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Effectiveness of the Recovery Movement
An Interview with Michael Flaherty, Greg Williams, Lee Kaskutas, and Alexandre Laudet

PAUL ROMAN: How does the Recovery Movement measure its effectiveness?

MICHAEL FLAHERTY: I believe I covered this above. The science and practice is still in its early formation but the measures introduced and discussed above are setting the early evaluation. There are many others. The measures studied are both quantitative and qualitative. Federal (SAMHSA) and state measures are usually broad and want to know status of the person, access, retention and outcomes. Counties similarly at this point. In years to come the measures noted in 8A above will come into play as our systems become more focused and sophisticated. Cost and cost-offsets measures—associate to closing revolving doors, people getting well, reductions in related societal costs etc. will be critical BUT we have to remember that today only about 10% of those needing treatment get or want it. We have to work at that 10% with Recovery Management while getting to the other 90% before we'll truly see a significant reduction in the annual $385 billion dollar annual cost of substance use disorders to American annually (ONDCP, National Strategy, 2013).

LEE KASKUTAS: I don't know. I guess by the number of people on its listserves, by the number of people at the September Recovery Month events, etc.

PAUL ROMAN: Is there evidence of this effectiveness?

MICHAEL FLAHERTY: Yes. There is really more evidence than most people think. In Connecticut, using an early ROSC approach, the state reduced acute care by 62% while increasing ambulatory care by 78% and new admissions by 40% while reducing the overall cost per person to the state by 14%—despite the adding many recovery support services. Philadelphia also reports similar expansion of services and positive system outcomes.

In their following of over 190,000 individuals the Access to Recovery Initiative had 73% of its individuals reporting no drug use at discharge; 23.4% more had stable housing, 30% more were employed; 62.4 had improved social relations and there was an 86% reduction in CJ involvement in this population. Scott and Dennis, in a four-year outcome study on early intervention and recovery management, found significant reductions in drug use, health and personal problems, need for acute care and involvement with CJ in their populations. Jim McKay and others have found improved treatment attendance when families and telephone contacts and in person interviews are part of continuing care; Melle and Moos and Moos have documented correlations and significant improvement in long-term recovery when associated to such supports; Wallace and

Weeks have done similarly with youth, observing improved adherence to treatment when focused on wellness or recovery in this population; Szapocznik had earlier documented the power of follow-up phone calls to reduce no-shows by 50% and early discharge from treatment by 24%.

Gary Zarkin and colleagues projected a cost-ratio benefit of using the chronic model vs acute to be for every dollar spent in acute care society saves $4.86. In the chronic model the savings grow to $37.72. Internationally, Le Boutillier, Leamy, Bird, et al. reported client improvement in 16 areas of clinical practice using Recovery Management in six countries. Ultimately those 16 practice areas (e.g., clients rights/respect; quality of care, social inclusion, personal vision, etc.) enhanced four practice domains: citizenship, organization commitment, self-defined and sought recovery and the therapeutic relationship. Alexandre Laudet has written for 15 years on the experience of and pathways to recovery and how to improve treatment practice to support it. Similarly Keith Humphreys on the effects of treatment and value of 12 Step or fellowship supports. I could on but will stop here. Recall that above we noted many others and that there are over 1,500 peer reviewed researched articles now that are related.

GREG WILLIAMS: Yes, there is evidence of such effects. As I described earlier, the current CARA 2014 federal legislation that will increase treatment, prevention, and recovery activities is been driven by the Recovery Advocacy Movement.

LEE KASKUTAS: I would not think that participation is adequate evidence of effectiveness.

PAUL ROMAN: Do you believe these measures are adequate to convince legislators and the general public that support for the Recovery Movement is a sound investment?

MICHAEL FLAHERTY: Yes – if its gets the chance to, if ONDCP, research, SAMHSA and states and providers join to, and if those in recovery continue to be examples of where we want to go. We need more collaboration from the research Institutes and providers on SU as a chronic illness and prevention, intervention, treatment enhanced by individual, family and community recovery as the way to address it. We need proven strategies to gain the needed support for treatment and recovery focused care if we are to move from our old acute systems and model into a 21st century understanding and model that reports the effectiveness of treatment and recovery to and for all stakeholders. This won't be easy given limited resources, the fear of change and the need for an honest admission of the magnitude of the problem and possibilities to solve it. We're getting there though.