining the use of this self-directed type of definition in their work, an RCO leader explains that they have often faced skepticism from researchers who have highlighted the shortcoming of such a definition in terms of measurement feasibility:

When I have talked to other researchers about the definition, "You're in recovery when you say you are." They say, "You can't measure that." Maybe you just haven't thought about a way to measure that, then. – RCO Leader 1

This RCO leader highlights the resistance faced in using this grassroots definition specifically from researchers. I suspect that this framing was emphasized, at least in part, because I had framed our conversation as a research interview about recovery policies. What this framing also suggests is perceived disconnect between the grassroots approach to self-defining one's own recovery and a more scientific or research-oriented approach.

In conversations comparing various definitions for recovery, a national advocacy organization leader, who had also previously been an RCO leader and national recovery trainer, compares SAMHSA's working definition with the self-defined grassroots definition. In describing the pros and cons of each definition, this participant highlights their own personal recovery while also highlighting the tension between accepting and foregrounding abstinence and recovery with the value of embracing "multiple pathways" to recovery:

> *Personally and professionally, I think that SAMHSA's definition of a process of change, and improving health and wellness, striving to reach full potential is much more appropriate in terms of my own personal recovery as well as what we've seen in the field. Because, especially when you say, and this is definitely the recovery community, grassroots kind of motto, is "you're in recovery if you say you're in recovery." So, it is a personal definition, and the catch there is that so many of our systems define it by abstinence… If sobriety translates into abstinence, then that is not as widely accepted because we honor all pathways to recovery. – National Advocacy Organization Leader 1*

This stakeholder, notably the only policy actor to do so, also describes recent research conducted by scholar John Kelly and colleagues to measure national prevalence of addiction recovery. In Kelly's work, when respondents are asked, "Did you used to have a problem with alcohol or drugs but no longer do?" approximately 9.1% of the population in the United States, or 22.35

million people are in recovery. However, only 46.6 percent self-identified as being in recovery, potentially attributable to the stigmatizing nature of the recovery label (Kelly et al., 2017).

How recovery is defined has implications for how individuals in recovery are counted which has consequences to policy and service delivery funding. For this reason, this survey question's approach to conceptualizing and operationalizing addiction recovery addresses the vagueness of other definitions that do not make reference to *what* an individual is recovering from while also taking into consideration that the recovery label may not capture all those who have actually recovered. In describing Kelly's research, this same stakeholder continues:

> *It says that even though we say there's 22-23 million Americans in long-term recovery… that half of them wouldn't define themselves as people in recovery. And so that means they might say, "Oh, I once had a problem with alcohol or other drugs but I no longer do." So, the fact is that we may or may not need to keep defining recovery because it is very much self-defined for half the people who once had a problem... The question remains, can people who once had a problem with alcohol or drug use return to normal use? I would have to say that probably a lot of people do. But I don't, I mean I think that the other piece is, "Do we wanna label people as in recovery if we don't have to, if they're not identifying with that word?" – National Advocacy Organization Leader 1*

Labelling individuals as people in recovery has several advantages including reducing the stigma of having had experiences with alcohol or drug problems as well as creating a collective group of individuals with a common identity trait who can magnify their policy voice, as was observed in the New Recovery Advocacy Movement. The recovery label is also stigmatizing and can impact one's ability to find housing, employment, and serves as a barrier to restoring other life

functions. For this reason, one should consider other ways of defining recovery, such as this survey question's description.

Table 4. Approaches to Defining Addiction Recovery		
Attributed To	**Definition**	**Pros/Cons**
Betty Ford Institute Consensus Panel (2007)	"Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship."	Pros: Addiction specific; addresses sobriety; rooted in 12-step tradition Cons: Abstinence-based; does not embrace value of multiple pathways
SAMHSA Working Definition (2012)	"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."	Pros: Process-driven; not abstinence-based Cons: Sobriety not specified; too vague
Grassroots Definition	"You're in recovery if you say you are."	Pros: Self-defined, inclusive; not abstinence-based; appropriate for grassroots advocacy Cons: Sobriety not specified; too vague; recovery label is stigmatizing
Survey Definition	"I used to have a problem with alcohol or drugs, but no longer do."	Pros: Self-identified; not abstinence-based; moves beyond stigma of recovery label; validated measure Cons: Sobriety not specified

Moving beyond a culture of abstinence towards multiple pathways of recovery

Policy actors generally described four types of recovery definitions (Table 4). Several definitional characteristics were discussed and highlighted including the health and life domains believed to most pertinent to defining recovery in their work. Notably, one of the most frequently contentious elements discussed—abstinence—highlights the larger transformations taking place in addiction treatment and recovery, including shifting values, technologies, and identities. A Single State Agency (SSA) administrator describes the tension that exists in their state between

policy actors who embrace abstinence as a necessary value in recovery and those who embrace harm reduction approaches such as the use of medication-assisted treatment (MAT):

> *You know, these are evidence-based practices, the field is changing, what works is changing. That was a part of it, and then another part is just the different cultures, you know? Older versus younger, alcohol versus heroin, and I think we kept trying to emphasize, "Hey, you know, everybody's trying to get to the same place. It doesn't matter if you're an A, B, or a C." – SSA Administrator 1*

In describing work in the local community to define recovery and achieve transformations towards a recovery-oriented system of care (ROSC), a county behavioral health authority who had undertaken sweeping systems transformations in their community describes how a culture of abstinence continues to be a barrier to recovery-oriented policy change:

> *I would say the biggest stumbling block was the discussion about abstinence. When you have old time AA community, I have a lot of them in here, when we started talking about medication-assisted treatment, well they didn't view that as recovery. "No, that's substituting one thing for another…" Our biggest points of discussion were trying to get past that hard line of abstinence and getting to a point where we're like, "There's many different paths and you can be a person that's in recovery and be on MAT." – County Behavioral Health Administrator 1*

In this community's case, the tension between abstinence and a "multiple pathways" approach to recovery is highlighted by the adoption of MAT such as methadone or buprenorphine, which are used to treat opioid use disorders. This community is situated in a state that has been particularly hard-hit by the national opioid epidemic.

A long-standing national recovery trainer who identified as a person in recovery and has spent many years travelling around the country giving states, counties, and local communities technical assistance on ROSC transformation and recovery-oriented policy changes explained that even in their work, the definition for recovery has evolved as have personal attitudes towards abstinence and harm reduction approaches. In discussing SAMHSA's working definition for recovery, the national trainer explains:

> *It's actually quite similar to the definition that I use in my work today. That certainly wasn't the case many years ago. I used to identify as a closed-minded 12-stepper, and what I mean by that is that I used to subscribe to a belief that unless you were in total abstinence, unless you were involved in a 12-step recovery program, then you probably weren't in real recovery. – National Recovery Trainer 3*

This national trainer's comment reinforces the point that perspectives on recovery can evolve through time and that contemporary perspectives on recovery have distanced themselves from "closed-minded" perspectives that originated from the Alcoholics Anonymous (AA) tradition.

How are definitions created?

Arguably, understanding how definitions for addiction recovery are created is more important than the definitions themselves, as these processes shed light on the power structures and decision-making processes that impact policy adoption and implementation. In a ROSC, person and community-driven values are placed front and center over the choices of policymakers and other elites. Thus, in a system of care that values recovery-oriented principles, people in recovery should define their own recovery.

Emphasizing community process over definition

In these conversations, stakeholders whose role involved providing technical assistance and trainings with states and local communities often described the pros and cons of each recovery definition but they did not necessarily align themselves with one definition over another. Some stakeholders even specified that convening community stakeholders together in a process of clarifying a definition for and elaborating the principles and values they wanted in a system of care was more important than the definition itself. One national trainer described the process typically used in community trainings:

> *Early on we would present to people the various definitions... I think one early training we did… had like five definitions and as we looked at the definition[s], we talked about, "So what is it in your conceptual alignment… when you come together as a community,,, that resonate for your community?…" Then, we did focus groups and we have [a] definition. What does the recovery—a person in recovery—what's their definition of recovery? People started pulling in the recovery community in to define recovery in [their] community. – National Recovery Trainer 4*

This community-driven process of identifying community values that align with supporting individual recovery and a recovery-oriented service delivery system highlight the importance of recovery as process-driven approach. And while states and communities often do adopt pre-existing definitions such as SAMHSA's working definitions, communities might tailor these definitions to their own needs and context. The same national trainer describes how this process might be operationalized:

> *A state, they say "We're going to take SAMHSA's recovery definition." A county within that state may say, "We like that, fine, but within the context of that definition, here is say*

our county's mission or our definition, our purpose so to speak within the context of what our state has said, here is what we deal with." – National Recovery Trainer 4

A second national recovery trainer describes their process for providing training and technical assistance to states and communities and the role of evidence and research:

What I do is typically this. First of all, I point to the science that exist… Then what we say is, "All right, here are the definitions for recovery that currently exist and we share something like what you have." Then we'll say, "What are your definitions in the community?" We make sure we have constituent representatives for each group so we have a full community voice and perception, which is what ROSC is. Then we say, "How does this community using these current definitions want to define recovery for itself?" – National Recovery Trainer 2

At state and community level, several stakeholders described a community-driven process for defining and describing recovery and its principles. However, some stakeholders explained how they, and the states and communities with whom they work, still align with SAMHSA's working definition because they participated in, or respect the stakeholders who had participated in, the development of the definition. As described above, however, even those who had been involved in the consensus-driven process of developing the Betty Ford Institute or SAMHSA definitions do not necessarily agree with the definitions developed during these process because these processes were an attempt to create consensus among a diverse set of stakeholders, because the definitions were developed several years ago and reflect the values and principles that were important at the time but do not necessarily reflect present-day values, or for some other reason.

Only a few stakeholders, notably who currently or had previously worked at SAMHSA, noted that some stakeholders might choose to adopt SAMHSA's definition because of the federal government agency's role in funding addiction recovery initiatives and services. Although this was less explicitly noted, one could also view national trainer's use of SAMHSA's definition for recovery as a starting point for community conversations about their own definitions as serving a comparable, although less direct, purpose.

The politics of who is at the table

As described above, the Betty Ford Institute definition for addiction recovery differs from SAMHSA's working definition in one key area—the explicit mention of sobriety. A key reason for this difference is that the stakeholders convened by the Betty Ford Institute in 2007 consisted of addiction treatment and recovery stakeholders while SAMHSA, in its creation of its current working definition approximately five years later, convened stakeholders from both the addiction and mental health communities. In these conversations, some stakeholders believed that convening a broader behavioral health community had its advantages while others highlighted the political nature of this decision.

In 2009, under the Obama administration, a new SAMHSA Administrator was appointed who prioritized mental health and addiction policy and systems integration often regardless of evidence of its improvement to service delivery or client outcomes. This integrated approach impacted recovery-oriented policymaking and funding decisions as SAMHSA increasingly involved both addiction and mental health recovery stakeholders in key decision-making efforts, including in the development of its working definition for recovery.

A national recovery trainer and researcher explains the implications of combining addiction and mental health definitions for recovery, including a vague definition that falls short in linking back to the pathology of SUD:

> *What's interesting is when you try to blend those into a single definition, into these sort of global behavioral health, you get some advantages in terms of SAMHSA's agenda trying to integrate substance use disorder and psychiatric treatment but you lose some things in that process as well. For example, you get the definition of addiction recovery that doesn't say anything about addiction. – National Recovery Trainer and Researcher 1*

A federal government administrator further describes how the organizational politics at SAMHSA impacted how recovery initiatives were organized. Under previous SAMHSA leadership, the Center for Substance Abuse Treatment and Center for Mental Health Services oversaw their own initiatives pertaining to recovery, but under the new SAMHSA Administrator, one Center's leader oversaw all recovery initiatives. A federal government administrator explains:

> *The task was assigned to the Director of the Center for Mental Health Services. And so, those issues were amalgamated with the substance abuse issues. So, the Administrator at that time felt that a common definition in terms of behavior health would serve the broader field. She saw behavior health as the operant construct, rather than substance use disorder or serious mental illness. – Federal Government Administrator 1*

A lead researcher on behavioral health recovery further elaborates the shortcoming of SAMHSA's behavioral health recovery definition as a consequence of organizational politics:

> *It says nothing about mental health or substance abuse. So, that was a political decision, that I think was a mistake in retrospect. But the SAMHSA definition was trying to create*

a definition under which both mental health and addiction folks could become integrated into one behavioral health field, and it was SAMHSA's decision to call it behavioral health. Which, a lot of folks in the addiction side don't like. – Behavioral Health Services Researcher 1

This behavioral health researcher is the stakeholder who disclosed having been involved in the consensus group developing SAMHSA's working definition and characterizes an outcome for which those involved were not satisfied. The same stakeholder offers additional context on how the mental health recovery stakeholders involved were dissatisfied with the final product:

I think [SAMHSA has] made it so vague and universal that it has lost a lot of its traction. That's part of the backlash on the mental health side, 'cause people saying that they're ignoring mental illnesses, because all they're doing is talking about recovery…They're very different communities. – Behavioral Health Services Researcher 1

An RCO leader with strong opinions about this shift towards behavioral health integration explains why they believe the addiction and mental health recovery movements should not be integrated:

I think that mental health recovery and addiction recovery, the way it is today, is oil and water. They don't mix… When they walk into a recovery community center, they say, "How can we help you with your recovery today?" and they will tell us, "But people don't usually identify as having both' if you even ask their diagnosis," which we don't. They might say, "I have depression" or "I'm bipolar" or whatever, or they might say "I'm recovering from a heroin addiction," whatever. They don't really identify as heroin and bipolar or something like that. It's just very rare. There's a few people that do, and

they're loud advocates in our state, but for the most part, people identify their recovery and they identify what they're in recovery from. – RCO Leader 1

This RCO leader describes how people in recovery strongly identify with the disorder from which they are recovering. In most cases, these individuals identify with one disorder rather than describing recovery from multiple problems. In considering the importance of recovery-oriented values including the ability to describe and determine one's own recovery, this observation is insightful about what occurs at community-level.

On the other hand, some elites explained that their perspective has evolved on the advantages of an integrated recovery definition and advocacy community. A national advocacy organization leader, who identifies as a person in recovery and has also had experience in addiction treatment policy, describes their evolving perspective:

I've been on my own learning curve with this… I worked on some SAMHSA things that were blended initiatives. I got to know the mental health perspective more and got to know leaders in the mental health peer and recovery community… I learned a lot about folks are in one camp or the other because they think they have to choose to be in one camp or the other. But they could easily be on either side of the aisle. Some of that is imposed. Some of it is historical. Some of it is systemic funding, like all those things. Some of it is just cultural. – National Advocacy Organization Leader 2

This national policy leader's comment is useful in highlighting how perspectives on recovery, including whether or not the addiction and mental health recovery communities should be considered separately or in tandem, can evolve over time. This idea of "folks" falling "in one camp or the other" due to structural forces is a noteworthy, particularly as this was acknowledged by the RCO leader who commented these systems are like "oil and water."

These two stakeholders' perspectives are in direct opposition of one another as the RCO leader is taking a grassroots recovery-oriented perspective heavily emphasizing the importance of self-determination in identity labelling. In contrast, the national advocacy organization leader is highlighting the structural attributes that, in some ways, devalues the importance of self-determination of identity.

An RCO leader who specializes in indigenous populations offers historical context to the conflict between mental health and addiction recovery stakeholders by describing previous divides that existed, particularly between the Alcoholics Anonymous and Narcotics Anonymous communities:

> *It sometimes comes to a cultural interpretation of what these things mean where, in some ways, in AA when it formed, it said, "This is for alcoholics. Don't bring your drug problems here." You know that, and Narcotics Anonymous formed, and then they were, "Don't bring your alcohol problems here…" It had a tendency to be a system of isolation. Well, in the Native culture, that same side is more about inclusion. Everyone is invited. – RCO Leader 2*

Another stakeholder who is a national addiction recovery trainer offers further insight into why individuals in the addiction recovery community might be reluctant of any policy efforts to promote an integrated behavioral health agenda:

> *Historically, the reason the people on the addiction side have been very skeptical about integration moves is if you think about it, historically, if those other systems of care have effectively treated addiction, there would be no specialty field of addiction treatment. – National Recovery Trainer and Researcher 1*

A federal government administrator explains the impact of SAMHSA's behavioral health approach to define recovery on funding for recovery initiatives and services:

> *Well, because under that administration, the focus was on behavioral health as a construct, grantees were required to address behavior health at large. So that's how it affected and some decisions were being made as to how to promote these constructs. – Federal Government Administrator 1*

Addiction and mental health integration efforts are perceived as a potential strength by some while, for others, it has its limitations, including the potential loss of perceived identity and history. As this federal government administrator notes, decisions about who is at the policymaking table have consequences to how policies are created and implemented, including which initiatives and services are funded.

Differences in understanding and lack of ownership of recovery

The Addiction Recovery Stakeholder project targeted policy elites who had historically been involved in the New Recovery Advocacy Movement and many of the conversations and initiatives related to addiction recovery that were discussed in-depth in this chapter. Interview stakeholders from the NDATSS State Case Studies were primarily from the addiction treatment and healthcare financing fields. Several of the addiction treatment stakeholders were very knowledgeable about recovery-oriented concepts. However, stakeholders primarily embedded in healthcare policy and finance, including state government agency representatives from Medicaid and commercial insurance and insurance plan representatives from Medicaid managed care organizations (MCOs) and qualified health plans were often unaware of these concepts and described a lack of ownership for adopting recovery-oriented policies and practice.

A state Medicaid agency administrator from a state that has expanded its Medicaid program explains how a majority of their agency's efforts are focused on the policy changes pertaining to the Affordable Care Act (ACA) and developing a new addiction treatment benefits package:

> *We haven't spent a lot of time focusing on that because we've been so busy putting this new benefit package together but I think we're mindful of the need for recovery-oriented, supporting recovery-oriented systems of care. Our sister [addiction services] agency… has really been more focused on that. – State Medicaid Administrator 1*

From this policy stakeholder's perspective, recovery-oriented policy initiatives are primarily the work of the Single State Agency (SSA) for addiction services.

In another state, a commercial insurance agency administrator was less aware of recovery-oriented concepts and equated recovery and recovery-oriented systems of care to services: *"I think it's a range of services if I've heard it, and I think we do cover most everything that I'm aware of…" (State Commercial Insurance Administrator 1).* Similarly, a Medicaid managed care organization representative in a different state equates recovery with services, as well: "*Yeah, of course, all the services we provide are meant to be recovery-oriented. As a health plan we only have a limited input into the aspect that you're talking about…" (Medicaid MCO Leader 1).*

This misunderstanding that recovery equates to particular services demonstrates how recovery-oriented concepts and policies are embraced and well-understood by certain kinds of policy stakeholders in the addiction service delivery system but remain unknown or misunderstood by others. The state Medicaid administrator, state commercial insurance administrator, and Medicaid MCO representative above, it should be noted, have roles

specializing in behavioral health services, including addiction treatment. This may be the reason why these stakeholders were quick to attribute "recovery" to particular services rather than to be aware that recovery can and should be the desired client outcome for individuals utilizing these services.

In addition to the misunderstanding of recovery-oriented principles, I was interested in understanding potential stakeholder skepticism around addiction recovery values and urged stakeholders to identify people who might represent this perspective. Rather than blatant disapproval of these values, however, stakeholders observed indifference and skepticism from others. A behavioral health researcher notes:

> *If the [university's] department of psychiatry is any reflection of the broader universe, which in addiction I think it probably is, there was more indifference than skepticism early on here. But it's become a fairly well accepted, among my addiction research colleagues now. – Behavioral Health Services Researcher 1*

A former state government administrator currently working in a behavioral health system where they are charged with implementing recovery-oriented behavioral health services describes some of the challenges faced in their new role:

> *When I got here, which is about two-plus years ago now, and I started talking recovery language and peer supports and recovery coaches, people looked at me like I had three heads. They had no idea what I was talking about. I've spent the last two-and-a-half years impacting the system around really needing to involve patients and their care and needing to have people with lived experience on inpatient units. – Behavioral Health Services Administrator and Former SSA Director 1*

Recovery definitions only go so far

The utility of developing definitions and concepts related to addiction recovery can only do so much for improving a system of care. Policy stakeholders describe some of the limitations to these past efforts and they acknowledge that other elements are needed in order to motivate systems transformation. An SSA administrator recalls efforts the state had made to convene stakeholders to define recovery and the lack of momentum thereafter to spur subsequent systems change:

> *I think what happened at the beginning is that a couple of years ago we did convene… a recovery council. We pulled in stakeholders and talked about what recovery is and put some definitions to it, but then, I think just the committee itself lost a little bit of momentum and... nothing got operationalized. I think a lot of ideas were there, but then the sense of urgency, the momentum, all those things that you need in order to go to the next step with something, just for some reason, fell apart. There's a lot going on in communities… I guess it feels fragmented to me. – SSA Administrator 3*

This state is comparable to many others that have attempted recovery-oriented policy change by attempting to define recovery within its communities. Like many other states and communities, this state also faced barriers to systems transformation including this perceived lack of momentum. The community-driven process of defining and describe recovery and its principles is a significant first step towards systems change. However, developing a definition for recovery is not sufficient as other facets are necessary for structural reform.

Discussion

Policy stakeholders in the addiction service delivery system have adopted various definitions for addiction recovery in their work. Through conversations with elites, we learned

that there are numerous perspectives on the current definitions of recovery being used. These definitions include and omit various characteristics and dimensions which have implications for their practical use in community advocacy mobilization, policy framing and implementation, and prevalence and service outcomes measurement. Some stakeholders in the addiction system aligned themselves with the Betty Ford Institute definition while others aligned themselves with SAMHSA's current working definition which was developed by mental health and addiction policy stakeholders.

Recovery values and principles originate from the 12-step tradition that emphasizes the central role of abstinence in recovery. And while early definitions for addiction recovery (including the Betty Ford Institute definition) have stressed the importance of abstinence and sobriety as central tenets, contemporary definitions (including SAMHSA's current working definition) omit abstinence which leaves interpretive space for acknowledging the role of relapse in recovery from this chronic disease and embracing multiple pathways to recovery, including medication-assisted treatment.

Alternatively, the contemporary grassroots recovery advocacy community has embraced the self-defined approach that "you're in recovery if you saw you are." This approach allows for self-determination but is criticized for being too vague, difficult to measure, and not taking into consideration that individuals may not self-identify as being in recovery because of the identity label's stigmatizing connection back to SUD. Then, although not necessarily a definition, the addiction recovery research field has adopted the description that individuals "once had a problem with alcohol and drugs, but no longer do," as this conceptual framing specifically attributes one's recovery to improvement from problems with alcohol and drugs without connecting back with such a label.

All of these approaches to defining recovery carry advantages and disadvantages in their utility and their use has implications for policymaking, service delivery, research and evaluation, and advocacy. Arguably more important, in some ways, than the definitions adopted and used by members of the addiction policy community is understanding *how* stakeholders come to choose particular conceptualizations. National experts in addiction recovery providing technical assistance and training nationwide to states and communities through SAMHSA funding for these services. Given SAMHSA role in funding states and local communities, states and communities would be inclined to adopt SAMHSA-aligned definitions and, in particular, the current definition developed by SAMHSA as organizations in fields are often impacted by sources of resources and funding. And although several national trainers explained that they offered SAMHSA's definitions as starting point in their work with states and communities, more important than the definition that was adopted by the community was that the community used a community-driven approach to defining recovery and elaborating its principles. Broadly, policy stakeholders explained that community stakeholders were brought together in local boards, stakeholder meetings, and in other groups to develop and select definitions that would work for their community to go through this process of involving people in recovery, their family members, and allies in defining recovery for themselves.

As we observe with the Betty Ford Institute and SAMHSA definitions, those selected to be part of the community-driven process impact how recovery is defined. Early iterations of definitions, including Betty Ford's and SAMHSA's earlier definitions included abstinence as an important component of recovery. However, leadership and objectives at SAMHSA changed over the years shifting towards a prioritization of behavioral health systems integration. In addition, the national portfolio on recovery was consolidated and overseen by SAMHSA's

Center for Mental Health Services; this shift resulted in the inclusion of addiction and mental health recovery stakeholders in the same room to develop a definition, which influenced a coerced collaboration of the addiction and mental health recovery fields and the omission of abstinence from the formal definition of recovery.

In broadening our consideration of addiction treatment and recovery policy stakeholders, we observe that some policy actors have limited understanding of these concepts altogether, including those whose role is primarily related to healthcare policy and financing. This has implications given the broader shifts in addiction treatment and healthcare under the Affordable Care Act towards physical and behavioral health systems and services integration.

Efforts to define addiction recovery are important starting points for policy change and the language and processes adopted at national, state, and local community level to define recovery are important considerations as they signify the values of the service delivery system and have implications for how addiction policies and services are planned and implemented.

Conclusion

The community-driven process of developing a definition for addiction recovery is an important and symbolic step for communities in their service delivery reform efforts. However, the policymaking process of developing a definition is insufficient as it does not guarantee momentum, either from the grassroots or the government agency level, towards adopting policy and systems transformations towards a ROSC.

In the next chapter, we discuss how policy stakeholders in the addiction service delivery system conceptualize a recovery-oriented service delivery system including the necessary components for systems transformation and the facilitators and barriers towards policy change.

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Chapter 5. Transformations Towards a Recovery-Oriented System of Care

"This is not a tweaking of addiction treatment as we know it, it's a radical redesign of addiction treatment." – National Recovery Trainer and Researcher 1

"You know, you could characterize it as just a Rube Goldberg cobbled-together kind of thing because I don't know that we have a really good manual or set of numbers." – National Addiction Policy Expert 1

Introduction

Whereas policy stakeholders in the addiction service delivery community develop definitions for recovery as frameworks for understanding the relationship between individuals with substance use disorders (SUDs) and the broader community, a recovery-oriented system of care (ROSC) is a conceptual framework for understanding how formal and informal services and supports within a professional and community-based setting can support an individual's recovery management and long-term wellness.

In this chapter, stakeholders in the addiction policy community describe their perspectives on how ROSC can and should be conceptualized in their work and they explain how they have developed these conceptualizations. Moreover, participants describe the facilitators and barriers to recovery-oriented policy and systems transformation. The findings in this chapter explore the question, how do policy stakeholders in the addiction recovery service delivery system conceptualize ROSC? And further, we attempt to better understand why ROSC has become an idealized conceptual framework for developing and transforming an addiction service delivery system.

As in Chapter 5, I describe the process of definition, conceptual framework, and policy development as a process of "conceptualization." This should not be mistaken for this terminology's use in social science research measurement development. Rather, for the purposes of this study, conceptualization refers to the process for which policy stakeholders develop

descriptions for ROSC in their work in the addiction service delivery system, including its affiliated definitions, principles and values, conceptual frameworks, and policies.

There have been previous efforts by scholars to identify how individuals in long-term recovery define addiction recovery, but limited work has been done to understand how policy elites conceptualize ROSC and its essential elements as an ideal system of care. Some efforts have been made to understand some state and community systems, including the state of Connecticut (Kirk, 2011) and city of Philadelphia (Achara-Abrahams, Evans, & King, 2011), and to understand these system's transformations and the impact of these transformations on client and community outcomes (see Chapter 2). However, little is known about how these service systems adopted conceptualizations for ROSC or which elements of a ROSC are most important for effective service delivery and improved client outcomes.

Methods

Chapter 3 offers a comprehensive description of the methodological approach to sampling selection, interview guide development, data collection, and coding and analysis. Data presented in this chapter come from interviews from both the Addiction Recovery Stakeholders Project and NDATSS State Case Studies.

NDATSS State Case Studies policy stakeholders were asked how addiction recovery concepts, policies, and services connected with their work in the addiction treatment policy and service delivery field. Depending upon the extent to which a policy stakeholder specified their work focused on recovery policies and services, follow-up questions related to policy development and recovery definition conceptualizations were posed. Findings presented in this chapter derive from transcript data coded as "recovery."

Prior to interviews for the Addiction Recovery Stakeholder Project, participants were sent preparatory documents via email including and descriptions of recovery concepts that are frequently used in the field. Stakeholders were provided with descriptions for ROSC developed by William White (2011) and the Substance Abuse and Mental Health Services Administration (SAMHSA, 2010) that would serve as starting points for conversations. Findings presented in this chapter derive from transcript data coded as "ROSC."

Results

Conversations with policy stakeholders about ROSC revolved around particular topics, including how they conceptualized ROSC in their work. We discussed the origins of ROSC as an idealized service delivery framework and the impetus for its conceptualization. Policy stakeholders describe the process of developing their descriptions of a ROSC and explain the status of ROSC transformation in their communities. Barriers and facilitators to systems transformation are identified, including the role of organizational leadership, the necessity of recovery-oriented service delivery transformation as a policy priority, and the continued challenges associated with having a professionally-driven addiction treatment system. Finally, ROSC is considered as a tangible systems transformation objective or philosophical idealized service delivery approach.

What is ROSC?

William White, an addiction recovery historian and researcher, developed among the first descriptions for a ROSC, which he explains is:

> *The complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families and the creation of values and policies in the larger cultural and policy environment that are supportive of these*

> *recovery processes. The "system" in this phrase is not a federal, state, or local agency, but a macro-level organization of the larger cultural and community environment in which long-term recovery is nested (White, 2008, p. 18).*

Two years later, the Substance Abuse and Mental Health Services Administration (SAMHSA) defined ROSC as:

> *A coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems (SAMHSA, 2010).*

From these definitions, we have an understanding that ROSC is more than just coordinated care within an addiction treatment service delivery system. ROSC relies on services and supports beyond the professionally-delivered system and, as White describes, requires the availability of community-based indigenous supports. Its scope may even extend beyond the formal and informal interventions and supports that have typically been considered for those with alcohol and drug problems. Or, in other words, the services and supports considered and included in a ROSC should directly address the life domains directly impacted by alcohol and drug problems; these services and supports should address disease remission and restore behavioral and physical health functioning, but also address other life domains impacted by SUD such as family and community connectedness and meaningful participation in school or the workforce.

In considering the relationship between the concepts of "recovery" and "ROSC," one must consider how policy stakeholders defined recovery in the previous chapter as a means of conceptualizing an ideal outcome for the relationship between an individual and their drug use and community. Recovery is operationalized through a community's delivery and individual's

utilization of services and supports through the use of recovery management techniques. This process of recovery management is best supported by a ROSC.

Evolving beyond "Treatment as Usual"

How is a ROSC different from the addiction treatment service delivery system as it has existed in the past? In 2007, stakeholders in the addiction recovery policy field convened in the National Summit on Recovery, one of the first meetings convened by SAMHSA to define recovery concepts including ROSC. In developing a conceptual framework for understanding what these stakeholders perceived to be the effective and ineffective elements of the existing addiction treatment system, they highlighted some of the following differences. The traditional addiction treatment service delivery system often focuses on the education, training, and "expertise" of credentialed professional counselors or clinicians while a ROSC centralizes the role and perspective of the client where services are person-centered, self-directed, and strengths-based. In the traditional addiction treatment system, family members, friends, and other community allies have limited involvement in an individual's treatment while in a ROSC, full involvement from loved ones and allies is expected. In the traditional addiction treatment system, services provided are typically generalized across all recipients and are delivered to address acute episodes while in a ROSC, service are individualized, comprehensive, and can be delivered across the lifespan to address the chronic nature of SUD. And, from a systems perspective, the traditional addiction treatment system is anchored in treatment facilities while in a ROSC, services are anchored in the broader community, inclusive of both professionally-delivered treatment services as well as other indigenous, community-based supports (Table 5).

The traditional addiction treatment system developed around the movement in helping professions to medicalize and professionalize care. In contrast, a ROSC values the role of formal

and informal services and supports, including supports provided professionally-delivered treatment, through peer support and mutual aid, and through family and friends.

Table 5. Differences between Treatment-as-Usual and ROSC		
Service System	**"Treatment-as-Usual"**	**ROSC***
Treatment Focus	"Expert"-centered	Person-centered, self-directed, strengths-based
Role of Family and Allies	Limited involvement	Full involvement
Service Provision	Generalized, acute episodes of care	Individualized, comprehensive, across the lifespan
System Context	Anchored in treatment	Anchored in the community

*Adapted from Center for Substance Abuse Treatment. (2007). *National Summit on Recovery.*

Impetus for ROSC transformation

The New Recovery Advocacy Movement began gaining momentum in the 1990s, at least in part due to the dissatisfaction of people in recovery with their negative experiences engaging in and perceived ineffectiveness of the formal addiction treatment service delivery system. Part of the New Recovery Advocacy Movement's policy advocacy was aimed at drawing attention to the perceived flaws within addition treatment and suggesting improvements for a person-centered system of care that took advantage of the indigenous community supports provided by people in long-term recovery, family members, and other community allies.

Another perceived shortcoming of the addiction treatment system is the treatment gap that exists between those who meet clinical criteria for treatment and those actually receiving services. According to the National Survey on Drug Use and Health, only 11% of those needing addiction treatment in the United States actually receive it (SAMHSA, 2015a). During policy stakeholder interviews, a national trainer and researcher on addiction recovery describes the low penetration rates for treatment access, both generally and across the lifespan, and compares these

rates with those observed in cancer and diabetes treatment. A systems transformation towards ROSC, in this stakeholder's perspective, would address that disparity and lag:

> *If we compared [substance use disorder] with breast cancer or if we compared it with diabetes. If the only time we're intervening with this disorder is when people are at terminal stages of cancer, then even if we're able to intervene and treat at that point, this is a very ineffective system of care… If we ask people, what's the time lag between the onset of diagnostic criteria for a substance use disorder and the first treatment. Right now, it's measured in years if not decades. Part of the function of a ROSC needs to be to reduce that figure. – National Recovery Trainer and Researcher 1*

Like many other stakeholders I spoke with whose work focuses around recovery-oriented principles, policies, and services, the pre-existing addiction treatment system is perceived to have many shortcomings that a ROSC transformation could address.

In addition to poor penetration rates for treatment admission, treatment outcomes are believed to be poor for many clients. A stakeholder, who is a national advocacy organization leader with experience in addiction treatment policy, explains ROSC to skeptical stakeholders who believe their addiction treatment work is already recovery-oriented. In comparing ROSC with treatment-as-usual, the stakeholder explains:

> *It's very different. So, first of all, the first question to ask is, "How are things working for you now? What kind of outcomes are you getting?" The second question is, "If you're not getting the right outcomes do you need to redefine what outcomes you want?" And the third question is, "It's a commonly known fact that when people are in treatment and leave treatment and go into the community, especially if there's a recovery hostile environment, and there often is, they're going to relapse. So, how do we stop that?"*

That's clearly not working. If we want to support long-term recovery, we have to put the supports and resources and services in the right places so that it helps people. – National Advocacy Organization Leader 2

This national organization leader frames the necessity for systems transformation in top-down systems perspective in considering systems, service, and client outcomes and the need for systems administrators and service providers to consider the consequences of client relapse once they may have disengaged with the formal service delivery system. These considerations reframe how service outcomes should be measured—particularly in shifting from short to long-term outcomes measurement.

A national trainer and researcher in addiction recovery describes the discord in how individuals with SUDs are treated as compared with patients in other sectors of healthcare:

Right now, we continue to throw people out of addiction treatment for confirming their diagnosis and that's a practice that will virtually be eliminated. There's no precedence for that in the rest of the healthcare system. In other words, you can't admit somebody for a diagnosis of substance use disorder, meaning they've lost control over their decisions to use and under what circumstances do you use once you start? Then have them use when you confirm their diagnosis and throw them out of a system of care as a result of that behavior. – National Recovery Trainer and Researcher 1

This policy elite's comment highlights the problematic nature of providing addiction treatment in acute episodes that misalign with the chronic nature of addiction that often entails relapse.

From the perspective of a stakeholder who is a national recovery trainer and researcher, many of the flaws in the traditional addiction treatment system stem from its early development

in the 1970s. This stakeholder explains how the addiction treatment system reproduced early forms of primary care and hospital organization, funding, and accreditation:

> *The problem we have is that in the early 1970s, when the modern treatment system came of age through federal funding and private insurance, is that we looked around and figured out how in the hell we develop credibility for this system and what we reached out to was we used the accreditation process for primary care hospitals. We basically modeled addiction treatment, the design and the flow of services on an acute care hospital. Now we're trying to deconstruct that acute care model. – National Recovery Trainer and Researcher 1*

This stakeholder highlights how in many ways, the traditional addiction treatment system has mimicked the structures put in place in other sectors of healthcare since the past several decades. This can be seen in the focused in addiction treatment on acute episodes of care and in the development of professional accreditation processes for counselors. Given this patterning after other healthcare systems, it is worth considering how these processes have resulted in both the effective and ineffective aspects of the current addiction service delivery system.

Origins of ROSC Conceptualization

ROSC, as a construct for conceptualizing an addiction service delivery system, was developed within the context of the New Recovery Advocacy Movement. A policy stakeholder, who is a recovery treatment and recovery historian researcher, describes how we evolve beyond thinking solely about recovery management as an approach to addressing clinical services and broadening consideration of the larger community as a system of supports to support an individual's long-term recovery:

> *The clinical focus that we've had historically, primarily viewed recovery as an intrapersonal process… We began to start to talk about the ecology of recovery and that there's this whole larger community influence that's been ignored. That was really the beginning. Since then, I've really got into this broadening that even further to talk about the old concept of community recovery… that the community itself needs a formal recovery process… How do we expand the physical, psychological, and social space within communities within which recovery can flourish? – National Recovery Trainer and Researcher 1*

This shifting focus from individual to community context suggests a departure from the approach to addiction treatment that had been adopted since the 1970s. As discussed in Chapter 2, the history of addiction treatment and recovery in the United States is strongly influenced by an early community-oriented focus attributed to societal beliefs at the time that addiction was a social disorder impacted by broader ecological forces and, thus, addiction treatment should address these broader domains. Addiction treatment—aligned with shifts observed in other sectors of healthcare—moved towards a focus on professionally-delivered individual treatment. This national recovery trainer and researcher's observation of ROSCs community focus suggests a pendulum shift towards broader ecological consideration in addiction treatment.

A county behavioral health authority describes the evolution of the county's system of care and the shifts in policy priorities from deinstitutionalization and community-oriented care in the 1990s to recovery and ROSC. Part of the reason for the recovery orientation, the stakeholder explains, is the technical expertise sought by the SAMHSA-funded Addiction Technology Transfer Center's (ATTC) technical assistance:

In the '90s, our focus was really on building services to get people out of living in the state hospital and into the community… After that, the next big reform concept was… recovery… Then, in 2009, is when we first started to see some of the problems with the prescription drug abuse… I called the Addiction Technology Transfer Center and told them what was going on, and they said, "Well, I'll help you on one condition… Whatever you build, you build within the context of ROSC." I told him, I said, "Well, I don't have any idea what you're talking about, but if you will teach me I will be happy to learn." – County Behavioral Health Administrator 1

The ATTCs are a national network of technical assistance organizations funded by federal grants to provide training and technical assistance related to addiction treatment and recovery to states, tribes, and local communities across the United States. Some ATTCs hold expertise in certain areas, including work with special populations and in certain programs and interventions, including recovery-oriented policies and services. In this county's case, they sought technical assistance from an ATTC with staff expertise related to ROSC systems transformation.

Stakeholder conceptualization of ROSC

Stakeholders conceptualize ROSC in various ways. There are a few traits to a ROSC that were frequently repeated in conversations with policy stakeholders. In particular, ROSCs can be multisystemic and inclusive of multiple kinds of community stakeholders. A federal government administrator for addiction policy describes how many local systems work in collaboration in a ROSC:

I don't like using the term ROSC in a singular because it sounds as though you've come up with this encapsulated something that you've created when in fact, what you're doing is you're working with systems plural. You're working with family systems and

communities. You're working with a criminal justice system, the healthcare system, the specialty substance use disorder system, the child welfare system, etc. – Federal Agency Administrator 2

From the perspective of this federal government administrator, ROSC is multisystemic and its scope extends beyond the specialty addiction treatment system.

In considering the scope of services delivered within a ROSC, a behavioral health services researcher explains that ROSC should support a vast range of recovery supports and inclusive of all addiction service within the continuum of care, from prevention and treatment through long-term recovery:

We viewed a ROSC as having treatment as well as recovery supports. The more I do this work, the more I think recovery supports are most important part of that system. I don't know that treatment is very effective by itself… So, ROSC should start with prevention, and early intervention… through active treatment, then on to ongoing recovery. What we added in [the state] was the community angle, it should also look at the citizenship status and how people are engaged in their communities. – Behavioral Health Services Researcher 1

This stakeholder's perspective that a ROSC should include a continuum of care sheds light on some of the policy barriers that exist towards this conceptual approach. First, federal, state, and local funding for addiction services are frequently sept separate for addiction prevention, treatment, and recovery services—and this separation of funding sources is evident in administrative and service provider role delineation at government agency level and in the organization of service providers. Moreover, this behavioral health researcher's observation that an individual's citizenship participation and community engagement should be considered within

a ROSC sheds light on the limited attention and resources paid to these domains in the current scope of addiction treatment system.

In addition, ROSCs are dynamic and can evolve in the same way that individual needs and resources evolve. A community builds towards a ROSC by developing its resources and supports. A federal government administrator explains for addiction policy explains:

> *The other principle I have is that essential to this approach is that it evolves. These relationships evolve as they grow, as they change… Over time, you'll develop relationships with different sectors, you'll learn better how to respond to community needs, you'll hopefully be evaluating those needs and responding from that perspective. Ideally, it's the kind of approach where macro assistance level improvement as well as organization and coordination. – Federal Government Administrator 2*

The process of conceptualizing ROSC

The process for which ROSC is conceptualized varies depending on stakeholder perspective. States and local communities solicit training and technical assistance experts, often through SAMHSA-funded ATTCs, to come to their communities to do this work. In earlier years of the New Recovery Advocacy Movement, William White was brought to these communities while the group of current national recovery trainers have been deeply influenced by his work. The policy stakeholders in this study who serve as national recovery trainers stress that community members—particularly people in recovery—should be convened to develop these concepts for their own communities.

A federal government administrator describes the process used by SAMHSA's Center for Substance Abuse Treatment to develop its conceptualization of ROSC:

Remember that public funds are used for those with the most severe problems. The ROSC definition is influenced by the observations that are inherent in the [Addiction Severity Index]… So medical issues, employment issues, religious issues, veterans' issues, drug use, alcohol use, legal issues, family and psychiatric issues, they're all there. So, what does a person need in order to minimize the stress in their lives?... So, the definition of ROSC can depart from that. – Federal Government Administrator 1

SAMHSA's conceptualization of ROSC is framed around the addiction-related domains included in the Addiction Severity Index (ASI), a validated measure of addiction severity frequently used in addiction treatment assessment. Inherent in the use of the ASI as the starting point for conceptualizing ROSC is the centrality of addiction treatment.

Repeatedly in conversations with government administrators and national recovery trainers, we learned about the process used with states and local communities to transform their service delivery systems into a ROSC. For many of these communities, William White, or one of the several national trainers who had worked closely with and been influenced by his work, had offered these trainings:

We actually invited [a national trainer] in from the ATTC to put together a full day. We had an all-day on "What is ROSC?" We had it open to all our providers, general community members and so on to try and introduce the concept to the community. It is conceptually something that resonates very well with people that are in recovery, very well with people like family members that are supportive. – County Behavioral Health Administrator 1

Many stakeholders described the process of utilizing the work of William White and SAMHSA in their work and not identifying the conflicts in choosing one definition over another.

A state government administrator explains that the challenge is not in choosing a conceptualization of ROSC, but rather, the lack of funding that continues to exist in the system of care for the services and supports that enable individual and community recovery:

> *I don't see any conflict, and so we kind of talk both ways… We've kind of incorporated that into our grants from housing grants to the other things that we're putting out, including the current opiate grants. So, being a small state and having done some work, we don't necessarily provide a formal definition in those that we've done. I think that the state has done a good job of adapting the harm-reduction model. I think the difficulty has been probably in just the lack of funding to develop more of the capacity within community services that need to exist. – State Government Administrator 2*

Given these state and local trainings are typically financed by SAMHSA, it is not surprising that SAMHSA-developed definitions and training resources would be used. As mentioned in the previous chapter, however, these policies, principles, and other documents and resources are shaped by political decisions at federal level that determine by which stakeholders are invited to the policymaking table.

Several of the policy stakeholders participating in this study hold professional roles as training and technical assistance providers for states and local communities where they provide opportunities to stakeholders within these communities to conceptualize recovery and ROSC as relevant to the local context. The stakeholders who have conducted ROSC trainings described a similar approach to working with communities to develop their policies which entailed community participation and ownership over whatever conceptualizations they developed.

A national recovery trainer explains that in their work, community understanding of the most important elements of a ROSC is more important than which definitions for ROSC are chosen by communities:

> *I'm not as concerned about what definition they choose. I'm more concerned that they understand the concept… What I do is, often times I use these two [definitions for ROSC], definitely [William White's definition] all the time. I put it up there as kind of a training tool and sometimes systems will adopt this, sometimes they will figure out their own definition… A ROSC is like a framework for leading a recovery focused system change effort. – National Recovery Trainer 5*

This process of community conceptualization of ROSC and its elements is similar to the process described by national trainers in how states and communities define recovery.

At a national level, advocacy organizations for addiction treatment and recovery policy emphasized an intentional choice to not adopt a definition for their work. A national advocacy organization leader explains how definition choice is superseded over participation from the recovery community:

> *I think we've never said we choose one [ROSC definition] over the other, both are frameworks [we use]. I think the key is people in recovery as individuals should have meaningful roles in the network system that's developed… The services are developed and implemented in a way that's informed by the recovery community… They can say, "Well this is what worked for me, and this is what didn't work for me." – National Advocacy Organization Leader 1*

A recovery community organization (RCO) leader and national trainer described ROSC by specifying that the system of care has multiple contributors and that each community member contributes their respective piece:

> *ROSC is about everybody coming together, working to identify what the issue is, and just contributing your part. We taught them no one person or one group has to do everything. That's not what this is about. All you have to do is your part. – National Recovery Trainer 3*

This national recovery trainer stresses the importance of considering all voices in a ROSC, which illuminates the importance of the process-driven approach to recovery and ROSC conceptualization described above by several of the national recovery trainers.

In a ROSC, stakeholders from the addiction treatment system and members of the recovery community should equal voice and roles in a system of care. Another consideration given this perspective is that other healthcare, social service, and other community members contribute their respective parts, as well. Given the important role of healthcare administrators in the implementation of the Affordable Care Act (ACA) and transformations in addiction treatment system, this perspective also suggests that individuals in primary care and those representing healthcare financing, including Medicaid, also hold important roles which should be considered.

Systems Transformation

From policy stakeholders' perspectives, systems transformation towards ROSC take many shapes and requires several elements. Frequently, system transformation was described as requiring a use of shared recovery language and values, addiction service policy reforms that aligned with recovery-oriented values, and systems collaborations.

A behavioral health service provider describes the use of recovery-oriented language and concepts as the first step towards systems transformation:

> *I think the first thing that I was aware of is that people weren't using recovery language… especially for individuals who have maybe more serious diagnoses…When we begin to give the message, "Of course you can do that," rather than the message of—I've been doing this for 30 years, and 30 years ago if somebody came in and had a new diagnosis of schizophrenia, I think what we all said was, "Well, you don't have to stay in the hospital for the rest of your life, but probably you're going to end up on disability." We didn't really think about jobs for them. We didn't really think about what they might want to do... – Behavioral Health Services Administrator and Former SSA Director 1*

Language, as it suggested by this stakeholder, frames the possibilities of recovery for clients and within a ROSC, a sense of hopefulness offered is an important element.

A national recovery trainer and researcher further elaborates the importance of conceptual understanding and community education in the process of systems change. This process, the national recovery trainer explains, is particularly challenging when working with individuals who believe that recovery-oriented practice already takes place in addiction treatment:

> *When I give a brief definition of a recovery management or a recovery-oriented system of care, people are saying, "These are fancy words for things we've been doing forever." They don't want to get into the details. As soon as I get into the details… they go, "Oops." And particularly, I talk about locus of service. We haven't even got into what happens after treatment… When I start talking about those and sustaining them for a*

minimum of five years, people just gulp and their faces turn white… because they're not doing virtually any of that. – National Recovery Trainer and Researcher 1

Another national recovery trainer describes the first steps they take in training states and communities towards systems transformation. The starting point is shared language and vision among stakeholders, then progresses to policy prioritization of systems transformation:

We try and get as many… stakeholders in the room at various points in time, to do some education, but also to engage them in conversation about, "Where's the system now? What would they like to be different?" That is usually, for me, the starting place around conceptual clarity, shared vision. Then, related to that, maybe looking at their data, trying to get a sense of urgency, why change?... That's where I start, and then we move into the practice alignment, which is, "Hey, what does this look like on the ground?" – National Recovery Trainer 5

This national trainer describes the transition from focusing on recovery language and conceptualization to practice alignment through policy reforms towards recovery-oriented values. The same stakeholder continues to describe the efforts a state government agency used to align its policies and agency organization in order to better adopt recovery-oriented practices and principles:

To make a long story short, after about four or five years [ago] the state created a state-wide transformation steering committee. They created a structure so that the state could support this effort, and they re-wrote their administrative rules early on so that they could pay for peer recovery support services and then by legislation, they changed the name of their substance abuse state office to the Office of ROSC. – National Recovery Trainer 5

For a state government administrator, part of working towards a ROSC transformation is elaborating recovery principles and integrating these principles into state policy planning efforts:

> *What's happening is we're kind of in the middle of a five-year state plan, where it's year three, going into year three and we wrote our state plan in the context of a recovery-oriented system of care a couple of years ago when we submitted our last one... I really felt like it needed a boost and so we applied for the Policy Academy and I think that really helped us better define what it was that we were looking for, that we were looking to develop. – SSA Administrator 3*

As mentioned above, conceptual understanding of recovery-oriented principles and values is an important first step that subsequently leads to policy planning and implementation to better align the system of care with recovery values. These processes require the collaboration and buy-in from partners in other systems.

A stakeholder, who is leadership at a national recovery advocacy organization, explains that systems collaboration and engagement are particularly integral for achieving systems change. In particular, it is necessary to convince addiction treatment providers that systems transformation is about collaboration rather than resource competition:

> *Well I think in terms of ROSC, I think it's just really important to engage… recovery support organizations are not wanting to create new silos, and they're not wanting to cause any turf issues or to rob Peter to pay Paul… It's about being good partners in the community, and you know some treatment agencies might say, "Alright. Well, we already do that." And it's about coming to an understanding of really listening to all perspectives because you may think that you're doing that… but you may not be. – National Advocacy Organization Leader 1*

Perceived Facilitators and Barriers To ROSC

Policy stakeholders identified several perceived facilitators and barriers to transforming the addiction service delivery system towards a ROSC. Leadership, mobilized grassroots community, and having recovery as an addiction policy priority are noted as important facilitators to transformation as well as barriers when in deficit of these characteristics. Further barriers include a misunderstanding of recovery and its principles, conflicts with addiction treatment providers including the continued perception that the existing addiction treatment system is effective, and continued debates between abstinence versus harm reduction approaches to treatment and recovery.

Leadership

In the early years of recovery-oriented policy adoption, SAMHSA's innovations would not have been possible, according to some stakeholders, without the commitment from SAMHSA's Center for Substance Abuse Treatment Director, Westley Clark, to adopt so many policy changes and to allocate funding for recovery-oriented initiatives and services. A federal government administrator reflects on the importance of having a SAMHSA leadership embrace recovery-oriented policy changes:

> *Number one, Dr. Clark. Yeah, he was the one I think that when this program has aligned, it started in '98, as the Recovery Community Support Program, which was developing the kind of [recovery community organization] but it was focusing more on education and advocacy. – Federal Government Administrator 2*

From the perspective of this stakeholder and others, SAMHSA leadership was instrumental in convening the recovery advocacy community through the Recovery Community Support Program, which spurred momentum for the New Recovery Advocacy Movement.

Motivated leadership embracing recovery principles can also serve as innovators and early adopters of policy change. A national recovery trainer explains that leadership who adopt early innovations can influence others:

> *Usually, there's a group of people at the top of the system who, when I say the top of the system, they're in some kind of leadership role. It doesn't necessarily just mean internal department system lead, it could have been advocacy community. – National Recovery Trainer 5*

Early adopters and innovators can exist at many levels of the addiction system. A county behavioral health authority from a large Midwest state convinced other counties within their state to adopt ROSC transformation through conversations with leadership in their state's county behavioral health association:

> *All of the [county behavioral health authorities] are part of a trade association. When I started down the ROSC path I took it to our trade association and I begged the president of our trade association. I said, "You have to read this stuff" because essentially [we] are perfectly positioned to help communities transform into a ROSC. I said, "Okay, we've got science on our side, in terms of improved outcomes. We got studies from other states where we can show savings. This is just a no-brainer." The president of our trade association did indeed read everything and so on, and so actually our entire association… adopted movement towards ROSC. – County Behavioral Health Administrator 1*

A state government administrator describes the importance of leadership at local level for promoting policy change:

If you don't have the kind of director or manager who is willing to get out there and say that this is important, and go to meetings, and become involved, it doesn't happen… You just rely on, "Oh, let the staff go do this." They go so far, but the leadership of whatever organization, and even in the local community. You know, the most successful areas are where we have people like the hospital director and people from the local faith community, and everybody ... Legislators. You know, really saying this is so important for our community. – SSA Administrator 1

In this case, this stakeholder is highlighting the role of supportive and motivated leadership of various sorts, including within the addiction treatment community, but also in the healthcare, spiritual, and policymaking domains.

In talking about the recent work being done by SAMHSA to convene state stakeholders together in Policy Academies to initiative recovery-oriented policy change, a national trainer explains the importance of leadership buy-in in these efforts and an effort to develop teams where participants at all levels are fully embraced:

So, [there] has to really be leadership buy-in that transformation is important and that recovery, as a concept, is important to embrace. It is integration of and involvement of people with less experience at all levels. So that when you get together a state team you want to make sure that the clinicians and the Medicaid codes, and whoever it is, and the peer-run organizations, they're all there. So, having the commitment to that diverse change team is really important… – National Recovery Trainer 6

In all of these instances, whether they be leadership within government agencies, in addiction treatment programs, or in adjunct systems including healthcare, social services, the faith-based community, among others, the key ingredient highlighted by all of these stakeholders was having

a figurehead that championed recovery-oriented values and policies supported systems collaborations in order to promote ROSC transformation. These leaders served as early adopters of recovery-oriented innovations and practices who could influence others.

Grassroots mobilization

In addition to consistently listing strong leadership as a necessary ingredient for ROSC transformation, policy stakeholders also described having active participation from a mobilized grassroots community as a necessary component for policy change. In several conversations, the state of Connecticut and county of Philadelphia were repeatedly referenced as exemplary recovery-oriented service delivery systems. A behavioral health researcher differentiates Connecticut and Philadelphia from other systems and explains that both governmental leadership and grassroots advocacy are needed to mobilize systems transformation:

> *Leadership is certainly important… But it also has to do with the grassroots advocacy, the vitality or viability of the grassroots advocacy organizations and communities as well. So, [the SSA Director] could do some of what he did in Connecticut because if the legislature tried to cut his budget, 500 people would show up at the State Capitol and say, you can't take my services away… So, it's really a partnership between strong leadership inside the system, and strong advocacy outside the system. – Behavioral Health Services Researcher 1*

This stakeholder describes the role of the recovery advocacy community in advocating for service funding for the state government behavioral health agency, particularly when service funding was threatened. In this case, the mobilized advocacy community has an important role in collaborating with state government agency leadership to secure agency funding for necessary services and policy change.

Recovery as addiction policy priority

In some cases, the challenge faced is that recovery-oriented policies and services are not deemed to be a top policy priority for policymakers and, thus, government leadership is not driven to implement ROSC systems transformations successfully. Other behavioral health policy priorities might be valued over recovery-oriented transformations, particularly when resources such as funding and staffing are scarce.

At the federal level, the Office of National Drug Control Policy (ONDCP) is charged with setting the Executive Branch's policy priorities pertaining to addiction treatment. Although there had been previous emphasis on recovery initiatives in the early years under the Obama Administration, recovery-oriented policy prioritization waned over time, particularly as a result of a leadership change. A federal government administrator who has worked on several federal-level recovery-oriented initiatives describes this policy priority change:

> *I think that [the agency director] was not really crazy about [the] recovery-oriented system of care concept. I think [he] kind thought of it as possibly a passing fad, which I don't think it is. I'm not sure, but certainly I don't think it was something he wanted necessarily to place the focus on… – Federal Agency Administrator 2*

In a state heavily impacted by the national opioid epidemic, a state government agency administrator describes how greater the opioid crisis has resulted in greater political attention addiction issues. Although the state had not prioritized recovery-oriented policies and services in the past, the impact of the epidemic could serve as leverage to adopt ROSC transformations to the addiction treatment system:

> *Well, you know the big priority across the state is the opioid use disorder and the epidemic that's resulting from it. All of the state's resources, not all, much of the state's*

resources are going toward that. [The state's] Action Plan is focused in prevention, treatment, and recovery support and rescue, the issues around reviving overdose…I think it's almost like, I hate to say as a positive thing, but it does seem like the stars are aligning right now. It's the perfect storm, I guess you might say in terms of that. – SSA Administrator 3

In this case, this stakeholder is framing political prioritization of the addiction treatment system more broadly. Rather than considering opioid epidemic and addiction treatment prioritization as competing priorities, they believe that the opioid epidemic will draw attention to the entirety of the addiction service delivery system, which will allow for sweeping policy transformations, such as the inclusion of recovery-oriented policies and services.

Misunderstanding of recovery principles and ROSC

One barrier to ROSC systems transformation is the lack of clarity and consistency in how the addiction field defines and understands concepts pertaining to recovery and ROSC. In some cases, a multitude of approaches to conceptualizing recovery and ROSC leads to misunderstandings of how to best plan and implement recovery-oriented policy change. Oftentimes, this is realized as a misuse of the term ROSC and equating ROSC with networks of treatment providers.

In some ways, it is easier for policy stakeholders to describe the conceptual elements of a ROSC given the definitions developed recovery scholars such as William White and by stakeholder groups convened by SAMHSA. Policymakers, government administrators, researchers, and advocates have had time to consider these concepts and what they mean to their work. As a way to avoid receiving direct repetition of these concepts as they are developed by SAMHSA and other stakeholders, I prompted policy stakeholders to consider what ROSC *is not.*

These conversations revealed that some stakeholders in the addiction service delivery system, including states and communities that seek training and technical assistance from national recovery trainers, hold varied understandings of ROSC.

A stakeholder who is an expert in addiction treatment and recovery policy describes how the idea of a ROSC is sometimes misunderstood, with some believing that the implementation of peer-delivered services equates to systems transformation:

> *I think a misconception with ROSC is a treatment organization will hire a couple of peers and they think they're doing ROSC… But the transformation is where you really want to go, right? And so just to do a little bit of tinkering and saying, "Well, we have recovery coaches on our treatment staff" It's sort of business as usual. The recovery coaches become treatment helpers instead of the treatment agency starting to respond to the recovery needs of their clients during treatment and then after treatment. – National Advocacy Organization Leader 2*

From this policy expert's observation, we understand that ROSC is more than just the inclusion of recovery support services in a system of care or the integration of peers into an addiction treatment staff as this approach to integration leads to recovery coaches serving as "treatment helpers."

A national treatment policy expert explains that states are moving forward in the implementation of recovery support services but there is a continued lack of conceptual understanding of a ROSC, which they believe to be perpetuated by the lack of empirical evidence of its effectiveness:

> *I think lack of a clear model of what a ROSC system is holds it back. The SAMHSA document doesn't really lay that out very well, and moreover, I hate to keep coming back*

to this, but lack of evidence, lack of data about what results are gotten from components, elements of ROSC. Like the full system, it's hobbling the effort. That said, all of the states are pushing forward to do more and more recovery services… There's no real cookbook for it, no clear one. Apart from the motivation to help patients to get the whole realm of services, the broad range of services that they can get benefit from. – National Addiction Policy Expert 1

A policy stakeholder who is a national recovery trainer and researcher describes how they have observed addiction treatment organizations often equating their work focused on the formal treatment system with ROSC without placing greater emphasis on the necessity of indigenous informal supports in a system:

There's been a lot of synergy back and forth between myself and those organizations. I think if there's any difference it would probably be that given their primary responsibility in terms of funding community-based treatment services, their focus on ROSC is going to be much more focused on the role of the treatment organization. I get lots of treatment organizations saying we are now a ROSC… It's impossible for a treatment agency to be a ROSC on their own. – National Recovery Trainer and Researcher 1

Addiction treatment programs making claim that their organizations are ROSCs highlight a misunderstanding of recovery values and principles. Unlike in the traditional addiction treatment system where treatment programs are the central locus of care, a ROSC emphasizes the role of the broader community, including formal and informal spaces where one might receive services and supports, regardless of whether they be professionally or volunteer-delivered. This claim that addiction treatment programs can be ROSCs also centralizes the role of clinical treatment professionals rather than valuing the importance of all kinds of individuals, including peers,

family members, and other community allies; this focus on treatment professionals does not align with recovery-oriented values of embracing a wide range of community members and their ability to facilitate an individual's recovery.

A ROSC is not a network of addiction treatment providers for similar reasons. A national recovery policy trainer describes a common misconception among states and communities that equate ROSC with networks of addiction treatment providers. The stakeholder explains:

> *I have a system that said… they "had"—they didn't even use the word "developing"—they had 20 plus ROSCs. I'm like, what in God's name is that? Still, years later trying to get them to understand that I don't think that's conceptually grounded, they're still struggling with that, to this day. – National Recovery Policy Trainer 5*

Some systems and communities have extended their misunderstanding of recovery-oriented values and principles even further. The same national recovery trainer describes a community that formalized what it believed to be a ROSC as government-recognized non-profit organization:

> *In one community, people started developing a 501(c)(3), like we're going to create a network and we're going to make it its own organizational entity and that's our ROSC. We're not going to let you play, because we don't like you… A ROSC is not something that you necessarily go and see. It's like, "Oh, I'm going to go and see the [city's] ROSC and it's going to be these six buildings and I'll be able to see the ROSC…" It's an approach, it's a framework. It's a value-driven framework for how a system structures and coordinates their system of care around recovery-based principles, philosophies. – National Recovery Trainer 5*

In the examples above highlighting misconceptions that an addiction treatment provider, a network of addiction treatment providers, and a government-recognized non-profit organization are believed by some to be ROSCs, we highlight a few points. From the perspective of the national recovery trainers and technical assistance providers working with these organizations and communities, we understand that there is a misunderstanding of the recovery-oriented values and principles that can and should be embraced in order for a system of care to be recovery-oriented, including the broader inclusion of stakeholders within a system of care, extending beyond the addiction treatment professionals. In addition, we observe the desire to move towards formalization within these systems. An addiction treatment provider wants to be formally recognized as a ROSC; a network of treatment providers wants to be formally recognized as a ROSC; and a community network formal government non-profit organization recognition as a ROSC. As one stakeholder pointed out, this formalization serves to exclude other community partners and suggests their desire to acquire legitimacy which facilitates the ability to garner additional resources. However, from the perspective of these national trainers, these approaches to formalization also miss the point systems transformation towards ROSC and the adoption of recovery-oriented principles and policies.

Opposition from addiction treatment community

Another barrier to ROSC transformation is the skepticism and opposition that recovery stakeholders perceive comes from some stakeholders in the addiction treatment field. A national trainer describes the resistance to ROSC transformation in a community where addiction treatment providers perceive recovery as added work beyond their scope of responsibility:

There was one system we were going into. They were basically saying, "Recovery? Well, we support recovery. Of course, we want people to get better. I am a case manager and I

work and do a lot of outreach and help people to get the resources they need and to see who they need to see, but now I also have to do recovery? Now, I also have to—what else do I have to put on my plate?...” So, people would feel that all of a sudden, “Okay, now I'm responsible for a whole person's life? What else can I put on my plate? I can't do this. It's too much.” – National Trainer 6

This stakeholder describes an addiction treatment case manager who expresses support for recovery-oriented values but also feelings of being overworked and overburdened by having to “be responsible for a whole person’s life” rather than solely their SUD. This case manager’s sentiment is indicative of the sentiment felt by addiction treatment providers in the publicly-funded addiction treatment system who frequently often have large caseloads and are asked to adopt new approaches to treatment as their addiction treatment programs acquire funding, often through short-term grants and contracts.

A second national trainer describes the opposition faced from an addiction treatment provider in adopting ROSC initiatives, including the delivery of recovery support services:

This executive director said, “I don't really care.” She said this to the state [government agency] and to my staff person in the room. She said, “I don't really care about the recovery support services project. We're funded to do treatment and that's what we're paid to do, that's where my focus is. The recovery support services [are] a much smaller part of our budget and I'm not going to realign our whole approach just for that project.” – National Recovery Trainer 5

The addiction treatment provider describe above by this national trainer expresses opposition to changing their approach to service delivery just to initiative a recovery support service project that the provider believes to be a small proportion of their budget. The notion that “we’re funded

to do treatment" connotes a perception that recovery support services are not part of the larger package of services that are considered to be part of addiction treatment to address individual's SUD. Moreover, this provider's comment emphasizes the point that funding received by service providers drives how they approach doing their work and what services they choose to deliver.

The New Recovery Advocacy Movement and current efforts to promote ROSC systems transformation are largely driven by recovery stakeholder perception of the ineffectiveness of the addiction treatment system. This viewpoint contrasts with the strong perception among some in the addiction treatment field that addiction treatment is effective and that the system does not necessarily require transformative reforms. An RCO leader describes their interactions with members of the addiction treatment community:

> *Sometimes, I think people get in those positions and get a little complacent and say, "We've been doing it this way and it works." Just because you've been doing it in this way don't mean it works, doesn't mean it's okay, and it doesn't mean you can't be open-minded to change. – RCO Leader 3*

This RCO leader's comment highlights the tension between those in the addiction treatment and recovery advocacy communities and the perception that addiction treatment providers can be complacent and resistant to change.

Abstinence versus harm reduction

The continued philosophical debate between an abstinence versus harm reduction approach to treatment and long-term recovery also serves as a barrier to ROSC systems transformation. A state government administrator describes the tension between abstinence-based advocates and those wanting to promote the use of medication-assisted treatment (MAT):

> *So, we're having some of those challenges, as well as dealing with, of course, existing schisms in the recovery community that are not unique to [our state], such as, "Do you believe in medically-assisted therapy?" Or, "Is it harm reduction or total sobriety?" Those are arguments within the recovery community, and I'm not a person in long-term recovery, but it slows the state's ability to build that system, which is unfortunate. – State Government Policy Administrator 1*

A county behavioral health authority in a large Midwest state describes this ideological tension in their local community:

> *When you have [an] old time [Alcoholics Anonymous] community, I have a lot of them in here, when we started talking about medication-assisted treatment, well they didn't view that as recovery. "No, that's substituting one thing for another…" Our biggest points of discussion were trying to get past that hard line of abstinence and getting to a point where we're like, "There's many different paths and you can be a person that's in recovery and be on MAT." – County Behavioral Health Administrator 1*

These ideological discussions in the recovery advocacy community continue to take place and serve as points of conflict among treatment and recovery service providers as well as within the recovery advocacy community. Although the contemporary recovery advocacy movement attributes a great deal of its origins to the abstinence-based mutual aid movement, many in the contemporary recovery advocacy movement express the need to value the effectiveness of many pathways to recovery, including harm reduction approaches such as MAT.

Discussion

The transformation of the addiction service delivery system towards ROSC is a complex and ongoing process. Policy stakeholders in the addiction recovery and treatment systems have

adopted many approaches to conceptualizing ROSC and its policies and principles but generally they have adopted a process-driven approach that takes into account the perspectives of several types of community members in the addiction field including, but not limited to, people in long-term recovery, addiction treatment providers, health and social service providers, and other community allies including those in the faith community and criminal justice system, among others. As with the process used to define recovery, states and communities frequently adopt pre-existing definitions and descriptions for ROSC that have been developed by SAMHSA and addiction recovery thought leaders such as William White. These pre-existing definitions are then tailored to meet the needs of the community. In discussing the pre-existing conceptualizations of ROSC, stakeholders pointed out the nuanced differences among these constructs, but they also pointed out that they generally appreciated certain elements from each conceptualization including the move towards multisystemic collaboration where all stakeholders had a role in supporting recovery management through the delivery of a range of services, including, but not limited to professionally-delivered addiction treatment.

Policy stakeholders have identified several key ingredients they believe to be necessary in order to attempt ROSC transformation including policy prioritization of the adoption of recovery-oriented policies and language, having supportive and dynamic leadership, and having a mobilized grassroots community. Including a lack of these key ingredients, stakeholders also identified several factors that serve as barriers to systems transformation, including a perceived ineffectiveness of and resistance to change by the addiction treatment stakeholders, the misunderstanding of recovery-oriented principles due to a lack of clear conceptualization, and pre-existing ideological tension between the harm reduction and abstinence approaches to recovery.

In reflecting upon the facilitators and barriers to ROSC transformation that have been identified by experts in the addiction service delivery system, it is worth considering how, from a policy perspective, the system can overcome these barriers and improve the and expand the adoption of these policy transformations. If insufficient leadership buy-in of recovery-oriented values is a big issue, then whose responsibility is it to adjust approaches and mindsets? Should SAMHSA provide trainings and technical assistance that moves beyond incentivization of incremental change towards transformational reforms? At state and county governmental level, should state and county membership associations train the government leadership they represent to better adopt these approaches to change?

In conversations about federal funding for recovery-oriented initiatives and services, many states and local communities are utilizing technical assistance and training from SAMHSA to improve access to recovery support services and develop infrastructure for peers in the behavioral health service delivery system. Fewer states and communities are doing the work of greater policy transformation. One could look at this comparison as a system having greater attention on smaller incremental policy changes rather than broader reforms. That lends itself to the question of whether ROSC transformation is obtainable through incremental improvements. Much more needs to be done to understand this process.

At this point, contemporary definitions and constructs for ROSC have existed for nearly two decades. While some states and local addiction service delivery systems have embraced this organizing framework for their addiction treatment system, there appear to be several barriers towards its broader adoption in the field. The current addiction treatment system values medicalization and professionalization processes and structures which is incongruent with the values of ROSC which values multisystemic collaboration and embraces the role of indigenous

supports and informal service providers. Some policy stakeholders remain optimistic about the direction of addiction services—particularly given the greater advocacy voice of people in long-term recovery now than even a decade or two ago. Other stakeholders, however, are concerned that the momentum of the New Recovery Advocacy Movement has flagged and that the opportunities afforded by the amplified advocacy voice and the health policy changes related to the ACA may be lost.

Conclusion

The process of policy transformation towards the idealized ROSC requires policy prioritization of the adoption of recovery policies and language, dynamic government and community leadership, a mobilized grassroots community, and multisystemic collaboration. This process of systems transformation still faces several ideological barriers related to the organization funding, organization, and delivery of the current addiction treatment system and the limited resources that exist to support the addiction service system.

In the next chapter, we explore the scope of recovery supports and services that policy stakeholders believe should be provided in a ROSC. Moreover, we explore the role of peers as service providers within the system of care.

And in following empirical chapter, we discuss how ROSC is operationalized within the context of the current behavioral health and healthcare environment. Stakeholders explore the relationship between recovery-oriented policy and service delivery reforms and policy changes pertaining to the Affordable Care Act and other federal and state level policy change.

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Chapter 6. Recovery Support Services and the Role of Peers

"Every person deserves to have someone in their life that's not paid to be there." – County Behavioral Health Administrator 1

Introduction

Policy actors representing state and local communities have undertaken efforts to define addiction recovery and its principles in order to develop policies that shape a recovery-oriented system of care (ROSC). As described in the preceding chapter, many stakeholders equated a ROSC with a service delivery system that offered a full range of services. In this chapter addiction service delivery system policy stakeholders describe the scope of services they believe should be administered within a ROSC, including which recovery support services should be delivered, who should administer these services, and in which service settings.

Policy stakeholders generally agree that recovery support services are the services and supports individuals need in order to engage in recovery management. Recover support services are described as the non-clinical services and supports individuals receive in addition to—or in lieu of—professionally-delivered addiction treatment. Stakeholders hold varying opinions on who should provide recovery support services, with most believing that peers with lived experience should administer these supports. However, some stakeholders noted that empathy and compassion are more important than lived experience and describe using a broader volunteer and professional workforce to deliver services. Policy stakeholders generally believe that peers can be volunteers or paid paraprofessionals, but they also stressed that peer professionalization requires the development of workforce regulations and payment policies. And while recovery support services can be delivered in addiction treatment and healthcare settings, ideally, addiction recovery advocates emphasize the importance of providing supports and services in the community-based settings. Stakeholders identified several barriers to successful implementation

of peer-delivered recovery supports services, including addiction treatment professionals' resistance to peer workforce inclusion, financing considerations including Medicaid clinical supervision requirements for peers, and challenges with service measurement and evaluation.

Recovery support services may include a range of services and supports that depend on one's definition of the scope these services. As a starting point for policy stakeholder discussion of this scope, the Substance Abuse and Mental Health Services Administration (SAMHSA) has offered examples of the various services that exist and the type of support they provide to individuals with alcohol or drug problems (Table 6).

Table 6. Types of Support and Associated Peer Recovery Support Services*

Type of Support	**Description**	**Recovery Support Service Examples**
Emotional	Demonstrate empathy, caring, or concern to bolster person's self-esteem and confidence	Peer mentoring, peer-led support groups
Informational	Share knowledge and information and/or provide life or vocational skills training	Parenting class, job readiness training, wellness seminar
Instrumental	Provide concrete assistance to help others accomplish tasks	Child care, transportation, help assessing community health and social services
Affiliational	Facilitate contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging	Recovery centers, sports league participation, alcohol- and drug-free socialization opportunities

*From Center for Substance Abuse Treatment, 2009

For example, peer mentoring and support groups provide emotional support to individuals as peers demonstrate feelings of empathy and concern and facilitate the development of feelings of self-esteem and confidence; parenting and employment trainings provide informational support as individuals acquire life skills and vocational knowledge; child care, transportation and health and social services provide instrumental support that facilitate individuals' abilities to participate in addiction treatment, attend school, or work; and recovery

community centers, recovery-oriented sports leagues, and alcohol and drug-free social events provide affiliational supports and offer individuals opportunities to build community relationships with others who are in recovery (Center for Substance Abuse Treatment, 2009).

The descriptions of recovery support services above are provided to serve as entry points for understanding policy stakeholder perspectives on recovery-oriented services and supports including their perceived scope of services in a ROSC, who should deliver them, in which settings, and the policy considerations that facilitate or challenge implementation and service delivery.

Methods

Chapter 3 offers a comprehensive description of the methodological approach to sampling selection, interview guide development, data collection, and coding and analysis. Data presented in this chapter comes from interviews from both the Addiction Recovery Stakeholders Project and the NDATSS State Case Studies.

NDATSS State Case Studies stakeholders were asked how addiction recovery concepts, policies, and services connected with their work in the addiction treatment field. Depending upon the extent that a stakeholder specified their work focused on recovery policies and services, follow-up questions related to recovery-oriented policies, systems, and services were posed. Findings presented in this chapter derive from transcript data coded as "recovery" that related to recovery support services and peers.

Addiction Recovery Stakeholder Project interview participants were prompted to discuss the scope of recovery support services they believed were and should be delivered within a recovery-oriented service delivery system. Conversations explored recovery support service, provider, and service types, policy considerations for effective service delivery. Findings

presented in this chapter derive primarily from transcript data coded as “recovery support services” and “peer.”

Results

Stakeholders describe recovery support services in a variety of ways. While some policy actors select to solidly frame recovery support services as “non-clinical” services that exclude professionally-delivered addiction treatment, others took a more inclusive approach, including all services and supports that contribute to an individual’s long-term recovery.

ROSC and its Scope of Services

In considering the scope of recovery support services that should be delivered in a ROSC, stakeholders commonly described the delivery of recovery support services with respect to the life functions they addressed. A recovery community organization (RCO) leader describes unhealthy lifestyle behaviors to frame the delivery of recovery support services:

> *Hepatitis, HIV, STD, certain drug usage, long term drug usage, often puts people in compromising violence, and more importantly it's a lifestyle. Those lifestyles are not healthy. So, when we talk about helping people understand recovery [oriented] care, we gotta focus more on lifestyle. You also have to focus more on living environment and making sure that we bring new coping skills to people. – RCO Leader 3*

This stakeholder’s description of essential recovery support services connects to the life functions that each of these services restores. From this perspective, the scope of recovery support services delivered in a ROSC should be diverse and be able to directly address the life domains impacted by substance use disorder (SUD).

Given the chronic nature of addiction and evolving process of recovery management, the service delivery system should be able accommodate the changing support and service needs of

individuals over time. A stakeholder, who is a national trainer and researcher, describes recovery support services in terms of the life functions they restore and within the framework one's long-term recovery management process:

> *If you look at a recovery management, assessment is going to be global rather than focused, it's going to be done repeatedly because the assumption is that people's needs are going to dramatically change... – National Recovery Trainer and Researcher 1*

These two comments above suggest that the scope of recovery support services in a ROSC should be tailored to the individual's need to restore various life functions impacted by SUD and accommodate the evolving needs of individuals.

For the purposes of this project, the phrase "recovery support services" is used to describe the range of supports and services provided to individuals in a ROSC. One stakeholder differentiated between recovery-oriented "services" and "supports." This behavioral health services researcher explains that "services" relate to deficits and impairments addressed by professionally-delivered addiction treatment while "supports" relate more so to the restoration of positive life functions. This stakeholder says:

> *We've distinguished between supports and services. Supports are more like tools people use to pursue their hopes, dreams, and aspirations. Whereas services are traditionally focused more on deficits and impairments, problems, symptoms, stuff like that. We viewed a ROSC as having treatment as well as recovery supports. The more I do this work, the more I think recovery supports are most important part of that system. – Behavioral Health Services Researcher 1*

Although selects to differentiate between addiction treatment "services" and the recovery-oriented "supports," this distinction was not described by others. Rather, most policy

stakeholders distinguished recovery support services from professionally-delivered addiction treatment.

Situating recovery support services within, or separate from, addiction treatment

Policy actors generally viewed recovery support services as distinct from professionally-delivered addiction treatment. In this case, addiction treatment services are "clinical" in nature and are administered by a professional workforce with licensure or certification to deliver these services, such as counselors, psychiatrists, psychologists, social workers, and other clinicians. In contrast, "non-clinical" services and supports can be administered by either trained clinical professionals or non-clinical paraprofessionals or volunteers, including peers, family members, and other community allies.

In describing the relationship between addiction treatment services and recovery support services, the common perspective was that an individual could achieve long-term recovery by receiving recovery support services as services adjunct to professionally-delivered addiction treatment or, in some instances, as an alternative to addiction treatment. In a conversation where this national recovery trainer and researcher was prompted to describe the relationship between addiction treatment and recovery support services, the stakeholder explains:

> *I see them as both [addiction treatment and recovery support services]. For individuals with low to moderate problem severity and moderate to high recovery capital, they may well be an alternative to clinically-oriented treatment. Here's what would be the advantage to that. For one, it's because the way the systems were set up and the social stigma attached to treatment—when treatment began systemically in the seventies is that almost everything about this system has been based on people in the latest stages of addiction. – National Recovery Trainer and Researcher 1*

This policy actor is describing how addiction treatment, as it is contemporarily framed, focuses on the later stages and more severe cases of SUD. For this reason, rather than considering the entirety of the continuum of care as a unified service delivery system—from prevention and early intervention, treatment, and long-term recovery support—the current service delivery system developed the stages of addiction that we call addiction treatment. And as the addiction treatment system developed around a particular set of acute interventions and approaches, the interventions, services, and supports that facilitate SUD prevention and long-term recovery developed into separate systems and structures, as well.

As this delineation was perpetuated over time, common terminology to describe recovery support services, particularly within the orientation of the addiction treatment system is as "ancillary" services. Most stakeholders did offer comments about their perspective on describing recovery support services as "ancillary" services. One stakeholder, who is a federal government administrator who works predominantly on recovery-oriented policy initiatives, describes how framing recovery supports as ancillary is problematic given its conceptual centralization of addiction treatment:

> *They're not ancillary services… because an ancillary service is ancillary to a clinical process. They may be viewed by certain clinicians as ancillary, but for that matter, somebody from peer recovery support services could equally view the clinical services as ancillary to what they do… It's really important when you're talking about recovery support services to make sure that they're not perceived as "treatment light," they're something different in nature... They're based on shared experience primarily and secondarily on training. – Federal Government Administrator 2*

Rather than describe the observed delineation between addiction treatment and recovery support, many stakeholders discussed the need to consider, from a clinical perspective, the entire continuum of care. Using the American Society for Addiction Medicine (ASAMs) framework for Patient Placement Criteria. Several stakeholders whose work was centralized in addiction treatment service delivery and policy referenced the ASAM in describing ROSC. A second national recovery trainer emphasizes the delivery of a full continuum of care in a community:

> *We try to put the ASAM continuum together so that medically a person can be matched at the proper level of care and then immediately we turn right over to what are the recovery support services absent in the community… We do recovery homes and we usually start those or get people involved in something like it but we start looking for where the gaps are in the population of the community itself… If you come into the community or you're a large vendor and you want to open up a mega rehab, you're going to have to agree to those principles of care. – National Recovery Trainer 2*

Types of recovery support services

Stakeholders in the Addiction Recovery Project were provided the opportunity to discuss the kinds of recovery support services they believed should be delivered within a ROSC. Much of this discourse revolved around ensuring access to the full continuum of care ranging from prevention to long-term recovery support services. Additionally, some policy actors described the recovery support services they believed to be the most essential in a ROSC, including post-treatment services and supports such as housing; peer-delivered recovery support services; and recovery support services that address a range of life domains including spirituality and religion, race/ethnicity and culture, and gender and sexuality.

Within the context of clients who have engaged in the formal addiction treatment system, a stakeholder, who is a national recovery trainer and researcher, stresses the importance of providing supports to individuals in order to ensure that they might be able to reengage in treatment in the case of potential relapse:

> *There's no question about that. Post-treatment recovery checkups and early re-intervention will do more to free up financial resources to then reallocate to enriching and building these larger recovery support systems than any single intervention you could do. Right now, over 60% of people entering addiction treatment have already had prior addiction treatment. – National Recovery Trainer and Researcher 1*

This stakeholder is describing the chronic nature of SUD and the necessity to engage clients in their own recovery management through recovery checkups that can, when necessary, lead to treatment re-intervention. Moreover, they highlight the cost effectiveness of this approach to continued long-term client engagement.

A variety of recovery support services were discussed during these interviews, but the most common type highlighted by several stakeholders related to housing. Stakeholders described the importance of providing recovery-oriented housing and the challenges of the addiction treatment system in being able to coordinate and finance these services. An SSA administrator describes the housing initiatives in their state:

> *We do have recovery housing in [the state] and we've been working to expand it, and also to think about other types of sober living environments and really just learning more about what it is that's out there, for the housing continuum… I think traditionally a lot of the challenge has been housing and I think it still is housing, but when you talk about*

somebody getting out of residential treatment and stepping down… a big part of that is housing. – SSA Administrator 3

This stakeholder highlights a few points in this comment, including the necessity of housing supports for individuals as they transition from residential treatment to lower levels of care that are outpatient and community-based. They also describe how housing-oriented services have been and continues to be a policy challenge to the addiction service delivery system. Although not mentioned explicitly, this points to the policy and funding barriers of the addiction treatment service delivery system, as it has and currently exists. Historically, the addiction treatment system has relied on federal funding most closely aligned with the Department of Health and Human Services, including from SAMHSA and increasingly from the Centers for Medicaid and Medicare Services (CMS). Federal funding for housing supports typically originates from the Department of Housing and Urban Development, which is a separate agency with its own financing and reporting requirements that serve as an administrative for service providers and clients.

Recovery support services for specific populations

Interview participants noted the need for services and supports in a ROSC that are individually tailored to the needs of individuals and communities, including those that are tailored towards gender, religious, and culturally specific needs.

The leader of an RCO primarily serving indigenous communities describes their organization's training and utilization of "wellbriety" coaches, which are similar to recovery coaches but with culturally specific attitudes towards spirituality:

We have "wellbriety" coaches… They're a little bit different twist to it because in the normal culture, you cannot bring your spirituality into the work... We don't separate

spirituality stuff… We work on two planes. One of them is the training institute, recovery coaches, and all those good things. What we're doing now is we're doing things to raise consciousness. It's like [lifting] the fog in the forest… We want them to see and hear what's going on. – RCO Leader 2

The stakeholder describes the how spirituality in the Native American tradition is not commonly embraced recovery coach work and, thus, "wellbriety" coaches were developed to provide tailored, culturally specific approach for Native American populations. This RCO leader further explains that these coaches serve the role of consciousness raising, which does not necessarily fall within the four categories of support provided by recovery support services described by SAMHSA (Table 6).

Other national trainers working with African American populations, in international settings, and with women also emphasized the importance of delivering services and supports that are culturally specific and tailor to the needs of specific populations. This approach to care, as one stakeholder pointed out, aligns with ROSC principles to promote "the pathways that seem to be successful and work for different people."

Peers and the value of lived experience

Participants were given the opportunity to discuss who should administer recovery support services. These conversations revolved around the role of lived experience and frequently included discussion about the tensions that exist between peers and addiction treatment professionals. In conversations where peers were the preferred provider of recovery support services, stakeholders discussed the traditionally voluntary nature of the peer support role, its workforce professionalization in some states, and the policy considerations of workforce professionalization.

During these conversations, policy stakeholders typically considered a broad range of services and supports that facilitated long-term recovery regardless of who was the service provider. A stakeholder who is a national recovery trainer and researcher describes this broad conceptual inclusion, which is common among participants:

> *I talk about recovery support services and I talk about peer-based recovery support services. You could have a broader category of recovery support services. I just refer to those, some people would include treatment in that, but I tend to think categorically of recovery support services as non-clinical services. That initiation and maintenance and enhancement of quality of life and recovery. When I talk about peer-based services, that's a subset of those. – National Recovery Trainer and Researcher 1*

In considering who should administer recovery support services, many of the stakeholders who participated in interviews emphasized the importance of engaging the recovery community and described the added value of lived experience in the provision of recovery support services. A national recovery advocacy organization leader explains how lived experience is an essential element for helping others to achieve and maintain their own recovery:

> *Our perspective is the services that we talk about should be provided by peers. There's something very different about a person that has had a lived experience who can meet people where they're at, and have those conversations and say, here's what I did when I had that happen, or when I tried to access treatment services, or when I was looking for a job, this is how I approached it. You know, you can't... somebody who doesn't have that history of alcohol and drug problems might not have be able to speak from their perspective. – National Advocacy Organization Leader 1*

In this passage, this stakeholder emphasizes the relevance of personal experience with the addiction recovery process in one's ability to support others' recovery management. This statement suggests that peers are better suited to provide recovery support services than other kinds of providers.

The same stakeholder further explains how the current emphasis on peers administering recovery support services connects back with the legacy of peer involvement in the New Recovery Advocacy Movement and ensuring that policies, systems change, and service delivery are driven by the recovery community:

> *I think that the work that has been done over the past… the foundation that was built there is what has informed the recovery community organization movement, and recovery support services from a peer perspective, and there's very strong reasons and evidence that peers should be people with lived experience. – National Advocacy Organization Leader 1*

This national recovery advocacy organization leader's comments suggest that people in recovery from alcohol and drug problems should have multiple roles in a ROSC. Peers can provide recovery support services that facilitate the recovery management of others. In addition, peers serve the community through advocacy for improved policy and service delivery.

Furthermore, some policy stakeholders stressed that the recovery management process should be community-based and not claimed as a process that takes places within formal addiction treatment settings:

> *What does recovery management look like? And who owns that? I think you still have treatment people who want to own that recovery management piece when I don't think it's appropriate… – National Advocacy Organization Leader 2*

This stakeholder, who has longstanding experience in recovery advocacy and addiction treatment policy, describes this claimsmaking of recovery management by some in the addiction treatment field, which centralizes the recovery management process around clinical professionals and central to formal addiction treatment settings rather than around peers and in the community. Rather than the treatment community having ownership over administering these services, this same stakeholder believes that recovery management processes should take place in the community and be the primary responsibility of peers:

> *In the community. By the organized community. First of all, it's not cost effective for clinicians to be doing recovery management. Except for in small doses, right? It's also less effective. So, if you have peers and community folks involved in that ongoing management and engagement, it just makes sense. – National Advocacy Organization Leader 2*

The two perspectives described above are from individuals who have been directly involved in the New Recovery Advocacy Movement and who identify as individuals in long-term recovery. In comparison, one should consider the perspective of government administrators, service providers, and other policy actors who might not identify as individuals in recovery and who have greater roles in the administration of policies and funding related to addiction services.

SAMHSA is responsible for providing a large proportion of the funding devoted to recovery support service-oriented policy implementation and direct service administration, including through service delivery grants and training and technical assistance initiatives. A national recovery trainer whose work is directly financed and overseen by SAMHSA describes the relevance of having peers administer recovery support services and explains that people in recovery have a certain "legitimacy" that they bring to the work:

It's somebody who has experienced recovery from a behavior health condition… somebody who has lived experience… it's the defining characteristic of that relationship, which, when you explain that to providers who may not have lived experience, saying, "Look, part of the secret sauce is that you are going to have a workforce who's been where the people are at that you're serving at the program, and that secret sauce, that additional dynamic, can allow that work force to inspire, motivate, walk with, in a whole different way than typical clinicians can do…" They don't have the same legitimacy as others sometimes. – National Recovery Trainer 6

Interestingly, this discourse of the legitimacy of peers is comparable to how professionals in the addiction treatment describe their training and accreditation as addiction counselors and as other clinical professionals. These descriptions can be understood as a professional claims-making of a particular skillset, training, or experience that deems these individuals most qualified to provide a particular service or support.

Should peers be volunteers or paraprofessionals?

Most policy stakeholders agree on the value of lived experience in the delivery of recovery support services. Stakeholders also explained that peer-delivered services can be administered in various ways that have organizational and funding implications. When peers provide recovery support services in a non-voluntary capacity and they, or the organization that they represent, get paid for service delivery, there are policy and practice tradeoffs to consider. A stakeholder who is a national recovery trainer and researcher explains that the peer workforce structure looks different across states and communities:

What you need is… the infrastructure to support those peers [who are] funded. If there's no infrastructure, there's some serious problems with peer services around continuity and

turnover and you're not screening out people that should have no business doing peer recovery support services. You get issues of financial and sexual exploitation. There's a nightmare of potential possibilities in potential harm – National Recovery Trainer and Researcher 1

This stakeholder's comment spotlights the need to develop policies and regulations around a peer workforce in order to ensure that particular standards around service continuity and worker protections are put in place. The movement towards workforce professionalization, from this stakeholder's perspective, also ensure particular continuities in the system of care.

One some communities, peer-delivered recovery support services are utilized in voluntary and paraprofessional forms. In describing the roles of peer recovery support service providers, a county behavioral health authority who has made several ROSC transformations in their community describes the dual use of peers as unpaid volunteers in some situations and paid staff in others:

We have a very distinct line in the sand on all that. We have paid peer support within our treatment agencies and we view the primary role of the paid person in our treatment agency as helping people stay engaged in the treatment process. Then we have, at our recovery support center, we have peer guides that are like hospice volunteers. They're not sponsors but they're peer guides. We view their primary role as helping people work their recovery plan. We use paid people to help people stay in treatment and we use volunteers to help people stay in recovery. – County Behavioral Health Administrator 1

This county behavioral health authority's description of their ROSC's use of peers clarifies that within a system of care, peers can provide various kinds of services and supports in a range of

settings. These roles and responsibilities should be clearly delineated and the appropriate policies and regulations put in place that are service and setting-specific.

Part of this county's approach to providing both volunteer and paraprofessionally-delivered recovery support services is to ensure that tailored services and supports are provided to the individuals who need them. However, the other reason for this dual function and role relates to the resource and financing constraints creating a two-tiered professional workforce. The same policy actor describes the career ladder that has been established in their system:

> *The way we look at it is like a career ladder. We can tell people, "If you're not sure if this is anything you're interested in in terms of making a career [out of it], you can be a peer guide and maybe be matched with one person or you can be a peer guide and lead a group." We've had examples where we've had peer guides who were like, "Man, I really like this. I think I'd like this as a paid job that I do." – County Behavioral Health Administrator 1*

This stakeholder describes the process taking place in this community to develop a stepped professional career ladder for peer-delivered services that serves several functions. First, providing peers with paid employment opportunities provides them opportunities to sustain their own recovery management while assisting the recovery management process of others. Second, this move towards professionalization develops and requires licensure and accreditation structures and regulations that ensure worker protections that was described earlier by another stakeholder as a potential policy challenge. Third, professionalization legitimizes a particular skillset and scope of work as being best delivered by peers rather than by addiction treatment professionals and other allies in the field.

Valuing other traits over lived experience

Although most policy actors in the addiction recovery community agreed on the importance of lived experience and the role of peers, there were few stakeholders who had a dissenting perspective that recovery support services can and should be delivered by anyone, including addiction treatment providers, family members, and other allies. The recovery support service delivery workforce should emphasize "peers" and lived experience less and, rather, place greater emphasis on the traits to care.

An RCO leader, whose community-based work has a national reputation for being exemplary of promoting ROSC transformation describes their disagreement with the popular opinion that one needs to be a peer in order to provide recovery support services:

> *I don't believe in the word "peer." I think "peer" has done a disservice to what we're about… Also, a lot of my colleagues think that you have to have lived experience to be a recovery coach, for example, or make telephone recovery support calls, or run an all-recovery meeting. Our experience is that's not true at all. We have three recovery coaches in emergency departments right now, and a manager, one of the recovery coaches openly says that he is an ally of the recovery community. He is a phenomenal recovery coach. I mean just incredible, nurturing, caring compassionate, and just there to help. – RCO Leader 1*

The same RCO leader continues by describing an experience with training other healthcare professionals in the delivery of recovery support services:

> *In our telephone recovery support program, we had an opportunity to get some interns from [a school of nursing]. These nursing students were not in recovery, knew very little about it, but they made calls and had the same results, maybe at times even better,*

because they were nurturing, they were caring, they were compassionate, asked the right questions. It's more about your attitude of service and care than it is about the actual lived experience… – RCO Leader 1

In the two passages above, this stakeholder describes the ability of health workers and other allies without lived experience to provide effective recovery support services in their community. In emphasizing the effectiveness and utility of these allies to support individuals' recovery management, this stakeholder is emphasizing the roles that all community members have in a ROSC to support individual and community recovery. Compassion is a trait that all community members can feasibly adopt in order to assist others in their path towards recovery. In contrast, lived experience is exclusionary and protects the value of people in recovery in the addiction service delivery workforce.

In considering whether recovery support services can and should be administered by peers, an SSA Administrator from a different state than the RCO leader above explains that people in treatment need a care coordinator at all stages of their recovery:

The thing that people identify most is they want somebody to stick with them… whether it's a recovery coach, or a treatment care manager, or something like that, where the person actually has somebody that's their champion and their coordinator, whatever, to be with them through the process… Because people who have been through the system several times, you know, they keep going to different people. I think that's a hindrance to the recovery process… And it should be paid, because I think we'd get better results if we had more stability. – SSA Administrator 1

From a community-based services perspective, a behavioral health services researcher who also believes that being a peer is not the most important characteristic for recovery support

service delivery places greater attention on the role of culturally appropriate services and supports, particularly in minority and faith-based communities:

> *So, particularly among communities of color, I think recovery supports need to be provided by people who are culturally relevant to them… That can often be faith communities, it can also be barbershops, or hair salons. So, recovery supports should be provided where people are most likely to access them. That's most often in community settings as opposed to clinical ones. There are roles, obviously, for recovery coaches, or peer staff in clinical settings, too. But the majority of recovery supports should be provided in community. – Behavioral Health Services Researcher 1*

In the passages above, these stakeholders describe the value of compassion, recovery support continuity, and cultural relevance over lived experience with recovery from alcohol and drug problems. From the perspective of this RCO leader, lived experience should not be a requirement for the delivery of recovery support services while with the SSA administrator and behavioral health services researcher, there was an emphasis of other characteristics as being equally, if not more, important than lived experience.

Recovery support service delivery setting

Policy stakeholders described a variety of settings where recovery support services can be administered, including recovery community centers, community settings with cultural importance such as churches and barber shops, addiction treatment settings, and healthcare settings such as emergency departments.

Recovery-oriented principles centralize the importance of the community as a locus for recovery. A state government administrator describes how in working with service providers in their state, they encourage service delivery to happen in local communities:

A lot of them are working under providers that are in grant things… There are some providers that use them more in facilities… Then, we have those that are working out of recovery centers... They go into the jails, meet folks outside, where they're at, but then we encourage that… Just like our person-centered case management, we try to train that the primary contact place should be within the community. – State Government Administrator 2

A behavioral health services researcher describes how SAMHSA's funding for recovery support services, particularly through the Access to Recovery grant, provided states with opportunities to finance recovery support services that could be administered in the community. In comparison, this stakeholder questions whether Medicaid policies for reimbursement would permit for flexible community-based service delivery:

Will Medicaid pay for something delivered in a barbershop is a really good question. I guess, it depends on who's running Medicaid in the future, and if the cost arguments can be made. At least, for the time being, you can argue that it's a way of reducing health disparities, because black men will not come to outpatient behavioral health clinics, but they go to the barber, for example. So, if increasing access is the first step toward addressing disparities, then we have to go where the people are. – Behavioral Health Services Researcher 1

In addition to the broader community, stakeholders described the delivery of recovery support services in settings specifically for people in recovery. An RCO leader describes the recovery support services being administered within their recovery community center:

A lot of what we do is still advocacy and promoting recovery, focusing on the solution, not the problem. Then we also ventured into recovery support services. We operate three

recovery community centers. We have a statewide telephone recovery support program. I guess you could say the education piece is more what we would call a formal training piece, to help sustain the organization and generate revenue through our Recovery Coach Academy. – RCO Leader 1

RCOs are often funded through government agency-administered grants for direct service delivery. A county behavioral health authority describes their county's process for promoting improvements to their community-based service delivery settings:

When we had a drop-in center, we had two part-time people that worked there with a low budget, and they weren't very motivated… What we did is that we set out a bigger goal and we let our money follow our mouths. We changed their budget… they hired a go-getter director, someone in recovery, who came in and was like, "Well this facility looks like an institution." The first thing he did was try and find ways to get it renovated and volunteers that would help paint and so on and so forth. They did a complete facelift. Then, because they were actively in the substance use recovery community, they were able to spread the word more and get people in. – County Behavioral Health Administrator 1

A national recovery trainer describes the work that needs to be done in order to prepare RCOs for the workforce considerations of having peers deliver services in partnership with behavioral health and primary care service partners:

There's an awful lot of community organizations out there that are peer operated… We work with them to build the capacity and skill sets that they need in order to be partners to behavior health systems that want to purchase their services. So, if I'm a substance use disorder treatment provider and I want to add a recovery coach component to my

agency, then I can do one of two things. I can hire recovery coaches and figure out, "How do I support them? How do I train them?" All those things that you do with a new workforce, or I can say to a recovery community organization in my community, "Hey, can I develop [a memorandum of understanding] with you and you provide the recovery coaches to my program?" In order for a community program to be able to do that, they need to have certain structures and infrastructure and capacity in place. – National Recovery Trainer 6

Given the impact of the national opioid epidemic, stakeholders also described the importance of delivering recovery support services in healthcare settings. A state government administrator describes the implementation of recovery support services in primary care settings including hospitals and in emergency departments:

One of the things that I think [the behavioral health administrator] was instrumental in helping put into place is to get the hospital community, emergency rooms, to accept recovery coaches as part of partnership with emergency rooms and hospitals… The recovery coaches, these are people who are trained, people who have recovered themselves, they go through training. To me, that's an indication in how close we are coming to really having people in recovery working and telling their story... – SSA Administrator 4

Peers in addiction treatment and healthcare settings

The use of peers in the addiction treatment workforce has the potential to work well if policies are created to promote peer inclusion and interdisciplinary service team collaboration. However, policy stakeholders also described potential policy barriers to the utilization of peers in addiction treatment and other formal healthcare settings.

An SSA administrator describes the process undertaken and challenges faced in integrating peers into addiction treatment teams. The stakeholder notes that, at first, resistance was faced in the addiction treatment community but eventually, collaboration was achieved:

> *We made it very clear that the peer mentor needed to be part of the treatment team and what their role was… The [addiction treatment] counselors really envied some of the work and the relationships, and the engagement, and how quickly that happened with the peers, compared to some of the work they had to do in a caseload. But, they also began to recognize that when a person relapsed, they were finding out about that relapse in a day or two, and that person was continuing to talk to them, because they continued to work with their peer mentor. – SSA Administrator 2*

In the passage above, this SSA administrator describes counselors' initial sentiment of envy over peers' relationships and responsibilities when working with clients. However, overtime, counselors understood the added value of peers in being able to identify instances of relapse sooner than they typically would have in the past.

Utilizing peers as recovery support service providers, particularly in addiction treatment and other healthcare settings, does have potential challenges and unintended consequences. A national recovery trainer describes their work in an addiction treatment system that developed a financing structure that would pay peers in 15-minute increments, which is a common unit of billing unit in healthcare:

> *Sometimes, the physical [health] strategy actually is a disincentive to do what needs to be done. Like in another system, again, they didn't think it through, and their peers are paid on like 15-minute increments and they don't get an enhanced rate to go out and do community-based work or to go look for somebody that they can't find and do a sort of*

outreach, or it's like if you're not sitting in the office with somebody in front of you, then you can't bill for that time. The state has inadvertently kind of narrowed the role of peers. – National Recovery Trainer 5

This stakeholder describes a state where the move toward peer reimbursement using a medical model of billing has inadvertently changed the working relationship between peers and clients in order to meet the reimbursement requirements that are typically used in medical settings.

Policy considerations for peer-delivered services

Frequently, conversations with policy actors gravitated towards the policy considerations for peer-delivered recovery support services. In particular, stakeholders described the organizational requirements and perceived challenges and barriers to administering peer-delivered services in the addiction treatment and healthcare systems, including workforce professionalization issues, collaboration challenges with the addiction treatment providers, barriers to recovery support service financing, and measurement of service outcomes.

Peer workforce development and collaboration with addiction treatment

As a result of continued work in the addiction treatment and healthcare fields, the peer recovery community has moved forward with workforce professionalization, including the development of licensure and credentialing structures in some states. In a state that has made some efforts to develop its peer workforce and establish a ROSC, an SSA administrator describes the implementation of a peer workforce certification that resembles the state's addiction treatment counselor certification structure.

[We] worked to put together a training curriculum for certification of peer mentors. We developed the policy around peer mentors, the policy for providers, and the certification process, both for the peer mentors, and we also developed a second phase of peer

mentoring, which was a peer mentor-in-training. This was pretty essential in our workforce, because kind of in parallel with developing the peer mentoring work, the state had moved from a certification to a licensure for substance use counselors. – SSA Administrator 2

As described earlier in this chapter, the movement towards peer professionalization has resulted in the ability to reimburse peers for providing support to others and is a claims-making process for valuing the role of lived experience in the addiction services field. This process of peer professionalization is increasingly taking place in states in both the addiction and mental health recovery fields, particularly as a means of seeking reimbursement for their services through Medicaid.

This quick transformation towards professionalization, however, has had some unintended consequences. A national recovery trainer who has worked closely with several states and local systems observes how the movement has focused more so on the process of professionalization rather than thoughtfully considering the scope of work and purpose of peers in this process. In working with a state that has a reputation for its work to develop a peer workforce, the stakeholder describes some of the shortcomings and challenges observed, particularly as the movement towards professionalization does not align with some recovery values and principles:

They pushed and advocated for, "We need peers in our system." What they didn't do was say, "What would these peers do? What's the vision related to that? What does the role look like? What's the overall purpose?" ... None of that happened. It was, "Let's get a certification. Let's put a training in place. Let's get people trained." ... They really are seen as one of the trailblazers… I did surveys with those peer staff to say, "What's your

experience? What are you doing?" The responses in those surveys could make you cry. People talked about not feeling valued, not feeling like they were getting to do what they were trained to do, feeling like they were the token person in the organization. People are saying that they're not allowed to talk about being in recovery. – National Recovery Trainer 5

This stakeholder's comment highlights that the problem when peer professionalization is not accompanied by a thoughtful and recovery-oriented process of determining scope of work objectives and policies.

Another national recovery trainer explains that a challenge that is commonly faced is the perceived difference between clinical and non-clinical services and supports. This differentiation consequently delineates addiction treatment provider and recovery support service provider roles:

I think people see recovery as that stuff and the clinical stuff is different, separate… I think all of these things are recovery support services. You have clinical recovery support services and you have non-clinical recovery support services. They are all with the shared goal of promoting, advancing recovery, but I will tell you, more often than not, I have system administrators talking about the recovery project, the recovery service, this is to fund recovery, and what they mean by that is the non-clinical stuff. – National Recovery Trainer 5

This conceptual delineation between "clinical" and "non-clinical" and between "addiction treatment" and "recovery support" can be observed in the resistance peers face in the addiction treatment community. As a county behavioral health administrator paraphrased, the initial reaction from the addiction treatment community was, "they aren't professionals but we

are" which is a claims-making sentiment about the importance of professional education, training, and credential.

A national trainer affiliated with a SAMHSA-funded Addiction Treatment and Technology Center describes persisting tension between clinically trained addiction professionals and peers:

> *Clinicians and certified staff and psychiatrists, psychologists, social workers, were saying, "Okay, so we went to school. We've been doing this work, and are you saying that we no longer need treatment and that peers are all that's needed and what we've done you no longer need us, you no longer need treatment. All we need to do is recovery support services and peers." That tension was there, and it was there then and it continues. – National Recovery Trainer 4*

This stakeholder's comment describes the perceived tension between clinically trained professionals and peers that was identified early on in the addiction treatment field and that continues in the present day. Within the context of this comment, this tension can be attributed to a few factors including a perception from addiction treatment professionals that their training and education is invalidated in the service delivery system by their lack of lived experience with alcohol and drug problems. Moreover, there is a perception that their scope of work in treatment is no longer needed as recovery support services are the now seen to be the focus of for service provision. These comments also suggest the continued limited understanding of some addiction treatment professionals of the role of recovery support services in clients' recovery management and the continued need for further education around ROSC and the role of peers in promoting clients' engagement in service delivery.

Financing recovery support services

Although there are several barriers to the delivery of recovery support services, the current policy environment has resulted in increased funding opportunities for recovery support services. Policy stakeholders described several ways in which recovery support services are increasingly being financed, including through Medicaid's increased reimbursement of peer-delivered recovery support services and states' reallocated use of block grant funds.

As peer-delivered services are increasingly being reimbursed through Medicaid, one of the primary challenges confronted is the requirement that a licensed clinician must supervise peer who delivers services. Given the difference in skill set and scope of work between licensed clinicians and peers with lived experiences, there are many problems with this supervisory arrangement. A behavioral health researcher describes the challenge that this arrangement faced in a state that was among the first to pursue a Medicaid waiver to permit this arrangement:

> *It's a licensed clinician, which is a big problem because peer staff should be supervised by people either with lived experience or who understand the value of lived experience. Those people are hard to come by… So, I understand the importance of having peer staff supervised, but having a clinical license doesn't really give you credibility for that purpose. Since it should be a very different service, or support than how most clinicians were trained. – Behavioral Health Services Researcher 1*

This policy barrier highlights the challenge of seeking recovery support service reimbursement through a health-oriented service delivery system that values clinical training and expertise.

As a result of the Affordable Care Act (ACA), Medicaid is increasingly being used to finance addiction services. However, given the stipulations attached to Medicaid dollars and the complexities of reimbursement, not all service providers are choosing to pursue Medicaid

funding. An RCO leader explains why their organization has selected not to seek Medicaid reimbursement for peer-delivered services:

> *As a recovery community organization, I don't want to start billing Medicaid for peer services, because that is such an incredibly inefficient way to get things done. I think that SAMHSA's had some wonderful grant programs, but their grant process seems to have, I don't know, reductions in staff and all that. Really, I think the block grants ought to be expanded and the block grants ought to be given to the states, where the single state agencies can have the ability to distribute that money in the way that they see fit and loosen the requirements. – RCO Leader 1*

This stakeholder explains that there are several funding sources for recovery support services that exist in the service delivery system, but that Medicaid has too many bureaucratic stipulations and that SAMHSA grant funding process is inefficient. From their perspective, states' block grants for addiction services are the ideal way to finance recovery support services given the flexibility and discretion of each state to use these funds.

Many policy changes have occurred in recent years that have allowed for states to use their block grant funds to pay for recovery support services. However, barriers still exist that prevent states from doing so, including block grant policy language ambiguity. An SSA administer describes this language ambiguity and the potential benefit if SAMHSA were to provide policy guidance on block grant use for recovery support services:

> *SAMHSA's moved things along, but it's important to identify the recovery components as being elements that can be supported by the block grant, and to be explicit about that because if it isn't explicit, it makes it harder for people to see that they can use money for those kinds of things… The block grant is so hard to change. It makes it a little tough,*

and I think most states struggle with it, unless there's new money, you know, do they want to take things away from one thing and put it in another? It's complicated, and a lot of states have turned their funding over to third parties, you know? Managed care companies and so forth, and that actually leads away from more community, toward more healthcare. – SSA Administrator 1

This stakeholder is recommending stronger policy guidance from the federal government on how states can use their block grant funding, including the flexibility to pay for recovery support services. In particular, they are emphasizing the challenge states face in changing how they spend their block grant dollars.

Measurement and evaluation

As recovery support services are increasingly administered within the addiction service delivery system and are financed through federal grants and Medicaid funding, greater attention is paid to the effectiveness of services and supports, including who administers services, in which settings, and at what dose. The challenge, however, is that there is limited data and little agreement on the effective evaluation of recovery support services. A stakeholder who is a national recovery trainer and researcher describes some of these concerns:

We don't have answers to these questions yet. Are recovery outcomes different when those services are provided by other people in recovery versus people without an experiential recovery background? And what's the best organization or location out of which those services can come, both in terms of cost effectiveness but also do recovery outcomes change? When a service comes out of a recovery community organization versus a treatment organization versus the behavioral manage care organization as an example. – National Recovery Trainer and Researcher 1

This policy actor's questions highlight the limited knowledge that exists around the effectiveness of recovery support services. This stakeholder's acknowledgement of the limited empirical evidence that exists stands in contrast to the strong opinions that stakeholders expressed in this chapter about ideal service delivery types and locations within a system of care that align with recovery-oriented values.

The existing research on recovery support service effectiveness has focused on populations with the most severe SUD problems. Little research has been conducted to understand the needs of those with low- to mid-severity issues, including which recovery support services are most effective and at what dose. Unfortunately, service and program evaluation of federally-funded addiction services remains limited. A stakeholder who is national explains some of the barriers to the lack of effectiveness data for recovery support services, particularly with SAMHSA-funded projects:

> *We can't monitor or evaluate any performance by any organization… Having said that, every time we look at doing any kind of technical assistance we are very specific about what is it that you're hoping to get out of it. A recent technical assistance request was from a recovery housing provider... In that example, we [said], "Okay. We will get approval to train your peer workforce to become recovery coaches and a metric for you to see whether this is succeeding is you're going to see if the percent you're losing the first 90 days decrease to 25. That's your outcome. That's your objective… Please report back to us." But I don't have any teeth to go back and say, "How did it go?" I can ask them, they can share that information if they want, but I can't say, "You must." – National Recovery Trainer 6*

This policy actor's comment explains how SAMHSA, the primary funder of recovery support services, does not require training and technical assistance providers to conduct follow-up evaluation and measurement of its programs. Although this stakeholder does not further elaborate why SAMHSA may not pursue further evaluation of these programs, this comment highlights the inability of these national recovery trainers being able to do so even if they wanted, which further perpetuates the limitations in empirical evidence in this field.

Discussion

Recovery support services are an integral part of a ROSC that facilitates the recovery management and long-term wellness of people living with alcohol and drug problems. Policy stakeholders in the addiction service delivery system generally believe that a wide range of services and supports should be administered within a ROSC that restore the life functions impacted by SUDs and that recovery support services should be tailored to address an individuals' specific and evolving needs. Generally, policy actors agree that people in long-term recovery, or peers, should deliver recovery support services given their lived experience with SUDs. However, some stakeholders believe that other characteristics including compassion, recovery support continuity, and cultural relevance are more important than lived experience and that other individuals, including addiction treatment professionals and other allies can effectively provide services and supports. Regardless of whether peers are serving in a voluntary capacity or are paid paraprofessionals, further policy considerations including workforce development, financing, and monitoring and evaluation factors must be addressed.

Given the increased use of peers as paid paraprofessionals in the addiction treatment system, it is worth exploring the implications of professionalization and the tradeoffs that might exist to individual and community recovery. Peer support holds its origins in the mutual aid

tradition of giving back to the community by serving as mentors to others who are early on in their recovery management process. This consideration lends itself to the question of what is gained and lost by having people in long-term recovery provide this mentorship in a paid, rather than voluntary, capacity? Are client outcomes unchanged regardless of whether a peer delivering recovery supports is a volunteer or in a paid role? Moreover, do peers in paid positions achieve a comparable sense of satisfaction from this role that fortifies their own personal recovery as it does for volunteers? These questions warrant further investigation given the continued trend in the addiction service delivery system towards peer professionalization.

Additionally, as peer workforce professionalization continues to progress in its structural formalization, it is important to closely examine its implications. The process of professionalization has had its advantages in the addiction treatment system and other sectors of healthcare including ensuring higher standards for practice, protecting patient and provider safety, and monitoring adequate workforce continuity, among other factors. These structures have improved the quality of services and patient outcomes.

On the other hand, one must critically consider why there may be opposition to the movement towards professionalization. In reflecting back upon the professionalization of addiction treatment and other helping professionals, such as social workers, the movement towards developing formalized licensure and accreditation has been accompanied by a medicalization of these fields. These changes have included a greater emphasis on clinical practices and a distancing from community-based and other macro-level practices. This incongruence is evidenced by the philosophical misalignment of lived experience (among peers) and clinical training and expertise (among addiction treatment providers and other health professionals). In other words, there is concern that the move towards peer professionalization

will reproduce structures of the addiction treatment and other health fields in a way that will devalue the importance of lived recovery.

Conclusion

Recovery support services that are tailored to meet individual needs are a necessary component of a recovery-oriented service delivery system. In order to ensure that these supports and services are delivered, considerations relating to funding, workforce, and other policy concerns must be addressed.

In next chapter, recovery-oriented policies, principles, and services are explored within the context of Affordable Care Act and other federal and state-level policy reforms and the national opioid epidemic. Policy stakeholders explore how, if at all, the implementation of recovery-oriented policies and services has impacted, or been impacted by, the implementation of broader health reforms and national attention on the opioid crisis.

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Chapter 7. Recovery in the Context of the ACA and Opioid Epidemic

"We kind of had a perfect storm in a good way, when it came to the passage of the ACA. A couple of events in our state that really brought the recovery community out of the woodwork and this raging opiate epidemic that sort of put this recovery system finally into gear." – Single Government Policy Administrator 1

Introduction

The New Recovery Advocacy Movement has spurred the increasing adoption of recovery-oriented policies and services among states and communities across the United States. In this chapter, we explore how policy stakeholders consider recovery-oriented policies and services within the context of current health policy reforms, including the Affordable Care Act (ACA), and the national opioid epidemic. Initially, the objective of this study was to better understand how addiction service delivery system policy stakeholders integrated, if at all, recovery-oriented policies and services in overarching federal and state-level policy reform efforts. As interviews with policy stakeholders progressed, however, it became nearly impossible to disentangle policy planning and implementation efforts that were done to address the opioid crisis from broader healthcare policy reform efforts given the pervasive impact of the opioid epidemic across the country.

The findings in this chapter are presented in two parts, exploring the questions: (1) how do stakeholders in the addiction service delivery system integrate recovery-oriented policies and services in the context of the ACA and other policy reform efforts and (2) how are stakeholders in the addiction service delivery system considering the opportunities and challenges of the national opioid crisis with respect to addiction policy reform?

Recovery and the ACA

Findings for this section primarily derive from the NDATSS State Case Studies interviews with stakeholders from eight states discussing addiction treatment policy planning and

implementation in the context of the ACA and other federal and state policy reforms. Some additional findings derive from Addiction Recovery Stakeholder Project interviews with stakeholders whose roles related to addiction treatment service delivery and policy. All stakeholders, including state government agency representatives, service providers, policy advocates for addiction treatment and recovery, and Medicaid managed care organization and qualified health plans, among others were prompted to consider how recovery-oriented policies and services fit into their work related to addiction treatment policy planning and implementation.

While some conversations were in-depth explorations of recovery-oriented principles and the alignments and tensions with the evolving addiction treatment system, other conversations were, in a sense, opportunities for stakeholders in the addiction treatment policy and healthcare financing domains to respond to the prompt of "addiction recovery" and provide a response in this broad field specific to their understanding of these policies and concepts. In many cases, these conversations revolved around recovery supports and services, including peer-delivered services. Some stakeholders broadly considered a continuum of care, ranging from prevention to recovery support services as "recovery-oriented" while other stakeholders had a deeper knowledge and understanding of recovery concepts and were able to sustain pointed conversations about recovery-oriented principles and values and their role in addiction treatment policy.

Funding for recovery-oriented services and other initiatives was frequently discussed with stakeholders. As a result of the ACA and Medicaid expansion, states are increasingly using Medicaid to finance addiction treatment and are reallocating Substance Abuse Prevention and Treatment (SAPT) block grant funding for recovery support services, including peer-delivered

services and housing support. In conversations with stakeholders in states that have adopted ACA-related reforms, conversations about health policy reform revolved around the provision of a continuum of services, including recovery support services, rather than around major recovery-oriented systems transformations. Notably, in some states that have not undertaken ACA reforms including Medicaid expansion, some of the most notable transformational changes to addiction service delivery system have taken place in order to align policies and practices towards ROSC.

Recovery and the Opioid Epidemic

The national opioid epidemic has attracted significant political and media attention to the addiction treatment service delivery system. In conversations with policy stakeholders, several themes emerged pertaining to whether policy actors believed the national opioid epidemic has contributed to the adoption of, or been stymied by, recovery-oriented policies and services. In some interviews, these conversations were directly related to the implementation of the ACA while in others, they were addressed as separate topics.

Policy actors discussed the opioid epidemic and addiction recovery highlighting a few points. Stakeholders noted that the recovery advocacy community's mobilization to address the opioid epidemic has been effective in some communities but not in others. With significant national attention on the epidemic, some stakeholders pointed out that the addiction service delivery system could take advantage of this attention by leveraging funding resources for recovery support services and peer workforce trainings. Moreover, some policy actors believed that the urgency of the epidemic has resulted in less resistance in the field to the adoption of some initiatives, such as the use of peer-delivered services in primary care settings.

However, stakeholders also pointed out some concerns. Federal grants targeting the opioid crisis devote little funding to recovery support services and initiatives. There are also

some philosophical discords in the field, including the narrow focus on opioids neglecting the impact other substances and risk factors impeding one's ability to manage their recovery. Furthermore, the ideological divide in the recovery community still exists between those aligning themselves with a 12-step, abstinence-based approach and those embracing multiple pathways to recovery including the adoption of medication-assisted treatment. Some grassroots community stakeholders pointed out that cultural shifts are taking place in local communities as people in recovery from opioid use disorders change perceptions on the value of embracing multiple pathways to recovery.

Methods

Chapter 3 offers a comprehensive description of the methodological approach to sampling selection, interview guide development, data collection, and coding and analysis. Data presented in this chapter come from interviews from both the NDATSS State Case Studies and Addiction Recovery Stakeholders Project.

NDATSS State Case Studies stakeholders were asked how addiction recovery concepts, policies, and services connected with their work in the addiction treatment field. Depending upon the extent to which a policy stakeholder specified their work focused on recovery policies and services, follow-up questions related to recovery-oriented policies, principles, and services were posed. Findings presented in this chapter derive from NDATSS State Case Studies transcript data coded as "recovery."

Addiction Recovery Stakeholder Project participants were prompted to discuss to what extent they believed recovery-oriented policies, initiatives, and services aligned with federal and state health policy reforms related to the ACA, Medicaid expansion, behavioral health parity enforcement, and other reforms. In instances when conversations about the national opioid

epidemic were not raised by participants, the interviewer prompted stakeholders to discuss how they believed the opioid crisis impacted or was impacted by recovery-oriented policies, initiatives, and services work being done in their field. Findings in this chapter derive from Addiction Recovery Stakeholder Project transcript data coded as "ACA" and "opioid epidemic."

Results

Recovery and the ACA

Policy stakeholders whose work focused primarily in addiction treatment or healthcare financing typically focused our conversations more so around the delivery of recovery support services and less so around recovery-oriented principles and transformational policy change. Conversations with these stakeholders about recovery support services commonly evolved into discussions about ensuring that the state could adequately finance the full continuum of services to address substance use disorders (SUDs), ranging from primary prevention, early intervention, treatment, and recovery supports. More specifically, these discussions focused on ACA-related funding mechanisms the system of care's ability to finance a full range of services, including recovery support services.

The recovery community was instrumental in its participation in advocating in addition treatment coverage in the ACA. A national recovery policy expert describes how the addiction recovery community had contributed to early national advocacy to get the behavioral health benefit, including addiction treatment, included as one of the ten Essential Health Benefits:

> *I think early on with the ACA there was a push and I don't think we did very well. We got addiction and mental health treatment as part of Essential Health Benefits but not really the peer and recovery support services. A lot of movement with the mental health folks to*

get Medicaid reimbursement for peer services—much less so for the addiction recovery peers. – National Advocacy Organization Leader 2

This stakeholder's comment sheds light on the recovery community's instrumental role in advocacy for behavioral health services and the community's strength as a collective voice for policy change. However, this comment also highlights some of the limitations in that early advocacy, as recovery support services, including peer-delivered services were not a major element of the policy conversation. Moreover, this stakeholder explains that, at the time, peer-delivered mental health services were moved forward with regards to Medicaid reimbursement but comparable advancement did not take place for peer-delivered addiction services.

As states moved forward with implementation of the ACA, they considered the role of recovery-oriented values, principles, and policies within their evolving systems of care and whether these reforms were complimentary in nature. A stakeholder who is a national recovery trainer explains why they believe that recovery-oriented principles complement the ACA and other health policy reforms:

[The state] was saying to communities, you could use the Affordable Care Act money like regular commercial insurance... You bill dollars and then keep your block grants to do these other wrap-around services such as prevention, early intervention, and ROSC. ROSC is in every one of them. ROSC is in a third of the current SAMHSA RFPs to be funded… ROSC is sort of the reason I think people say why they do what they do. If you can't offer a person recovery, then we've lost the reason. – National Recovery Trainer 2

This perceived alignment between health policy reforms and recovery can be observed in SAMHSA's funding of training and technical assistance efforts in the years following the ACA's enactment. A second national recovery trainer describes how they provided training and

technical assistance to states and communities looking to take advantage of ACA reforms, including Medicaid reimbursement for recovery support services:

> *We were able to provide awards and technical assistance to organizations who were specifically looking at providing recovery supports and helping them figure out a way to help people get enrolled because of the ACA… or figure out how to get them paid for, and how do you work with a payroll, or how do you look at getting Medicaid ready and what does all that mean. We've done five years of that kind of work… Right now, there's a lot of work around how do you finance it. How do you get ready to be able to be a provider of recovery support and how do you work with an agency to do that? – National Recovery Trainer 6*

This stakeholder's comments highlight the work that was done at SAMHSA and among states to leverage the policy changes related to the ACA to be able to reimburse for recovery support services.

Medicaid expansion and recovery support service funding

As a result of Medicaid expansion, it was believed that the SAPT block grant, which has been the largest payer of addiction treatment services in many states, would be able to be used for other purposes including for services that are traditionally not covered by Medicaid such as such as housing and other non-clinical supports.

Policy stakeholders from states that had expanded Medicaid describe a pattern of utilizing more Medicaid funds to finance addiction treatment, thus freeing up other funding sources, including block grant funds. In a state that expanded Medicaid as a result of efforts to address the opioid epidemic, a state government administrator describes the observed shift:

> *We found that some of our treatment providers were actually billing our contracts less because now they were billing… Medicaid for clients that are eligible for those services… That has resulted in actually billing less to our contracts which has allowed us to repurpose some of those funds for things like prevention services and screening brief intervention, referral to treatment, medication-assisted treatment, peer recovery support services, those sorts of things. – SSA Administrator 5*

This funding shift is a pattern that had been anticipated by SAMHSA and other policy experts as a result of increased Medicaid reimbursement of addiction treatment. This shift is coupled with financing and organizational changes within the behavioral health system. From the perspective of a Medicaid managed care organization's (MCO) leadership in a Medicaid expansion state, we also observe the increased reimbursement of peer-delivered services through an insurance plan.

> *As part of our care management teams, we have hired peer specialists, those individuals in recovery. Certainly, the state has now added both peer specialists, as well as recovery coaches, those individuals who have lived SUD experiences, as part of this new Medicaid menu… [The Medicaid managed care plan], two years ago… recognized the need for our members who were in recovery to be able to speak with someone who has traveled that road, experienced what our member is currently experiencing, and then teach them how to navigate that based on their own experiences. We have hired staff who have lived experience. – Medicaid MCO Leader 2*

Although several Medicaid managed care plans noted the increased reimbursement of recovery support services, including peer-delivered supports, this MCO is notable for the extensive nature of its reforms, including the intentional hiring of staff with lived experience.

A state Medicaid MCO association's representative in a Medicaid expansion state describes policy conversations in the state about utilizing block grant funding to pay for other kinds of services given that Medicaid would be used to pay for addiction treatment:

> *We have had conversations about using the block grant for other purposes with the assumption that, again, Medicaid expansion was going to pick up with some services. So, in 2015, we have a state behavior health planning advisory council that's a really required group that advises the office of behavior health and the block grant. The recommendations that came out of there to shift funding and I think ultimately, they decided to shift 5% of the treatment block grant to recovery services… and I think 5% to do some early intervention for SBIRT screening and intervention. And there was a fairly contentious discussion about whether we should do that or not. And I think originally, the recommendations from those stakeholders in that group was probably a higher amount, probably 10% each. – State Medicaid MCO Association Leader 1*

This stakeholder points out the policy negotiation that took place in their state to ensure the block grant's use for financing recovery support services. Initially, the proposed policy was to utilize roughly 20% of the block grant for screening, brief intervention, and referral to treatment (SBIRT) and recovery support services. However, there was resistance from the addiction treatment community and this total was reduced to 5% for SBIRT and 5% for recovery support services.

Barriers to Medicaid financing of recovery support services

Stakeholders described several policy shifts that are taking place across states resulting in increased coverage of recovery support services. In light of all these policy reforms, however,

they also pointed out that several barriers to implementing recovery support services within health policy reform efforts.

Although some stakeholders had described projected and observed gains in Medicaid coverage for addiction treatment and peer-delivered recovery support services as a result of the ACA, this was not the case across all states. A stakeholder who is a national expert on addiction treatment state policies explained that, in reality, Medicaid is not the major payer for recovery support services that it was anticipated to be:

> *Medicaid has turned out not to be a good vehicle for funding of recovery services… Peer recovery organizations have great difficulty qualifying for Medicaid. And we've heard of one or two of them that went through everything they needed to do to enroll in Medicaid and, after they had it for a while, they dropped it… That requirement under the Medicaid Act of clinical supervision for these kinds of adjunct services… If they're not in clinical services, it is kind of a back-breaker… [Peers believe] they have an independent role to play in helping people reach recovery that ought not to be directed and managed by clinicians, who, by and large these days have theoretical training, some practical, clinical training, but very limited personal experience in terms of recovery. – National Addiction Policy Expert 1*

As this stakeholder notes, Medicaid is not a good payer for peer-delivered services given the requirement of having a clinical supervisor oversee peers. And, this placement of people in recovery with lived experience under clinical treatment providers is problematic given the potential incongruence between recovery-oriented and clinical supervision values.

As described in the previous chapter, several policy barriers exist in the move towards Medicaid reimbursement of peer-delivered services, including issues related to scope of work,

clinical supervision, and as the following stakeholder notes, the requirement of criminal justice background checks. Individuals in recovery from SUDs frequently face past or ongoing criminal justice problems, which makes the certification of peers a challenge. A state provider association leader describes this barrier:

> *One of the things about lived experience for a lot of people in recovery is that they might have criminal history that's linked to their SUD… Someone who's recovering and has some experience with the criminal justice system can actually offer a lot of perspective to other people who are currently endeavoring with recovery and are involved in the criminal justice system… The Medicaid policy says they can deliver the service, they just can't get paid by Medicaid for it. That's a state policy choice. We know other states haven't done that. That makes it hard to build a workforce when the financing mechanism isn't necessarily there for the workforce. – State Treatment Provider Association Leader 1*

In the situation described above, the inability to reimburse for peer-delivered services in cases where peers have had previous criminal justice involvement does not take into account the extensive criminal justice system involvement of those in recovery from SUD. Ideally, peers can and should be able to be reimbursed for their work in facilitating others' recovery management regardless of their past experience with the criminal justice system. This barrier highlights the discord between current health financing structures and recovery-oriented values.

In another Medicaid expansion state, a state government administrator describes how recovery community organizations (RCOs) in their state wanted to move forward with organizational changes in order to bill Medicaid for peer-delivered recovery support services.

However, the SSA administrator is concerned about the RCO's organizational readiness for Medicaid reimbursement processes:

> *We began to have those conversations, I think, since [the recovery community organization leadership] was very interested in moving toward having Medicaid funding for recovery services. You know, planned to move in that direction. It was a tension point. I think that there was a decision that, "No, that wasn't going to happen right off." Mainly because the recovery centers probably weren't able to have a business model to support. It was a practical decision more than a philosophical decision. There just wasn't the infrastructure, unless they were able to partner with a larger organization. – SSA Administrator 1*

In the situation described above, the SSA administrator describes the challenge being able to get the RCOs ready for administrative processes related to Medicaid reimbursement. This concern about RCO readiness for Medicaid reimbursement was a frequently voiced concern about addiction treatment providers, as well. The addiction treatment system, unlike with the rest of healthcare including the mental health system, has historically relied less on Medicaid funding in the era prior to the ACA and readiness for ACA-related policy reforms would require substantial transformations for both addiction treatment and recovery community-based service providers, alike, to reimburse for services through Medicaid.

Leveraging roles in health financing and regulation

As mentioned in the previous chapter exploring how policy stakeholders define addiction recovery (Chapter 4), stakeholders primarily in the realm of healthcare financing were less knowledgeable about recovery-oriented concepts as compared to their counterparts in addiction treatment policy and service delivery.

This lack of understanding of recovery-oriented policies and services wasn't true of all stakeholders whose work primarily fell in the realm of healthcare financing and regulation. Some of these stakeholders were quite aware of recovery-oriented policies and services while others were less knowledgeable about recovery concepts but were knowledgeable about recovery support services. A Medicaid MCO representative from a Medicaid expansion state discusses recovery within the context of recovery supports such as recovery housing and care coordination—areas that the stakeholder believed a Medicaid managed care plan could impact the system:

> *From a payer perspective… a number of things are in place and full or part billable to a health insurer… On the more care coordination end of things… our care coordinators, we keep and manage access to nonmedical services at the local level and we encourage as part of a comprehensive care plan our care coordinators to assist our members in finding access to not just medical care and behavioral healthcare but social supports, vocational services, and so forth… – Medicaid MCO Leader 3*

In another Medicaid expansion state, a Medicaid MCO leader discusses their commitment to instilling recovery-oriented principles into an insurance approach:

> *[A supportive housing organization], we had them come and train all of our supervisors on understanding housing so that when members have housing issues, our people work smarter about how to help them get the housing, which housing it is, how you work the system… We train people on recovery principles, so we've used the SAMHSA guidance to train and help people to understand that… [And] while peer support is not a direct service in the Medicaid benefit plan, we have found a way to at least get a peer bridge or*

model working for people who are being discharged from inpatient programs... – Medicaid MCO Leader 4

In the comments above from two MCO plan representatives, we observe that in some instances, Medicaid managed care plans are finding ways to leverage their role and integrate recovery-oriented principles and finance support recovery support services. It should be noted that these particular MCO leaders had training and previous experience as addiction treatment clinicians, potentially influencing their approach to treatment financing and regulation.

Recovery in States Rejecting ACA

In conversations with stakeholders about the intersections between recovery-oriented policy and ACA reforms, some considerations arose relating to the barriers to policy reform, including state government opposition to ACA-related reforms including Medicaid expansion.

In a state with political leadership that has openly rejected the ACA, the SSA has been unable to utilize any funding specifically related ACA, including Medicaid expansion. However, the state government agency has still been able to make significant transformations towards a ROSC, including several policy changes and initiatives and the utilization of a Medicaid-reimbursable peer workforce:

We have recovery foundations training that's happening with our providers, which is really about ROSC and about how the systemic change within organizations, it supports not only the peer movement, but just recovery in general. We have recovery symposiums that we fund and communities where they put on their own community recovery forums with different partners in the community. – SSA Administrator 6

A regional behavioral health authority in a state that selected not to expand Medicaid describes how the state government agencies have moved forward with policy transformations to develop a ROSC even as Medicaid expansion was not adopted in the state:

> *Recovery transformation, what that means to me is that the state [behavioral health agency] not only in concept has embraced a specific concept that recovery starts from a position of a client themselves. In other words, the way that recovery services have always been delivered in the state, up until recently, was top down. A client would come into our system and then immediately be handed over to a therapist, who then gave instruction to a client. Now, we're trying to turn that around and deliver person-centered recovery services with a big emphasis on peers. That has really happened over the last two to three years. – County Behavioral Health Administrator 2*

In the same state, the pattern of funding increases for addiction treatment and reallocation of block grant dollars did not occur. So, rather than a focus on delivering more recovery support services, focus has been and continues to be on aligning services with recovery-oriented principles and policies:

> *I think we have an opportunity with their funds to work towards some of the more recovery-oriented initiatives… That has nothing to do with ACA, though, because there's no dollars that became available... It's really more about philosophical things of available dollars and supporting a whole continuum. – SSA Administrator 6*

In the three passages above from states and local communities where ACA reforms including Medicaid expansion have not been adopted, we observe a strong commitment towards recovery-oriented values and policy transformation. This philosophical alignment and discourse was not observed in conversations with policy stakeholders in Medicaid expansion states where, rather,

conversations were more so focused on financing and policy reforms for recovery support services. There are several potential explanations for this difference. One possible explanation is that these states and communities that have not adopted ACA reforms are, in fact, more committed to making recovery-oriented systems transformations than the states that are preoccupied with making ACA-related reforms. Another more likely explanation is that addiction policy stakeholders in Medicaid expansion states are more focused on service delivery and policy transformations related to service financing and, thus, those are the current policy priorities that require their attention. In contrast, in non-Medicaid expansion states, there is greater attention on recovery-oriented philosophical and systems realignments given resource constraints and the need to find other means of improving access and quality of care.

Grassroots perspective on the ACA

From the grassroots advocacy perspective, there were several RCO leaders with whom I spoke that embraced and remained optimistic about the policy changes that might come to the addiction service delivery system as a result of the ACA and other federal and state policy reforms. On the other hand, there were also those stakeholders who noted that these changes were "beyond their control," signifying a sense of detachment from the policymaking process pertaining to the ACA and addiction services.

An RCO leader who works primarily with indigenous communities describes the challenge that the grassroots recovery advocacy community faces given their dependence on SAMHSA and other federal agencies on grant funding:

> *Well, one fashion where a lot of that comes to us is the Indian Health Services. And they have been running under budget for years… And we're starting to see now that some of the grants that would normally come [from] the Feds, the Indian grants are getting cut or*

cut short or eliminated… We are trying to use the technology, some of the webinars and things that we didn't have years ago to do some of this, but a lot of people are suffering right now with what's going on. – RCO Leader 2

This RCO leader describes their organization's reliance on federal government funding and how the organization's work is reliant on the political and economic forces sometimes beyond their control, including at times of financing retrenchment.

A second RCO leader describes how grassroots leaderships' focus on the ACA and financing shouldn't take priority over focusing on other facets of their work. This stakeholder voices their oppositional perspective to the ACA:

I don't give a shit, I'm sorry… There's some providers that are CEOs and they're well aware of funding mechanisms. They say if the ACA is turned around it would be devastating to their program. If I had to be completely honest… the best thing that can happen for their program because we're not really doing all that well by people. There's that piece to it. It's always more about funding and survival than it is about the service and the care they deliver, at least at the administrative and system level. – RCO Leader 1

From this stakeholder's perspective, addiction service providers with a heavy reliance on the ACA are more focused on financing and organizational survival. Implicit in their comment is that these organizations that would be impacted by ACA failure are not devoting their attention on what matters most—the recovery population they serve.

Recovery, treatment financing, and political uncertainty

Stakeholder interviews took place in the timeframe immediately after the 2016 presidential election and a time of great uncertainty around ACA repeal and ongoing

conversations about potential Medicaid retrenchment. The environmental uncertainty resulted in stakeholder concern over any changes taking place within the addiction service delivery system.

Many of the addiction treatment policy reforms relating to the ACA are contingent upon the ACA's financing. This is a prominent shortcoming for policy transformations described in the 2016 U.S. Surgeon General's Report on Alcohol, Drugs, and Health (U.S. Department of Health and Human Services, 2016). A stakeholder who is a national recovery trainer and researcher explains why the addiction treatment system's heavy reliance on the ACA for transformation change serves as a limitation to service delivery system reform:

> *One way to think about that is if you look at the Surgeon's General report and the recommendations that came out of that report, if there was an Achilles' heel of that report with how much of that report was contingent on the availability of ACA. Because what they were talking about so much in the report was the integration of addiction treatment within multiple sectors of primary healthcare in the United States. So, in some ways, if we don't have ACA or an alternative that includes access to these [recovery support] services, then much of what the vision of that report will collapse almost instantaneously. – National Recovery Trainer and Researcher 1*

Apparent in the conversations with policy stakeholders is that recovery-oriented policy and service considerations in the context of health reform relate to the infusion of funding made available through the ACA reforms, including Medicaid expansion and the development of an addiction treatment health benefit. However, financing for services should not be the be all end all to ROSC systems transformations. The same national recovery trainer and researcher continues by describing the possible implications of ACA repeal:

People say, "Well, what if it collapses?" The biggest problem right now is in terms of how people think about this stuff is everything is contingent upon money… What I keep trying to say is some of the most innovative efforts right now in terms of recovery support do not cost the system one penny. If you look at the thousands of recovery residents that have risen in the United States to provide recover focused housing, the Oxford Houses, etc. The vast majority of that has been provided with virtually almost no federal or state dollars. – National Recovery Trainer and Researcher 1

This stakeholder's comment emphasizes the need to consider more than just the financing implications of the current policy environment and potential ACA repeal. As they note, innovations can require little to no funding such as with the proliferation of recovery houses through the Oxford House model. Moreover, this comment can be compared with observations made by stakeholders from non-expansion states where they were taking on systems transformations efforts to adopt recovery-oriented policies without the influx of ACA-related funds.

The instability of the current policy environment can have other consequences besides those which are primarily related to service financing. A federal government administrator describes how uncertainty related to the ACA has impacted service providers and their willingness to adopt innovations and transformational change:

People are uncertain about the ACA at the moment. That may have influenced some of the decision-making at the provider level… So, recovery management, which is an essential component of chronic diseases and an essential component of recovery, cannot be, shall we say, infused with the kind of wherewithal it needs in order to be sustainable

unless the decisions that affect healthcare can be normalized and stabilized. – Federal Government Administrator 1

This stakeholder's comment suggests that the instability of the current service delivery system and policy environment is hindering addiction treatment providers' ability to fully adopt recovery-oriented practices, such as recovery management, in their usual practice. This perspective is unique from the observations made by other policy stakeholders in that it emphasizes the connection between clinical practice with contextual factors in the policy environment.

Recovery and the Opioid Epidemic

Conversations with policy stakeholders were initially framed around health policy reforms pertaining to the ACA and the adoption of recovery-oriented policies, values, and services. However, it was difficult to disentangle these conversations from conversations pertaining to the opioid crisis as policy actors described how the policy reforms they were undertaking were directly addressing—and being directly impacted by—the national opioid epidemic.

Policy stakeholders generally agreed that the national opioid epidemic has directly impacted their work in the addiction field, at least to some extent. In some instances, national funding to target the epidemic has resulted in increased funding for recovery support services, but not in all cases. Some stakeholders explained that the recovery community has had an integral role in policy and community-based efforts to address the epidemic while other stakeholders noted their limited participation in early policy conversations. Furthermore, some stakeholders described how the epidemic has resulted in an increased acceptance of harm reduction approaches in the recovery community, including the use of MAT.

Opportunities for recovery

Policy stakeholders generally agree that the national opioid epidemic is a considerable policy priority for the addiction service delivery system that also serves as an opportunity to leverage recovery-oriented policy change and greater funding for recovery support services.

A national recovery advocacy organization leader describes how the recent policy work to address the epidemic has been promising, given the specific attention and resources devoted to the delivery of recovery supports and services:

> *Well, I'm optimistic in that we have a lot more information now, and we have direction, we know what's working, we know what doesn't and so, I'm optimistic because we're seeing it play out on the federal level and on the state level. [At] the federal level, with the President's Opioid Commission report, there's a lot in there around recovery support services including collegiate recovery programs and recovery housing. – National Advocacy Organization Leader 1*

This sentiment is consistent with several other stakeholders who describe state and local efforts to obtain funds through national grants devoted to the epidemic such as the State Targeted Response Grants made available through funding from the 21st Century Cures Act.

Moreover, given the increased funding for opioid-related interventions, there is increased attention on the addiction service delivery system and the potential role of peers. A national recovery trainer describes these opportunities, particularly as they relate to the professionalization of the peer workforce:

> *I think that the increase in peer roles, and the different settings where the peer workforce is now present is an education of just how far that has come… I also think that the*

certification and accreditation of the peer work that's happening… I think it's gotten a lot of attention because of the opiate overdose crisis as well. – National Recovery Trainer 6

This stakeholder highlights how the prioritization of the opioid epidemic has led to greater attention the potential role of peers in the service delivery system. States and local communities can leverage this opportunity to develop peer workforce certification and accreditation structures.

Evolving attitudes around recovery

The drastic nature of the opioid epidemic has resulted in evolving attitudes around recovery, including observations of lessening resistance to recovery-oriented services and harm reduction approaches. For example, a behavioral health services administrator and former SSA administrator describes how emergency department staff have been more welcoming towards peers:

We're obviously in the middle of an opioid crisis, so [the state government agency] actually funded… an agency that is run by a person in long-term recovery, and their staff are all people in recovery… We were able to get funded to put two of [their recovery coaches]in two of our emergency departments pretty recently… I thought the emergency departments were going to give me a hard time about this, but the two we chose were two that had been really hard hit with a lot of opioid overdoses, and so they welcomed this. As I'm looking at the data every month, the first month they got 100% of the people they saw into treatment. – Behavioral Health Services Administrator and Former SSA Director 1

In this example, we observe how peers were implemented in primary care settings with limited resistance from the medical staff. As this stakeholder explains, the urgency of the opioid crisis

has resulted in a more welcoming environment for the peers, as they were able to ensure linkages for all clients who had entered the emergency department to addiction treatment.

Furthermore, an SSA administrator points out that some grassroots community leaders have observed cultural shifts taking place in RCOs as people in recovery from opioid use disorders increasingly constitute group membership and are helping to change perceptions on the viability of having multiple pathways to recovery, including the use of MAT:

> *A lot of the people in the recovery centers [were] having challenges with alcohol and other substances weren't real friendly and open to opiate addicted individuals. I think as the landscape changed, that's really changed as well, and the recovery center's recruiting more people that were in recovery from opiate addiction, and that's really helped move things a lot…Some people were very against the medication, and you know, everybody did a lot of work. You know, these are evidence-based practices, the field is changing, what works is changing. That was a part of it, and then another part is just the different cultures, you know? – SSA Administrator 1*

These ideological changes have also been observed with allies not directly involved in addiction treatment or recovery support. An RCO leader describes how, as a result of their work addressing the opioid epidemic, first responders and law enforcement have been more sympathetic to the addiction population and stigma has dissipated to some extent:

> *I think that first responders are tired of watching kids die and that's why Narcan has exploded. I also think it brings attention much more to the addiction problem. That's a lot of what's fueling funding for grants in the emergency department, but what we're also seeing is the heroin is just a smaller piece. There's a lot of alcohol. It's still the number one problem. It's an interesting offshoot, if you will, or collateral response, is that they*

want to deal with all the addiction in heroin, when a lot of other people are seeing now that it's been there all along. – RCO Leader 1

Arguably, the drastic nature of the opioid epidemic has spurred attitudinal shifts around peer-delivered services, harm reduction approaches such as MAT, and the stigma related to those with alcohol and drug problems.

Unintended consequences on recovery

Although stakeholders spotlighted several of the opportunities offered by the growing policy attention paid to the opioid crisis, some policy actors also pointed out some of the unintended negative consequences of the crisis on recovery-oriented policies, values, and services.

Some stakeholders expressed concerns over the policy and media attention focused on the opioid epidemic as it drew attention away from other areas of concern. As previously mentioned, the federal government has devoted considerable resources to the opioid crisis through the 21st Century Cures Act. Some stakeholders are concerned, however, about the limitations to this funding. A federal government administrator describes how federal funding for the opioid epidemic is primarily for providing clinical treatment and very little is allocated for recovery support services:

The $500 million for opioids, in the Cures [Act], it was what? $1 million, $3 million for recovery? Out of the $180 million that they envisioned. The focus is on treatment. Who is out dealing with recovery? – Federal Government Administrator 1

This stakeholder sheds light on the limited funding made available for recovery support services. Moreover, they also describe the financing barriers that exist in the service delivery system

between services that are deemed to be addiction treatment and those deemed to be recovery support.

An RCO leader voices concern about the limited focus of current national attention on curbing the opioid epidemic on addiction treatment, and MAT, more specifically:

> *Often in the [state] and all these opioid forums that every city is having, they talk about medication, and medication-assisted treatment, medication that's insured coverage, Suboxone, Narcan, Naloxone, blah, blah, blah, blah, blah, and I always see my hand in the air and they say, "Crap, what are you going to say now?" I always say that the answer to the heroin epidemic, to the opioid crisis, to the addiction affliction, is not treatment, it's not medication. I say that again. I say, "The answer is long-term, life-redeeming, life-sustaining, recovery." – RCO Leader 1*

From this RCO leader's perspective, the discourse on how to address the opioid epidemic should revolve less on addiction treatment and MAT and more on the value of long-term recovery.

Discussion

In recent years, recovery-oriented policies and services have increasingly been implemented in the addiction service delivery system. However, these recovery-oriented policy changes have not taken place in a policy vacuum. The ACA has resulted in drastic changes in the organization, funding, and delivery of addiction treatment that has arguably transformed the addiction service delivery system more so than any other policy in recent history. Moreover, the national opioid epidemic has drastically impacted states and local communities and has cast a spotlight on the addiction service delivery system.

Policy stakeholders explored the intersections among recovery-oriented policies and initiatives and federal and state-level policy reforms intended to improve the accessibility and quality of addiction treatment and to address the opioid crisis.

Recovery and the ACA

Addiction service delivery policy reforms vary across states, with a big distinction in policy reforms among Medicaid expansion and non-expansion states. In states that have adopted ACA reforms including Medicaid expansion, addiction treatment is being financed through Medicaid allowing states to use other funding sources, including the SAPT block grant, to funds recovery-oriented services and initiatives.

In Medicaid expansion states, conversations with policy stakeholders revolved around the provision of recovery support services and not around recovery-oriented systems transformations. States are increasingly using Medicaid to finance addiction services, which is freeing up block grant funds for other purposes. However, it is also important to keep in mind that the adoption of ACA reforms is not necessarily the key ingredient for ROSC transformation. Medicaid expansion states are making investments in recovery support service delivery rather than broader philosophical and policy transformations. In states that have not adopted ACA reforms, some of the philosophical changes related to ROSC transformation are underway. This difference in focus among expansion and non-expansion states is likely due to the fact that states that have adopted ACA reforms are devoting their efforts to broader systems transformations related to the financing and delivery of addiction treatment. On the other hand, non-expansion states are not adopting such drastic reforms, have less growth in the resources entering their system as a result of the ACA, and are, thus, needing to find other kinds of policy innovations, such as ROSC systems transformations, to improve their systems of care.

Given the political uncertainty of the current policy environment with respect to discourse around ACA repeal and replace and prospective Medicaid retrenchment, stakeholders are concerned about the focus in the service delivery system on financing concerns and on the instability of the policy environment's impact on their ability to effectively implement recovery-oriented policies and services.

Recovery and the Opioid Epidemic

Generally, policy stakeholders discussed the opioid epidemic and addiction recovery in a few ways. The mobilization of the recovery community to address the opioid epidemic was effective in some communities but not in others. With national attention on the opioid epidemic, some stakeholders pointed out that the addiction service delivery system could leverage this attention through recovery-oriented policy reforms and greater funding for recovery support services. Moreover, the urgency of the epidemic has resulted in less resistance from some stakeholder in implementing some initiatives, including peers in emergency department settings. Some stakeholders pointed out some concerns, however, including the fact that little funding from national grants targeting the epidemic are devoted specifically to recovery. In addition, the narrow policy focus on opioids neglecting the impact of alcohol, other substances, and other risk factors impeding one's ability to obtain recovery.

The ideological divide in the recovery community persists between those embracing multiple pathways including harm reduction and those aligning themselves with a 12-step, abstinence-based approach. However, some grassroots community leaders have observed that cultural shifts are taking place in RCOs as more people in recovery from opioid use disorders are changing perceptions on the value of embracing multiple pathways to recovery.

Conclusion

In this chapter, we explored how policy stakeholders considered recovery-oriented policies and services within the context of current health policy reforms and the national opioid crisis. Although policy actors highlighted the opportunities to leverage the current national focus on health policy reform and the opioid epidemic by adopting recovery-oriented policies and services, they also pointed out several challenges and barriers to effective planning and implementation.

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Chapter 8. Conclusion

Overview

As a result of the New Recovery Advocacy Movement, recovery has increasingly been used as an organizing framework for addiction policies and services in recent years. In this study, I explored how policy stakeholders in the addiction service delivery system developed their definitions for recovery and descriptions of its values and principles, its conceptualization as a system of care, and its essential scope of services and supports. Furthermore, I contextualized how recovery-oriented principles, policies, and services are being implemented in the current addiction service delivery system with respect to the national opioid crisis and current federal and state-level health policy reforms, including the Affordable Care Act (ACA).

Summary and Discussion of Results

I explored how policy stakeholders in the addiction service delivery system define recovery and elaborate its underlying values and principles. In Chapter 4, I learned that stakeholders define and describe addiction recovery in a variety of ways, with discourse revolving around the relevance and limitations of explicit mention of abstinence and SUD. Stakeholders also described the importance of self-directed and community-driven processes of defining recovery and examined how recovery definitions and descriptions influence measurement efforts. Given the value placed on community participation in recovery-oriented practice, I examined the relationship between community-directed approaches to defining recovery and elaborating its values and the role of federal and state government agencies in funding recovery-oriented initiatives and in influencing the adoption of particular definitions over others within state and local systems of care. I also explored the contextual nature of

recovery definition adoption, as participation in the policymaking processes heavily influence the development of these definitions.

Although countless efforts have been made to define recovery and elaborate its values and principle, stakeholders also acknowledged how these efforts only go so far in bringing about greater changes to the addiction field. In Chapter 5, policy stakeholders described the perceived shortcomings of the current addiction treatment system and their perspectives on an idealized recovery-oriented system of care (ROSC), including its essential characteristics. Transformation towards a ROSC was described as a complex, ongoing process that required innovative and supportive government leadership, a mobilized grassroots advocacy community, and prioritization of recovery-oriented policy transformation.

Recovery support services are an essential element for individuals with substance use disorders (SUDs) to manage their recovery. In Chapter 6, policy stakeholders generally conceptualized recovery support services as non-clinical services and supports people use in addition to—or in in lieu of—clinical addiction treatment. Most stakeholders stressed the value of lived experience and having peers administer recovery support services. However, some policy actors had a different perspective and believed that other characteristics including compassion, the ability to provide recovery support continuity, and cultural relevance were more important than lived experience. In instances when recovery support services are administered by peers, stakeholders described the workforce considerations necessary to address when peers are paid professionals, including issues pertaining to licensure and accreditation, financing, and supervision. In a ROSC, recovery support services would ideally be tailored to an individual's needs in their stage of recovery management and would be delivered in a variety of settings, including in healthcare and addiction treatment settings but also in community-based settings.

The increasing adoption of recovery-oriented policy changes in recent years has occurred within the context of other health and behavioral health policy priorities, including the implementation the Affordable Care Act (ACA) and the addiction service delivery system's efforts to address the national opioid crisis. In Chapter 7, I examined how federal and state-level health policy reforms were impacting—and impacted by—efforts to adopt recovery-oriented policy changes and to implement recovery support services. States and communities adopting ACA-related policy reforms, including Medicaid expansion, were taking on efforts to pay for recovery support services through Medicaid reimbursement and reallocated use of state block grant funds. Moreover, these states and communities were developing policies in order to reimburse for peer-delivered recovery support services. In comparison, states that were not adopting ACA-related reforms were not undergoing transformative policy and financing reforms to their addiction treatment systems and were, thus, not receiving an influx of funding to finance more recovery support services. These states and communities, however, were adopting ROSC transformation efforts as a means of improving the accessibility and quality of their service delivery systems. Policy stakeholders typically described the opportunities afforded by the policy prioritization of the national opioid epidemic and the ACA. However, stakeholders expressed concerns over several challenges and barriers including the service delivery system's continued focus on financing and delivering addiction treatment rather than recovery support services, the uncertainty of potential ACA repeal and Medicaid retrenchment in the current political environment, and the acute focus on opioid use disorder treatment.

How do we consider these conversations about recovery definitions, recovery-oriented systems of care, recovery support services, health policy reform, and the opioid epidemic in constellation and distill these stakeholder perspectives to what matters most? These

conversations provided insight in the range of policy actor perspectives in the addiction service delivery system, but they have also highlighted the constraints to how we conceptualize addiction treatment, its scope of services, its workforce, and its system of care.

Historically, SUDs have been addressed through three mechanisms of support including informal family and friend networks of support, peer-based recovery and mutual aid groups, and professionally-directed addiction treatment (White, Kelly, & Roth, 2012, p. 297) as well as through punitive intervention through the criminal justice system. And, as discussed in Chapter 2, it is nearly impossible to disentangle the influence of mutual aid approaches from professionally-driven addiction treatment given the role of Alcoholics Anonymous (AA) in the development of so many early models of addiction treatment.

Addiction treatment, as it exists today, took shape in an era of medical professionalization of helping fields and professions. Fields such as addiction, psychology, and social work have moved towards the development of workforce licensure and accreditation standards that value education and training over lived experience and a growing reliance on healthcare-allocated funding. This medicalization of addiction treatment has left little room for peers with lived experience as recovery support providers, especially in healthcare settings guided by the rules attached to healthcare funding, such as the Medicaid reimbursement requirement that peers be supervised by licensed clinicians.

The medicalization of addiction treatment has also constrained the role of the community as providers of recovery support services, as a setting for service delivery, and as advocates for recovery-oriented policy change. In comparison, in its ideal form, a recovery-oriented addiction service delivery system values the role of all community members, including clinicians, people in recovery, family members, and other allies in shaping a recovery-oriented environment and

providing support to those with recovering from alcohol and other drug problems. As states and local communities attempt to transform their addiction service delivery systems towards a ROSC, they must consider these tensions and potential policy and stakeholder barriers towards reform.

Furthermore, this study primarily focused on the perspective of policy elites given their decision-making power with respect to service delivery and policymaking. How do the attitudes and actions of elites impact the non-elites who are most impacted by their decision-making? Historically, addiction treatment clients have had a minimal role in their own service delivery and policy planning and implementation. This shift towards ROSC increases non-elite responsibility, power, and decision-making in their treatment and long-term recovery planning, in direct service delivery, and in community-based and policymaking advocacy. One might argue that these increases in self-determination and responsibility are a good thing. One should also consider how increased responsibility for one's own wellness and recovery impacts the roles and responsibility of the addiction treatment community and other service delivery actors.

Returning to Bacchi's framework for understanding the framing of social problems and their policy solutions (Bacchi, 2016), this study spotlights the heterogeneity of policymaking perspectives in the contemporary addiction service delivery field and the evolving nature of problem and policy framing. Recovery advocacy stakeholders perceive a problem with the current addiction treatment system that can only be resolved through increased participation of people in recovery as service providers and policymaking partners. In contrast, addiction treatment policy and healthcare finance stakeholders foreground the problem of treatment access and quality and view system reform through financing and regulations reforms as the best approach to reform.

As policy actors explored the many roles of recovery within the context of addiction service delivery systems, they described the ideological tensions that currently exist within addiction treatment, behavioral health, and healthcare. Within the recovery community, there is a persisting but evolving tension between abstinence-based values and acceptance of harm reduction approaches to recovery that has been exposed by the urgent need to address the national opioid crisis through the use of medication-assisted treatment. As recovery support services are increasingly financed through Medicaid, the tension between peer volunteerism and workforce professionalization is worth further examination. As peers increasingly become part of addiction treatment and integrated healthcare teams, there is resistance and skepticism about their legitimacy among clinical treatment staff and other health professionals.

The national opioid epidemic has shed light on the need for an effective addiction treatment service delivery system and the urgency to address the crisis has led to policy improvements across the country. ACA reforms, including expansion of Medicaid coverage and other health policy reforms, have undoubtedly provided opportunities to improve access to addiction services, but it is important to consider the constraints of these improvements. Policy and funding constraints persist and limit the ability of states and local communities to offer adequate housing supports to people with SUDs. Additionally, the constraints of health insurance-based funding such as Medicaid limit the kinds of recovery support services that are paid for and inhibit the delivery of services and supports in certain community-based settings.

A transformation towards ROSC requires sweeping organizational and policy reforms to addiction service delivery that extend beyond the capabilities of the ACA. States that have selected to adopt ACA reforms are preoccupied with financing reforms that are intended to improve the accessibility and quality of addiction treatment and the need to curb the opioid

crisis. Policy actors in these states were not focused on sweeping recovery-oriented systems transformation. Rather, they were making incremental policy change efforts to improve the accessibility of recovery support services, including peer-delivered services and support. While some policy stakeholders in the addiction service delivery system remain optimistic about the systems change efforts and policy improvements that have been made in recent years, particularly with respect to the ACA, other stakeholders are concerned that the momentum of the New Recovery Advocacy Movement has been lost and that addiction service delivery systems transformation has not happened quickly enough. Furthermore, as a result of changes in federal government agency leadership and the 2016 presidential election, several of the key leaders in the federal government who had been early adopters and advocates of recovery-oriented policy innovations are no longer in decision-making positions.

Study Limitations

When considering the results for this study, it is important to keep in mind its limitations. This study focuses on national, state, and local perspectives on addiction recovery policy and service delivery. Several of these stakeholders resided in Washington, DC or elsewhere but were nationally focused in their scope of expertise. Additionally, stakeholders represented 12 state agencies and a county and metropolitan region in two additional states. Although these stakeholders represented a range of perspectives and geographic regions, it is important to consider the limitations to the generalizability of these findings.

Given the focus of this study on the policy elites of the addiction recovery community, many of these stakeholders worked in states and local communities that had undertaken substantial policy transformations towards ROSC and, thus, these policy actors had been involved in national conversations about recovery-oriented policies and services. In considering

the challenges and barriers towards recovery-oriented policy adoption, it would have been appropriate to speak with a greater number of policy stakeholders in states and local communities that have faced significant challenges to adopting recovery-oriented policy change. However, it should also be noted that this study also benefited from its national scope and concentrated focus on a handful of states and local communities, as this approach offers greater insight into the policy decision-making and implementation process in these sites. This information can be considered by SAMHSA and other federal and state entities as they consider the provision of training and technical assistance in order to promote recovery-oriented policy change.

Last, I approached this study with limited focus on policy stakeholder identity and did not collect data on participant race/ethnicity, age, gender, socioeconomic status, or other personal characteristics. Given the involvement of these participants in federal and state-level policy decision-making, one can make certain assumptions about education and privilege. As I began to analyze interview transcripts, I began to make assumptions about race and ethnicity—particularly when interviews did not explicitly address issues of race/ethnicity or culture. That being said, participants of the New Recovery Addiction Movement and the perspectives of policy stakeholders selected for this study were predominantly white and middle class. More efforts could have been made to understand the heterogeneity of voices from the recovery advocacy community.

Implications for Policy and Practice

Recovery is an evolving organizational framework for understanding addiction treatment including the effectiveness of service delivery and client and community-based outcomes. Addiction health services research has been embedded in and centralized around the medical

model of services research and operation. This leads to data collection and evaluation efforts that are, by default, juxtaposed with medical standards for wellness and care. The results of this study suggest the need to broaden conceptualizations of addiction service delivery to more closely align with public health and community-based approaches. This widening in perspective could extend the scope of services that the addiction service delivery system finds and administers in order to reduce policy barriers towards the provision of housing and other recovery support services typically not financed by health insurance and government grants. Moreover, this reframing could also have implications for the measurement and evaluation of services and supports and outcomes for recovery.

This study highlights the continued need for education and training pertaining to recovery-oriented values and principles and, in particular, the need to strengthen collaborations between addiction recovery and treatment communities and between the addiction field and other sectors of healthcare. Federal and state government agencies, including SAMHSA and the SSAs, must identify the policy barriers that exist for the implementation of improved addiction treatment systems, especially those towards financing and delivery particular recovery support services, including housing and peer-delivered services and supports.

With regards to practice, the Medicaid requirement that peer workforce must be supervised by a trained clinician has particular relevance to clinical workers. Specifically, trained clinicians must learn how to work in collaborative teams with peers and how to promote the value of lived experience when working with clients with SUDs. Additionally, addiction treatment providers must evolve beyond clinical practices that are focused on acute care and reframe practice towards a community-based, chronic care model. Furthermore, practitioners in the addiction service delivery system, such as social workers, are particularly well situated to

promote client-driven treatment decision-making and community-based advocacy, which are essential elements for a recovery-oriented system.

Future Research

This study elucidates several possible directions for future qualitative, quantitative, and mixed-methods studies. First, the variation in policy stakeholder perspectives on how best to define recovery warrants further examination of recovery's core elements and the operationalization of these definitions as service and client outcome measures.

Second, more can be done to better understand the essential elements of a ROSC. What elements of a service delivery system should states and counties change in order to achieve ROSC transformation? How can federal and state government agencies best support these policy reforms through training and technical assistance efforts?

Third, policy stakeholders in this study highlighted the range of recovery support services they believed were essential in a system of care, including peer-delivered services and supports. However, little is known about which services and supports are financed across states, including those that might typically be financed through non-health and behavioral health treatment sources for funding.

More can be done to understand the heterogeneity of perspectives in the addiction treatment and recovery fields. Perspectives of a more diverse group of stakeholders, including greater perspective from grassroots communities (e.g., Latino and Asian Pacific Islander American recovery communities, religious and spiritual groups, and immigrant groups, among others) would be beneficial in depicting more complete picture the policy community's perspectives.

Finally, what does recovery-oriented policy and service delivery look like in the mental health community? How is ROSC operationalized in other countries with notable recovery movements, such as Australia, Canada, and the United Kingdom? These comparisons would provide insight into policy and service delivery processes that might serve beneficial as the addiction service delivery system continues in its own efforts to improve its system of care.

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Appendix 1. Glossary of Acronyms

AA: Alcoholics Anonymous

ACA: Affordable Care Act

MAT: Medication-assisted treatment

MCO: Medicaid Managed care organization

NASADAD: National Association of State Alcohol and Drug Abuse Directors

NDATSS: National Drug Abuse Treatment System Survey

ONDCP: Office of National Drug Control Policy

RCO: Recovery community organization

ROSC: Recovery-oriented system of care

SAMHSA: Substance Abuse and Mental Health Services Administration

SSA: Singe State Agency for addiction services

Appendix 2. NDATSS State Case Studies Interview Guide

Topic: Participant and Agency Background
1) To start, can you tell us about your agency/organization and your specific role(s)? [Probes: role (formal and informal), tasks and responsibilities, agency affiliation, length of time in the position, professional background]

Topic: State Policy Priorities
2) What are the state's policy priorities with regard to SUD services? [Probes: state priorities, organizational priorities, is Medicaid reform a priority, is commercial insurance a priority]
3) How would you describe the broader landscape for healthcare and behavioral health?
4) Are there any health or behavioral health policies or legislation [in the state] that have been passed or enacted in the past few years that are worth noting? If so, please describe them.

Topic: Medicaid
5) Medicaid coverage impacts many people with behavioral health issues. Can you talk about your [state]'s priorities with respect to Medicaid and SUDs? [Probe: IMD Exclusion, waivers]

Topic: Commercial Insurance and the Insurance Exchange
6) How does your work intersect, if at all, with the work being done with commercial insurance and SUD service coverage? [Probe: Insurance Exchange and Qualified Health Plans; parity]

Topic: Recovery-Oriented Services and System
7) How do the concepts of recovery and recovery-oriented systems of care fit in, if at all, with your work in addiction service delivery system?
8) What recovery support services are being implemented in state? [Probe: identify service types, peer-delivered services, funding sources, policy facilitators and barriers]
9) How, if at all, is the state adopting recovery-oriented policies and ROSC systems transformation? [Probe: key players, collaborations, efforts with training/technical assistance, financing, policy barriers and facilitators]

Topic: Data Systems and Reporting
10) How would you describe data systems and reporting requirements in your system? How might they be changing or evolving as a result of recent policy changes? [Probes: interoperability; performance, quality, process and outcomes]

Topic: Systems Integration
11) How would you describe the efforts that are taking place regarding systems and services integration? [Probes: primary care; mental health/behavioral health; systems and services]

Additional Topics
12) Given the recent **election and change in leadership**, how have you been considering potential changes to health policies and the SUD service system?
13) How has the **opioid epidemic** played a role, if at all, in the work that you do?
15) Are there **stakeholders** in your state with whom we should connect?
16) Are there any **topics** that you think are important to share that we have not discussed?

Appendix 3. Addiction Recovery Stakeholder Project Interview Guide

Interview Guide Questions

1) Please tell me about your role and your agency/organization as it relates to addiction recovery. [Probes: Organization affiliation, professional role, years of experience]

Topic: Defining Recovery

2) SAMHSA's working definition for recovery is: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." How would you define "recovery" as compared with this definition? [Probe: process for developing definition; what is SAMHSA's definition lacking; what *isn't* recovery; mental health recovery]

3) Recovery management "is a philosophy of organizing addiction treatment and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery" (White, p. 18). How did you come to develop your definition for recovery management? How might your conceptualization differ from others?

Topic: Recovery-Oriented System of Care

4) ROSC "refers to the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes. The 'system' in this phrase is not a federal, state, or local agency, but a macro-level organization of the larger cultural and community environment in which long-term recovery is nested" How did you come to develop your conceptualization for ROSC? What *isn't* a ROSC? How might your conceptualization differ from others?

Topic: Recovery Support Services

5) Which services do you think are most important to include in a ROSC? [Probes: Primary care services, SUD clinical treatment services, ancillary services, peer-delivered services, mutual aid groups]

6) In which types of settings are these services delivered? Are there challenges to getting certain kinds of services delivered in certain settings over others? Why?

7) Who should administer these services (e.g., peers, clinical treatment providers, others)?

Let's talk more specifically about peer-delivered services. What are some of the challenges of implementing these services?

Topic: Process and Outcome Measures

8) What kinds of outcomes would we want to see from these services for someone to recover? [Probes: Health, mental health, addiction, social, educational/professional]

Topic: Healthcare Reform

9) Thinking more broadly about the implementation – and evolution – of healthcare reform (including ACA, parity, Medicaid expansion, the SAPT block grant funding, among other policy changes), how has healthcare reform impacted the development of a ROSC? What constraints does healthcare reform have on implementing a ROSC? What facilitating factors does healthcare

reform have on implementing a ROSC? [Probes: ACA, parity, Medicaid expansion, block grant, funding reforms, peer professionalization]

Topic: Historical Context

10) Why is this shift towards a ROSC happening now? [Probe: Historical events in healthcare, recovery advocacy (HIV, mental health etc.)]

11) What is working well? What have been the challenges? [Probe: behavioral health, mental health]

12) Which other **stakeholders** are important to connect with to get a better understanding about this topic?

13) Are there **other topics** you think are worth discussing that we have yet to discuss?

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