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Improving Community Health Through Policy Research

TREATMENT & RECOVERY FOR SUBSTANCE USE DISORDERS IN INDIANA

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

Substance abuse is a significant public health concern. When drug or alcohol use regularly causes a person substantial life consequences, he/she has likely transitioned from occasional, potentially problematic, use to having a substance use disorder (SUD). In 2014, almost half a million Hoosiers (8.5%) met the criteria for SUD.

SUDs are associated with significant morbidity, mortality, and social and economic consequences. For example, Indiana's drug-induced mortality rate quadrupled from 4.8 per 100,000 persons in 2000 to 19.2 per 100,000 persons in 2014. The staggering social and economic costs of SUDs suggest that more effort needs to be placed in not only preventing the development of SUDs, but also in providing timely and appropriate treatment for affected individuals.

Indiana had 294 active substance use treatment providers in 2013. Most of these treatment facilities had outpatient treatment centers (93.1%); a small percentage provided residential (10.5%) and hospital inpatient care (12.0%).

In 2013, there were nearly 26,000 admissions to substance abuse treatment programs in Indiana. The substances most frequently abused by the state's substance abuse treatment population were alcohol (57.3%), marijuana (48.3%), and opiates/synthetics (22.0%).

Treatment systems have traditionally used an acute-care approach to address SUDs. The new paradigm proposed by the Substance Abuse and Mental Health Services Administration (SAMHSA) is a continuing-care model. It acknowledges the long-term nature of SUDs and emphasizes the need for ongoing access to services built around the concept of recovery.

Recovery-oriented systems of care (ROSC) require agencies and providers to develop a full continuum of SUD services. This continuum of services should include not only traditional inpatient, residential, and outpatient services, but also nontraditional services, such as recovery maintenance, peer services, and community-based recovery support services.

Key informants interviewed for this study made policy recommendations to address existing barriers and allow for a recovery-oriented system of care to emerge more rapidly in Indiana. They suggested the creation of policies to:

1. Promote accurate information about addiction and recovery, using the language or terminology of recovery.
2. Mandate inclusion of representatives from the recovery community in all aspects of recovery-related planning.
3. Promote a recovery-oriented system of care approach.
4. Tie funding to the use and expansion of recovery services.
5. Require the use of best practices for recovery.
6. Provide recovery services for individuals in the correctional system during incarceration and after they return to the community.
7. Improve employment opportunities for peer recovery workers and integrate them into organizations that serve individuals who are in recovery from SUDs.

SUBSTANCE ABUSE

Substance abuse is a significant public health concern. The National Household Survey on Drug Use and Health (NSDUH) estimated that in 2014 approximately 9.8% of the U.S. population 12 years of age or older used illicit substances, including nonmedical use of prescription drugs, and 22.9% of Americans engaged in binge alcohol use in the past month.[1] Although the majority of individuals who occasionally participate in risky drinking or illegal substance use never experience serious consequences, others may find that over time their alcohol or drug use escalates to the point where it impairs their day-to-day functioning. When drug or alcohol use regularly causes a person substantial life consequences, she or he has likely transitioned from occasional, potentially problematic use, to having a substance use disorder (SUD).

The American Psychiatric Association (APA)[2] describes the primary characteristic of a SUD as continued use of a substance in spite of significant substance-related problems. Individuals with SUDs can have symptoms that are cognitive, behavioral, and physiological in nature. These symptoms result from underlying changes in brain circuits or brain chemistry and serve to support ongoing substance use. Examples of symptoms include:

- having strong drug cravings or urges to use;
- ignoring responsibilities in order to use;
- spending more and more time using;
- developing tolerance (i.e. needing more of the drug to achieve the same effect); or

- experiencing withdrawal (i.e. having significant physical discomfort when blood or tissue levels of the drug decline below a certain threshold).[2]

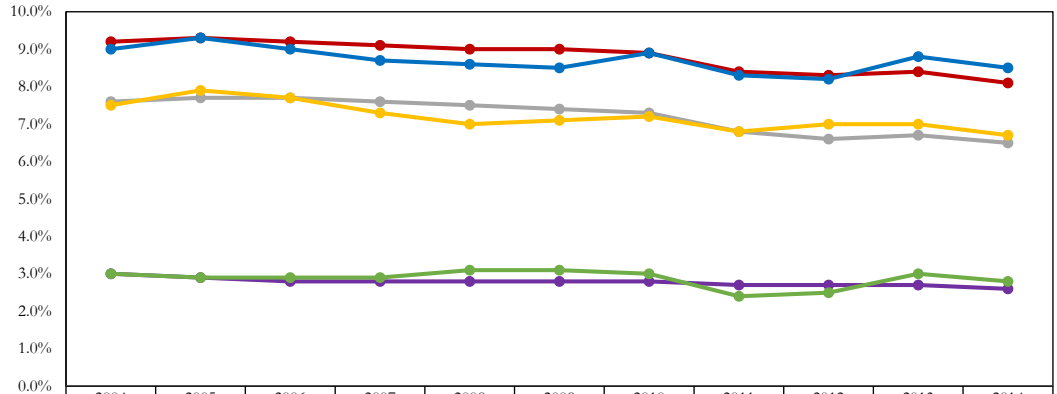
The APA has discontinued the practice of using the categories of substance abuse and substance dependence to demarcate the severity of a SUD,[i] preferring to view them as falling on a continuum of impairment ranging from mild to moderate to severe.

This technical report will discuss prevalence rates of SUDs both nationally and in Indiana; examine trends and critical issues related to the treatment of SUDs; describe the concept of recovery and how incorporating recovery into interventions for individuals with SUDs can result in better long-term outcomes; and provide a qualitative analysis of how recovery is being addressed in Indiana, along with policy recommendations to include a recovery-related focus into Indiana's SUD service system.

Prevalence of SUDs

The NSDUH provides prevalence estimates for SUD at both the national and state level.[ii] According to findings from their 2014 survey, 21.5 million U.S. citizens, or 8.1% of the population 12 years of age or older, had met the criteria for any SUD in the past year. Of those, over 17.2 million met the criteria for an alcohol use disorder (6.5%), 6.9 million met the criteria for an illicit-drug-use disorder (2.6%), and 2.7 million (1.0%) exhibited signs of both. Past-year prevalence rates were similar in Indiana with 464,108 Hoosiers (8.5%) meeting criteria for any SUD; 365,826 (6.7%) having an alcohol use disorder; 152,882 (2.8%) having an illicit-drug-use disorder; and 54,601 (1.0%) estimated to have both. Since 2004, there has been little change in either the national or state SUD prevalence rate (see Figure 1).

Figure 1. Changes in Prevalence Rates of SUDs over Time (NSDUH 2004-2014)



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Any SUD - US	9.2%	9.3%	9.2%	9.1%	9.0%	9.0%	8.9%	8.4%	8.3%	8.4%	8.1%
Any SUD- IN	9.0%	9.3%	9.0%	8.7%	8.6%	8.5%	8.9%	8.3%	8.2%	8.8%	8.5%
Alcohol SUD - US	7.6%	7.7%	7.7%	7.6%	7.5%	7.4%	7.3%	6.8%	6.6%	6.7%	6.5%
Alcohol SUD - IN	7.5%	7.9%	7.7%	7.3%	7.0%	7.1%	7.2%	6.8%	7.0%	7.0%	6.7%
Illicit Drug SUD - US	3.0%	2.9%	2.8%	2.8%	2.8%	2.8%	2.8%	2.7%	2.7%	2.7%	2.6%
Illicit Drug SUD - IN	3.0%	2.9%	2.9%	2.9%	3.1%	3.1%	3.0%	2.4%	2.5%	3.0%	2.8%

Alcohol use disorder is the most prevalent SUD in the U.S. In terms of illicit drugs, marijuana use disorder is the most common, impacting 4.2 million (1.6%) citizens 12 and older annually followed by SUDs tied to the use of prescription opioid analgesics, which affect 1.9 million persons (0.9%) annually. SUDs related to cocaine, heroin, hallucinogens, inhalants, stimulants, tranquilizers, and sedatives together affect less than one percent of the U.S. population over 12 years of age.[1] Estimates for the prevalence of SUDs resulting from the use of specific illicit substances are not currently available for Indiana.

[i] Until 2013, substance abuse was defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress and manifested by at least one of the following symptoms occurring within a 12-month period: recurrent substance use resulting in failure to fulfill major role obligations; recurrent substance use in situations in which it is physically hazardous; recurrent substance-related legal problems; or continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance. Substance dependence was defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress and demonstrated by three or more of the following in the same 12-month period: tolerance; withdrawal; taking a substance often in larger amounts or over a longer period than was intended; or having a persistent desire or unsuccessful efforts to cut down or control substance use (APA, 2004).

[ii] To maintain consistency across time, the NSDUH continues to use the DSM-IV definition for SUDs which distinguishes between substance abuse and substance dependence.

National prevalence estimates based on the National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III) rely on the DSM-V definition for SUDs. Based on the NESARC-III, in 2013 13.9% and 3.9% of US adults 18 years or older met criteria for a past year alcohol or illicit-drug-use disorder respectively. The NESARC-III's estimates are significantly higher than the 7.1% and 2.6% estimates for alcohol or illicit-drug-use disorders for persons 18 and older reported by the NSDUH. The difference between the estimates is attributed to underdiagnosing of SUDs, particularly substance dependence, when using the DSM-IV criteria.[3-5]

Demographic Characteristics of Persons with SUDs

The prevalence of SUDs in the U.S. varied according to demographic characteristics such as age, gender, and race/ethnicity. Young adults were significantly more likely to experience these disorders than any other age group; males had a higher prevalence of SUDs than females; and non-Hispanic Blacks had a significantly higher prevalence of illicit substance use disorders than other racial/ethnic groups (see Tables 1A and 1B).[6]

Table 1A. Differences in Prevalence Rates of Alcohol and Illicit Drug Use Disorders by Age, Gender, and Race/Ethnicity (NSDUH, 2014)

		Alcohol Use Disorders[1]		Illicit Drug Use Disorders[1]		Illicit Drugs OR Alcohol		Both Illicit Drugs and Alcohol Disorders	
		N	(%)	N	(%)	N	(%)	N	(%)
Age Group	Under 18	678,000	(2.7)	868,000	(3.5)	1,249,000	(5.0)	297,000	(1.2)
	18-25	4,285,000	(12.3)	2,320,000	(6.6)	5,696,000	(16.3)	909,000	(2.6)
	26-39	5,223,000	(9.1)	2,035,000	(3.5)	6,491,000	(11.3)	767,000	(1.3)
	40-59	5,231,000	(6.1)	1,517,000	(1.8)	6,326,000	(7.4)	422,000	(0.5)
	≥60	1,578,000	(2.5)	338,000	(0.5)	1,840,000	(2.9)	76,000	(0.1)
Gender	Male	10,945,000	(8.5)	4,422,000	(3.4)	13,731,000	(10.7)	1,636,000	(1.3)
	Female	6,049,000	(4.4)	2,655,000	(1.9)	7,749,000	(5.7)	955,000	(0.7)
Race/ Ethnicity	White Non-Hispanic	11,059,000	(6.5)	4,133,000	(2.4)	13,721,000	(8.1)	1,471,000	(0.9)
	Black Non-Hispanic	1,889,000	(6.0)	1,313,000	(4.1)	2,713,000	(8.6)	489,000	(1.5)
	Other Non-Hispanic	1,132,000	(5.5)	450,000	(2.2)	1,433,000	(6.9)	149,000	(0.7)
	Hispanic or Latino	2,915,000	(6.7)	1,180,000	(2.8)	3,614,000	(8.5)	481,000	(1.1)

Table 1B. Differences in Prevalence Rates of Alcohol and Illicit Drug Use Disorders by Age (NESARC-III, 2013)

		Alcohol Use Disorders[1]		Illicit Drug Use Disorders[1]		Illicit Drugs OR Alcohol		Both Illicit Drugs and Alcohol Disorders	
		N	(%)	N	(%)	N	(%)	N	(%)
Age Group	18-29	5,834,000	(11.2)	3,197,000	(6.2)	8,104,000	(15.6)	927,000	(1.8)
	30-44	4,772,000	(7.9)	1,548,000	(2.6)	5,751,000	(9.5)	569,000	(0.9)
	45-64	4,433,000	(5.4)	1,304,000	(1.6)	5,260,000	(6.4)	477,000	(0.6)
	≥65	978,000	(2.2)	161,000	(0.4)	1,114,000	(2.5)	25,000	(<0.1)

Grant et al.[3,4] reported higher prevalence estimates for alcohol use and drug use disorders based on data from the NESARC-III. However, the pattern of prevalence rates was similar to the NSDUH with males and younger individuals having higher rates of alcohol use and drug use disorders. In terms of race, Grant et al.[3] determined that White and Native Americans had similar rates of alcohol use disorders and both rates were higher than those for other racial/ethnic groups. The rate of drug use disorders was estimated to be similar for Non-Hispanic Whites, Non-Hispanic Blacks, and Native Americans and all were significantly higher than rates of drug use disorders among Asian/Pacific Islanders and Hispanics.[4] Prevalence estimates of alcohol use and other substance use disorders based on demographic characteristics are not available from either the NSDUH or the NESARC-III at the state level.

Consequences of SUDs

Health & Social Consequences

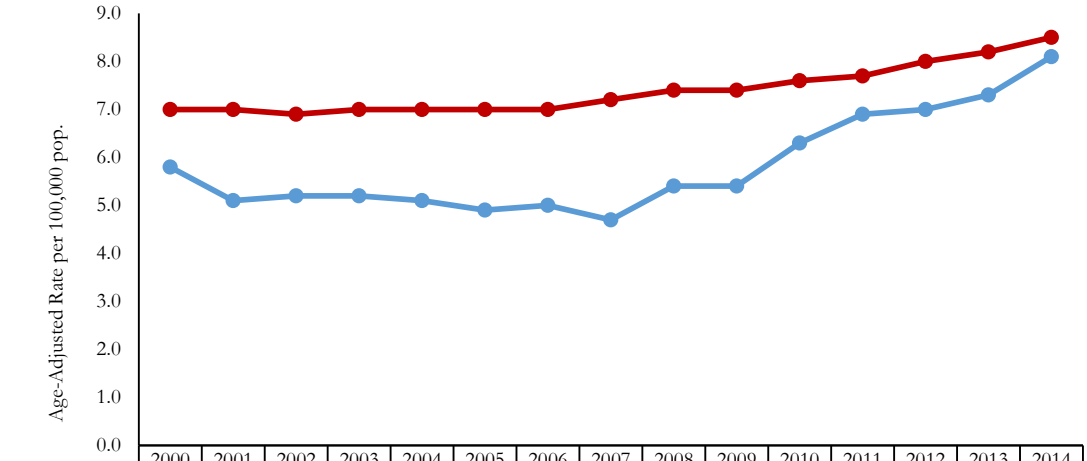
Substance use disorders are associated with significant morbidity, mortality, and social and economic consequences. Individuals who have SUDs are at increased risk for numerous health problems compared to the general population, with the nature of these health problems varying with the drug or combination of drugs a person uses.[7] Similarly, persons with SUDs are at heightened risk for impairment from motor vehicle accidents and other types of accidental injuries.[7-9] Mortality rates among persons with SUDs are higher than those for the general population due to deaths from drug-induced illnesses, accidents, and drug-related overdoses.[7] Figures 2 and 3 detail changes in alcohol and drug-induced deaths in the nation and Indiana since 2000.

The alcohol-induced mortality rate rose significantly in Indiana, from 5.8 per 100,000 persons in 2000 to 8.1 per 100,000 persons in 2014; since 2001 Indiana's rate has been steadily approaching that of the U.S.

Until 2008, the rate of drug-induced deaths was significantly lower in Indiana compared to the nation. After 2007, however, Indiana's rate began to gradually exceed that of the nation. Indiana's rate of drug-induced deaths has risen from 4.8 per 100,000 persons in 2000 to 19.2 per 100,000 persons in 2014; i.e., a four-fold increase.

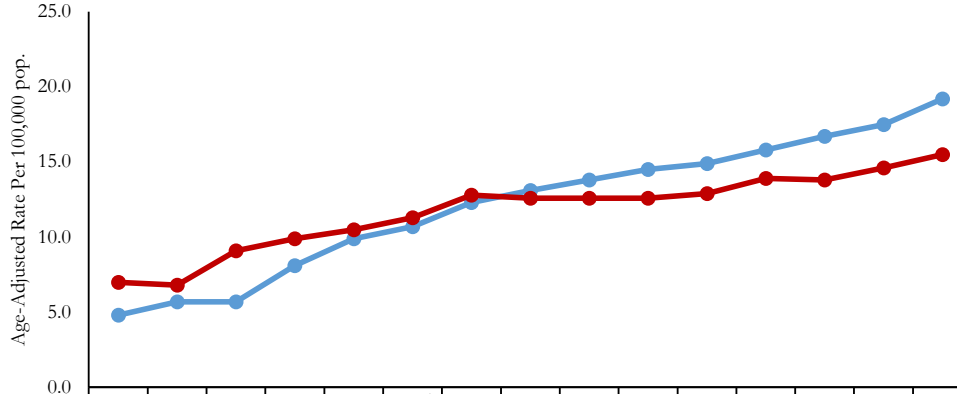
Substance use disorders place individuals at heightened risk for mental health disorders, particularly major depressive disorder and death from suicide.[10,11] Other consequences that individuals with SUDs face may impact both the affected person and his or her family through contact with the criminal justice and child welfare system, an inability to maintain stable employment, continued use of substances by women during pregnancy, or transmission of blood-borne illnesses via unprotected sexual activity.[8,9,12]

Figure 2. Indiana and U.S. Alcohol-Induced Mortality Rates per 100,000 (CDC Wonder, 2000-2014)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	5.8	5.1	5.2	5.2	5.1	4.9	5.0	4.7	5.4	5.4	6.3	6.9	7.0	7.3	8.1
U.S.	7.0	7.0	6.9	7.0	7.0	7.0	7.0	7.2	7.4	7.4	7.6	7.7	8.0	8.2	8.5

Figure 3. Indiana and U.S. Drug-Induced Mortality Rates per 100,000 (CDC Wonder, 2000-2014)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	4.8	5.7	5.7	8.1	9.9	10.7	12.3	13.1	13.8	14.5	14.9	15.8	16.7	17.5	19.2
U.S.	7.0	6.8	9.1	9.9	10.5	11.3	12.8	12.6	12.6	12.6	12.9	13.9	13.8	14.6	15.5

Economic Consequences

The numerous health and social consequences associated with SUDs place a tremendous economic burden on the nation. Bouchery, et al.[13] determined that during 2006, excessive drinking, including drinking associated with alcohol use disorders, cost the U.S. over $223.5 billion. The bulk of this cost was associated with lost productivity due to alcohol use ($161.3 billion); however, $24.6 billion was due to increased healthcare costs, of which 43.4% went towards specialty treatment for alcohol use disorders; $21 billion was tied to increased criminal justice costs; and $16.7 billion resulted from other effects linked to drinking. In 2007, illicit drug use cost the U.S. $193 billion. As with alcohol use, the majority of the costs attributed to illicit drug use stemmed from lost productivity ($120.3 billion), followed by crime-related costs ($61.4 billion), and health-care costs ($11.4 billion).[14] Apart from alcohol, estimates for the economic impact of specific drugs of abuse are limited. Hansen et al.[15] determined that nonmedical use of prescription opioids cost the nation $53.4 billion in 2006 while Mark et al.[16] estimated that heroin addiction cost the U.S. $21.9 billion in 1996 or approximately $26.9 billion in 2006 dollars.

TREATMENT

The staggering social and economic costs of SUDs suggest that more effort needs to be placed in not only preventing the development of SUDs but also in providing timely and appropriate treatment for affected individuals.

Types of Treatment

Treatment services for SUDs have traditionally been grouped into several general modalities ranging in intensity from high to low. In high intensity treatment modalities, individuals are regularly supervised, are likely restricted from leaving the treatment setting, and are required to participate in several individual and group counseling sessions throughout the day. In more moderate intensity environments, persons generally have more freedom to come and go from the facility but likely have to follow specific guidelines regarding participating in counseling, engaging in housekeeping activities, and being present at the facility. Low intensity treatment modalities are community-based, typically provided at mental health centers, where individuals go for group and/or individual counseling one or more times a week.

High Intensity Services

- Inpatient hospitalization – consists of detoxification or medically managed withdrawal services that help the body clear itself of alcohol and/or other substances of abuse along with initial, intensive treatment that prepares an individual to enter a community-based treatment setting.
- Residential treatment (short-term, less than 30 days) – generally offered at specialty rehabilitation facilities and provides intensive but brief treatment often using a 12-step approach.

Moderate Intensity Services

- Residential treatment (long-term, more than 30 days) – typically offered in non-hospital settings and focuses on helping individuals with SUDs learn effective coping skills, build resources, and reintegrate into the community.
- Partial hospitalization – generally offered in hospital settings where individuals will spend a portion of the day involved in group and individual counseling.

Low Intensity Services

- Intensive outpatient – usually provided at outpatient mental health clinics where individuals will primarily attend group counseling for nine or more hours a week.
- Standard outpatient – generally provided at outpatient mental health clinics and individuals will typically attend weekly group or individual counseling sessions.[17]

Treatment Admissions

The Treatment Episode Data System (TEDS), maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA), is the primary source of both national and state-level data on individuals who receive treatment for SUDs. The TEDS Admission (TEDS-A) data set maintains basic demographic and drug-use-related information on substance use treatment admissions that take place annually throughout the country.[iii]

Analyses of treatment admissions in this report are based on (1) national TEDS data to provide comparisons between Indiana and the rest of the United States (available from SAMHSA; most recent dataset is from 2013) and (b) Indiana-level TEDS data (available through Indiana's Division of Mental Health and Addiction; most recent dataset is from 2015).

Demographic Characteristics

According to 2013 TEDS data, there were 1,683,451 admissions to substance use treatment programs nationally, of which 25,960 occurred in Indiana. The greatest percentages of Indiana's treatment admissions came from criminal justice referrals (47.0%) followed by individual/self-referrals (29.4%) with the remaining admissions stemming from alcohol/drug counselor, health care provider, educational institution, employer, and other community agency referrals (23.7%). Nationally, more treatment admissions in 2013 were from individual, alcohol/drug counselor, and educational institution referrals and fewer were from criminal justice and employer referrals (see Table 2). The majority of Indiana's treatment admissions for 2013 represented a person's first (47.6%) or second (28.4%) episode of care. When compared to Indiana, a larger percentage of individuals entering treatment in the rest of the country had at least three prior treatment episodes and a smaller percentage had no prior or only one prior treatment episode [18] (see Table 2).

Table 2. Referral Sources and Prior Treatment Episodes (TEDS-A, 2013)

	Indiana	U.S.
Principal Source of Referral		
Individual/Self-Referral	29.4%	36.9%†
Alcohol/Drug Abuse Counselor	3.1%	9.2%†
Other Health Care Provider	7.6%	7.3%
School (Educational)	0.5%	1.0%†
Employer/EAP	0.6%	0.4%†
Other Community Referral	11.9%	11.7%
Court/Criminal Justice Referral/DUI/DWI	47.0%	33.5%†
Number of Prior Treatment Episodes		
No prior treatment episodes	47.6%	40.2%†
1 prior episode	28.4%	21.2%†
2 prior episodes	12.1%	12.4%
3 prior episodes	5.5%	7.6%†
4 prior episodes	2.4%	4.4%†
5 or more prior episodes	4.0%	14.2%†

† Percentages between Indiana and the U.S. are significantly different at $P < / = .05$

[iii] The TEDS data records admissions to treatment in a given year. Individuals with more than one admission will be represented multiple times in the data. Due to the population on which the TEDS data are based, the information may not be representative of all individuals in drug and alcohol treatment and typically represent admissions that are paid for through public funding. Indiana's TEDS data are limited to information on individuals entering or leaving substance use treatment who are 200% below the federal poverty level and receive state-funded treatment.

Various demographic characteristics were significantly associated with treatment admissions at the State and national level. Men made up a larger percentage of admissions to substance use treatment than women; non-Hispanic Whites accounted for the majority of treatment admissions compared to non-Hispanic Blacks, non-Hispanics of other races, and Hispanics; more treatment admissions consisted of individuals between the ages of 25 to 39 compared to persons in other age groups; most individuals entering treatment had never been married, had completed a maximum of 12 years of education, and were unemployed (see Table 3). There are small, but statistically significant differences between Indiana and the nation in the percentage of admissions within the marital status, education level, and employment categories and these are noted in Table 3.

Table 3. Demographic Composition of Treatment Admissions (TEDS-A, 2013)

	Indiana	U.S.
Gender		
Male	62.4%	66.4%†
Female	37.6%	33.6%†
Race/Ethnicity		
Non-Hispanic Black	14.3%	18.8%†
Non-Hispanic White	78.1%	60.9%†
Non-Hispanic Other Race	3.2%	5.7%†
Hispanic	4.4%	14.7%†
Age		
Under 18	4.2%	6.1%†
18 to 24	22.8%	17.7%†
25 to 39	45.8%	40.6%†
40 to 54	22.1%	28.1%†
55 and Older	5.1%	7.5%†
Marital Status		
Never married	62.7%	64.5%
Currently married	14.2%	14.0%
Separated	1.3%	5.9%†
Divorced/Widowed	21.8%	15.5%†
Education		
8 years or less	6.4%	7.3%†
9-11 years	24.3%	24.9%†
12 years	46.4%	42.4%†
13-15 years	19.3%	19.8%†
16 or more years	3.5%	5.5%†
Employment Status		
Full-Time	21.1%	15.0%†
Part-Time	12.4%	7.4%†
Unemployed	44.9%	38.0%†
Not in Labor Force	21.5%	39.6%†

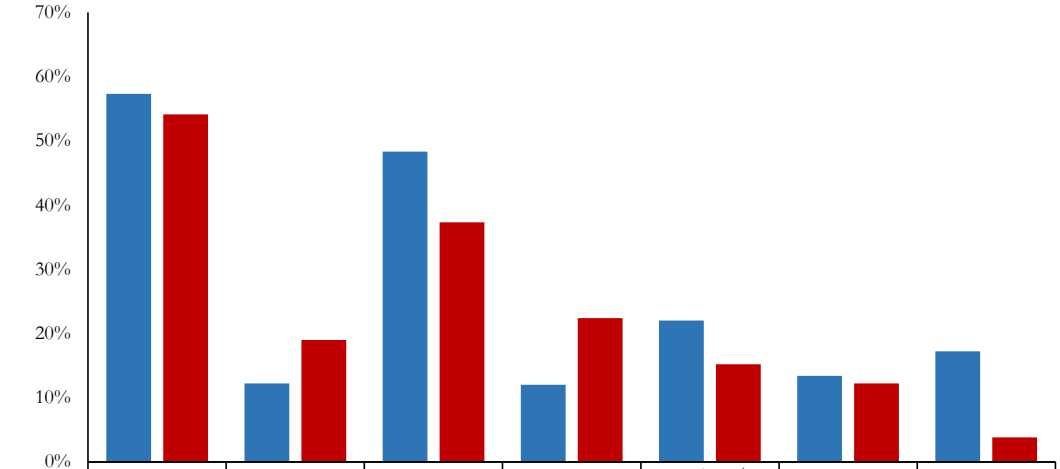
†Percentages between Indiana and the U.S. are significantly different at $P < / = .05$

Since 2000, Indiana has experienced slight increases in the percentage of treatment admissions accounted for by women (from 32.2% in 2000 to 39.6% in 2015), by Hispanics (from 3.6% in 2000 to 7.3% in 2015), and by individuals 55 years of age or older (from 2.9% in 2000 to 5.9% in 2015) and decreases in admissions for men (from 67.8% in 2000 to 60.4% in 2015), non-Hispanic Blacks (from 18.7% in 2000 to 11.5% in 2015), and persons between the ages of 40 and 54 (from 26.3% in 2000 to 22.3% in 2015).[19]

Patterns of Drug Use

TEDS data for Indiana indicated that in 2013, the drugs most frequently used upon admission to treatment were alcohol, marijuana, opiates/synthetics, methamphetamine, heroin, and those classified as other drugs. The pattern of drug use for U.S. admissions was similar; however, use of alcohol, marijuana, methamphetamine, opiates/synthetics, and other drugs was reported by a smaller percentage of persons nationally while cocaine and heroin use was endorsed by significantly more U.S. treatment entrants (see Figure 4). More Hoosiers (64.4%) reported polysubstance use (i.e., using two or more substances) at treatment admission than did so nationally (55.3%).[18]

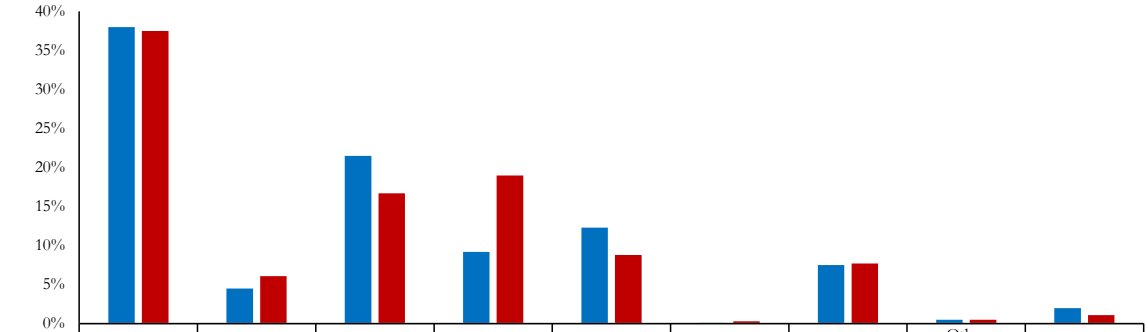
Figure 4. Percentage of Treatment Admission with Reported Use of Substances (TEDS-A, 2013)



	Alcohol	Cocaine	Marijuana	Heroin	Opiates/ Synthetics	Meth	Other
Indiana	57.3%	12.2%	48.3%	12.0%	22.0%	13.4%	17.2%
US	54.1%	19.0%	37.3%	22.4%	15.2%	12.2%	3.8%

In Indiana, the most commonly reported primary drug of abuse was alcohol (38.0%), followed by marijuana (21.5%), opiates/synthetics (12.3%), and heroin (9.2%). However, if we combine the opiates/synthetics and heroin categories into one group, it becomes evident that in one-fifth of treatment admissions, an opioid served as the primary drug of abuse (see Figure 5).[18]

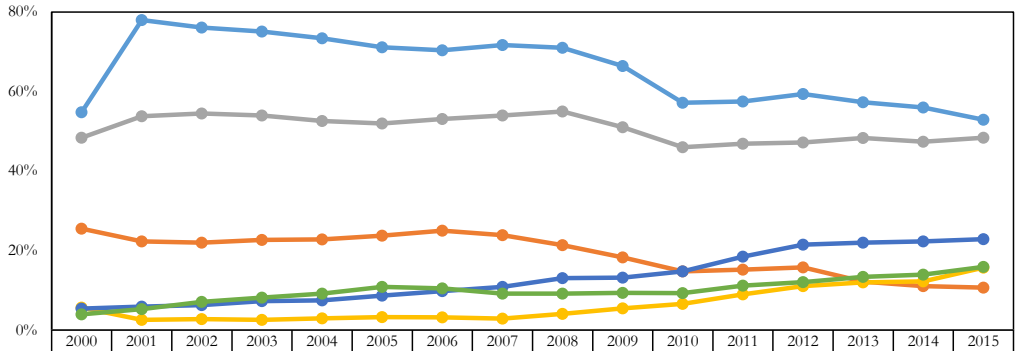
Figure 5. Percentage of Treatment Admission with Reported Primary Use of Substances (TEDS-A, 2013)



	Alcohol	Cocaine	Marijuana	Heroin	Opiates/Synthetics	PCP-Hallucinogens	Meth-amphetamine	Other Amphetamine or Stimulants	Tranquilizers & Sedatives
Indiana	38.0%	4.5%	21.5%	9.2%	12.3%	0.1%	7.5%	0.5%	2.0%
US	37.5%	6.1%	16.7%	19.0%	8.8%	0.3%	7.7%	0.5%	1.1%

Over time, fewer Hoosiers entering treatment have reported using alcohol or cocaine, while more have indicated using heroin, opiates/synthetics, methamphetamine, and unclassified other drugs (see Figures 6 and 7).[19] Across all years of data reviewed, PCP and hallucinogens as well as tranquilizers and other sedatives accounted for very small percentages of overall treatment admissions.[19]

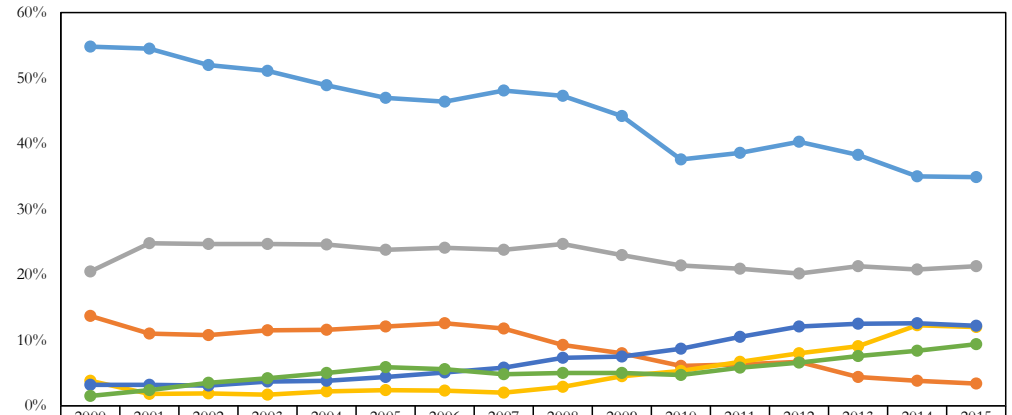
Figure 6. Percent of Indiana Treatment Admissions by Drug Use Category (TEDS-A, 2000-2015)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Alcohol	54.8%	78.0%	76.1%	75.1%	73.4%	71.1%	70.4%	71.7%	71.0%	66.4%	57.2%	57.5%	59.4%	57.3%	56.0%	52.9%
Cocaine	25.5%	22.3%	22.0%	22.7%	22.8%	23.8%	25.0%	23.9%	21.4%	18.3%	14.8%	15.2%	15.8%	12.2%	11.1%	10.7%
Marijuana	48.4%	53.8%	54.5%	54.0%	52.6%	52.0%	53.1%	54.0%	55.0%	51.0%	46.0%	46.9%	47.2%	48.3%	47.4%	48.4%
Heroin	5.7%	2.6%	2.8%	2.6%	3.0%	3.3%	3.2%	2.9%	4.1%	5.5%	6.6%	9.0%	11.1%	12.0%	12.3%	15.7%
Opiates/Synthetics	5.4%	5.9%	6.3%	7.3%	7.5%	8.7%	9.8%	10.9%	13.1%	13.2%	14.8%	18.5%	21.5%	22.0%	22.3%	22.9%
Methamphetamine	4.0%	5.3%	7.1%	8.2%	9.2%	10.9%	10.5%	9.2%	9.2%	9.4%	9.3%	11.2%	12.1%	13.4%	14.0%	15.9%

Across all years of data reviewed, PCP and hallucinogens as well as tranquilizers and other sedatives accounted for very small percentages of overall treatment admissions.[19]

Figure 7. Percent of Indiana Treatment Admissions by Primary Drug Category (TEDS-A, 2000-2015)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Alcohol	54.8%	54.5%	52.0%	51.1%	48.9%	47.0%	46.4%	48.1%	47.3%	44.2%	37.6%	38.6%	40.3%	38.3%	35.0%	34.9%
Cocaine	13.7%	11.0%	10.8%	11.5%	11.6%	12.1%	12.6%	11.8%	9.3%	8.0%	6.1%	6.3%	6.7%	4.4%	3.8%	3.4%
Marijuana	20.5%	24.8%	24.7%	24.7%	24.6%	23.8%	24.1%	23.8%	24.7%	23.0%	21.4%	20.9%	20.2%	21.3%	20.8%	21.3%
Heroin	3.8%	1.8%	1.9%	1.7%	2.2%	2.4%	2.3%	2.0%	2.9%	4.5%	5.3%	6.7%	8.0%	9.1%	12.3%	12.0%
Opiates/Synthetics	3.2%	3.2%	3.1%	3.7%	3.8%	4.4%	5.1%	5.8%	7.3%	7.5%	8.7%	10.5%	12.1%	12.5%	12.6%	12.2%
Methamphetamine	1.5%	2.4%	3.5%	4.2%	5.0%	5.9%	5.6%	4.8%	5.0%	5.0%	4.7%	5.8%	6.6%	7.6%	8.4%	9.4%

Availability of Formal Treatment Services in Indiana

A significant factor affecting whether individuals with SUDs receive treatment and are successful is the availability of appropriate services. SAMHSA and the American Society of Addiction Medicine (ASAM) emphasize that persons with SUDs require access to services of varying intensity levels that take into account the drug or drugs used and also address the challenges faced by the population to which they belong.[20,21] Unfortunately, most communities are either unable to offer the wide range of services suggested by federal agencies or unable to offer them at a level which meets the community's needs.

SAMHSA's National Survey of Substance Abuse Treatment Services (N-SSATS)[iv] reported that in 2013, Indiana had 294 active substance use treatment providers; however, service data were received from only 275. Based on their response to the N-SSATS, most of Indiana's treatment facilities have outpatient treatment centers (256, 93.1%); a small percentage provides residential (29, 10.5%) or hospital inpatient care (33, 12.0%). Compared to Indiana, the percentage of treatment facilities offering outpatient (81.4%) and inpatient hospitalization

[iv] The N-SSATS collects data on an annual basis from all public and private facilities in the U.S. that provide SUD treatment. Individual providers and correctional facilities are not included in the survey. Treatment providers can be a program-level, clinic-level, or multi-site entity.

(5.2%) services was significantly smaller in the U.S., while the percentage offering residential services was significantly higher (24.7%).

Given the makeup of Indiana's SUD service providers, outpatient forms of treatment are the most available to Hoosiers. The service offered with the greatest frequency by outpatient providers is regular individual and/or group counseling (96.5%) followed by intensive outpatient services (58.6%) with fewer facilities providing day treatment/ partial hospitalization (14.1%), detoxification (8.6%), or medication maintenance for opioid use disorders (7.8%). Of the 28,288 Hoosiers participating in SUD treatment services at the time the 2013 N-SSATS was completed, 97.1% were enrolled in outpatient services with nearly half (48.8%) receiving regular individual and/or group counseling. The availability of outpatient services in Indiana was similar to the U.S. with two exceptions: a greater percentage of facilities in Indiana offered regular outpatient services while a smaller percentage offered outpatient methadone maintenance. Among Indiana's residential service providers, the majority (82.7%) offered long-term residential services, less than half (44.8%) provided short-term residential services, and just under a quarter (24.1%) supported detoxification services. Approximately 2.0% of Hoosiers in SUD treatment in 2013 were enrolled in residential programs. Although residential services were less prevalent in Indiana than the U.S., within residential programs the percentage that offered long-term, short-term, and detoxification services was similar to that found nationally.

Nearly all hospital inpatient facilities in the state (97.0%) had detoxification services and over half (57.5%) offered inpatient treatment services. In 2013, only 1.0% of Hoosiers in treatment were receiving services in hospital settings. In comparison to hospital inpatient facilities in the U.S., a similar percentage of Indiana's facilities offered detoxification services while a significantly smaller percentage provided inpatient treatment services.

Due to individual differences among persons with SUDs, it is important that treatment facilities offer services that take into account the unique needs of the various groups of people who seek care.[22,23] Across Indiana's facilities providing N-SSATS data in 2013, 189 (68.7% of all treatment facilities) offered at least one program targeting a specific subgroup of the SUD population. The most widely available specialized programming was for adult women, provided by 87 facilities; followed by programming for adolescents and for persons with co-occurring mental illness and SUD, available at 82 facilities (see Table 4). In the U.S., the percentage of treatment facilities having any specialized programming was greater than in Indiana. Compared to Indiana's treatment facilities, a larger percentage nationally reported offering programming for adult women, senior citizens, persons who are LGBTQ, veterans, military family members, persons involved in the criminal justice system, dually-diagnosed individuals, and persons with HIV. It is important to note that while treatment facilities may indicate that they have specialized programming, the actual nature of the programming can be quite variable ranging from holding separate groups with population-specific curriculums to simply having organizational policies of openness to all populations.[23]

Table 4. Indiana Treatment Centers Offering Specialized Programming (NSSAT-S, 2013)

Population	Outpatient Facility	Residential Facility	Hospital Facility	Total Facilities	% of All Facilities
Adult Women	64	13	10	87	31.6
Adolescents	65	2	15	82	29.8
Co-Occurring	65	4	13	82	29.8
Adult Men	51	14	10	75	27.3
Trauma	60	6	8	74	26.9
Criminal Justice Clients	66	4	1	71	25.8
Pregnant/Post-partum Women	29	4	2	35	12.7
Veterans	15	5	4	24	8.7
Senior Citizens	14	2	6	22	8.0
LGBTQ	16	1	3	20	7.3
HIV/AIDS	8	2	4	14	5.1
Active-Duty Military	7	1	3	11	4.0
Military Families	4	1	2	7	2.5

As the number of treatment admissions for Hispanics appears to be rising in the State, having staff members who can work with these clients in their native language is becoming increasingly important. Thirty-two (32) of Indiana's treatment facilities in 2013 had Spanish-speaking service providers of which 23 were outpatient facilities, three were residential treatment facilities, and six were hospitals. Even though the percentage of treatment facilities able to offer services in Spanish is low nationally (25.2%), the percentage able to do so within Indiana is significantly lower (11.6%, $x^2 = 26.5$, $p<.001$).

One service which is of critical importance to Indiana, given the increasing trend in the use of heroin and other forms of opioids, is medication-assisted treatment. The N-SSATS reported that 14 Indiana facilities operated federally-recognized opioid treatment programs (OTP) in 2013 and at the time of the survey, they were serving approximately 9,713 Hoosiers. All OTPs offered methadone maintenance, 10 offered Suboxone treatment, and eight provided Vivitrol treatment. Four additional outpatient treatment facilities had Methadone maintenance services, 32 offered Suboxone management, and 31 provided Vivitrol. A smaller percentage of Indiana's treatment facilities operated opioid treatment programs (5.1%, Indiana; 9.1%, U.S.; $x^2= 5.4$, $P <.05$) or offered Methadone (6.6%, Indiana; 11.7%, U.S.; $x^2= 6.8$, $P <.01$) or Suboxone treatment compared to facilities in the U.S. (15.3%, Indiana; 21.2%, U.S.; $x^2= 5.5$, $P <.05$).

Although not included in the N-SSATS, individuals with opioid use disorders can receive Suboxone from specially certified physicians. SAMHSA's Buprenorphine physician locator reports that Indiana has 114 practitioners who can provide Suboxone treatment. Of Indiana's 92 counties, only 23 have one or more approved prescribers; however, the majority of prescribers are located in the state's more populated, urban counties.

Treatment Utilization – Needs and Barriers

According to the NSDUH, 1.6% of the U.S. population 12 years of age or older (nearly 4.2 million persons) received treatment for their use of alcohol or illicit drugs in 2014. Among those who received treatment, 54.3% (2.3 million) were reported to have a SUD. The estimate for the use of services by individuals in the region of the country which includes Indiana is equal to the nation (1.6%). When applied to Indiana's population, the regional estimate indicates that in 2014, 87,362 Indiana residents 12 or older engaged in some form of alcohol or drug treatment with 47,438 of those likely having a SUD. Nationally, individuals with SUDs who received treatment, did so from more sources with a greater percentage relying on services from inpatient hospitals, rehabilitation facilities, mental health centers, emergency departments, and medical doctors compared to individuals without a SUD. Among individuals who received treatment, the greatest percentage used self-help groups (56.6% with SUD; 52.5% without SUD).[24]

For persons with SUDs, receiving specialized care can help bring about better long-term outcomes, particularly in regards to reduced substance use[25,26] and criminal justice involvement;[25] unfortunately, a vast majority do not receive it. The NSDUH estimated that during 2014, nearly 22.5 million U.S. residents 12 years of age or older (8.5% of the population) were in need of treatment from a specialty drug or alcohol treatment facility. Of the persons who needed specialty treatment for illicit drug or alcohol use, approximately 2.6 million (11.6% of those in need) received it, while the remaining 88.4% went without care. The NSDUH does not provide state-level estimates of treatment need; however, assuming the overall level of need in Indiana is similar to the nation, approximately 464,108 Indiana citizens 12 and older were in need of specialty treatment for illicit drug or alcohol use. During 2014, the NSDUH estimated that approximately 2.4% (131,042) and 6.4% (349,446) of Hoosiers 12 years of age or older were not receiving the specialty treatment for illicit drug use and/or alcohol use problems that they needed.[24] There are a number of reasons why persons with SUDs may not get the treatment they need.

Many individuals with SUDs do not seek treatment because they do not perceive that they need it. In 2014, of individuals classified by the NSDUH as having a SUD, an estimated 96.0% did not feel that they needed treatment.[6] As the severity of SUDs increase gradually over time, persons with these disorders often fail to realize they have a problem and consequently do not seek services until they experience significant impairment and social consequences from their alcohol or substance use.[27,28]

Stigma is another barrier preventing many people with SUDs from seeking care. A large and potentially growing percentage of the U.S. population holds particularly negative attitudes about persons who suffer from SUDs.[29,30] Results from a number of national surveys

show that the general public believes persons with SUDs are dangerous, not worthy of help, responsible for their condition, and should be avoided. Further, although the majority of the public perceives treatment for SUDs as ineffective, they consider people with SUDs, compared to individuals with mental illness or physical disabilities, as being the most able to overcome their condition.[30,31] Americans also typically support policies that deny employment and housing to persons with SUDs, oppose policies designed to help persons with SUDs, and do not view such discrimination as a serious problem.[30] Not surprisingly, many people with SUDs report instances of unfair treatment or rejection when others learn of their disorder, and believe that most people with SUDs are devalued and discriminated against.[32] Fear of stigmatization by others appears to be a key factor in whether someone with a SUD receives treatment. The more a person believes that they will be stigmatized or rejected by people in their community if their SUD status becomes known, the less likely they will be in treatment or ever seek care.[33,34] Data from national surveys and studies on treatment-seeking support stigma's role in deterring people from accessing care. The reasons given for not getting or for delaying treatment among individuals who need it are primarily attitudinal and stigma-based such as believing that one should be strong enough to handle the problem alone and without professional help; fear of embarrassment from discussing the problem; and fear of what others might think if they found out about treatment.[35-41]

Other barriers which keep people who need specialty alcohol and drug services from getting them reflect the overall structure of a community's service system. In many instances, specialty treatment services are either unavailable or insufficient to meet the demand resulting in long waiting lists for care.[22,37,42] Specialized treatment services might primarily be located in more populated regions of a community, making access difficult to those in rural areas. Similarly, specialty services may be placed in more affluent neighborhoods within a community, requiring economically disadvantaged individuals to travel significant distances, something many cannot afford to do.[43] The cost of services is an additional structural barrier with untreated persons citing lack of insurance or an inability to pay the bill as reasons for not getting treatment.[6]

Outcomes of Treatment

Data on the outcomes for Hoosiers who receive substance use treatment are limited to information in SAMHSA's Treatment Episode Data System-Discharges (TEDS-D) data set. The TEDS-D provides information on the type of facility from which a person was discharged, the reason for discharge, as well as demographic and drug-use related data. National and local-level TEDS-D data are presently available for 2006 through 2012. In 2012, Indiana treatment programs discharged 24,740 persons. These discharges were mainly from non-intensive outpatient programs (85.7%) and most (78.3%) occurred after at least 30 days of treatment. The majority of individuals leaving services had been referred by the criminal justice system (50.4%) or by individual/self-referrals (29.2%). Among Hoosiers discharged, only 35.2% did so through completing their treatment with the remainder primarily leaving against professional advice (40.9%), or through termination by the facility (15.9%). Relatively few discharges resulted from transfers to other programs (1.5%), incarceration (2.3%), death (0.2%), or for other reasons (4.0%). Outcomes were similar for individuals with and without prior episodes of treatment. The percentage of discharges through completing treatment was significantly greater in the nation (42.9%) while the percentage terminated (6.3%), leaving against professional advice (26.4%), or leaving for other reasons (5.3%) was significantly smaller when compared to Indiana (see Table 5).[44]

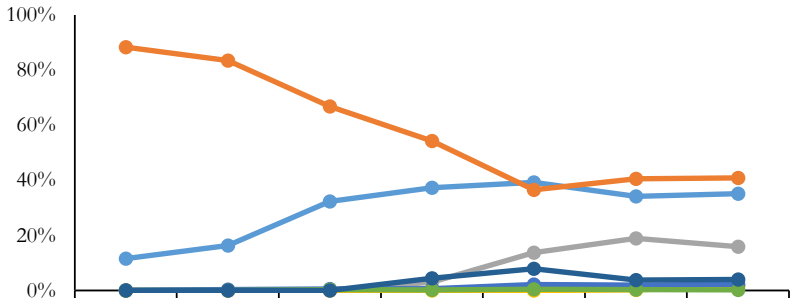
Table 5. Characteristics of Indiana and U.S. Discharges from Treatment (TEDS-D, 2012)

	Indiana	U.S.	X2	P
Referral Source			4227.2	<.001
Individual/Self-Referral	29.2%	35.9%†		
Alcohol/Drug Abuse Counselor	2.3%	9.8%†		
Other Health Care Provider	7.7%	7.4%†		
Educational Institution	0.4%	1.2%†		
Employer	0.6%	0.4%†		
Other Community Referral	9.3%	12.2%†		
Court/Criminal Justice	50.4%	33.1%†		
Service Setting			15437.9	<.001
Detox, 24 Hour, Hospital Inpatient	0.6%	3.5%†		
Detox, 24 Hour, Free-Standing Residential	2.9%	17.5%†		
Rehabilitation/Residential Hospital (Non-Detox)	0.4%	0.4%		
Short-Term Residential	1.8%	10.4%†		
Long-Term Residential	1.2%	7.8%†		
Ambulatory, Intensive Outpatient	7.4%	12.8%†		
Ambulatory, Non-Intensive Outpatient	85.7%	46.6%†		
Ambulatory Detoxification	0.0%	1.1%†		
Reason for Discharge			8434.5	<.001
Treatment Completed	35.2%	44.9%†		
Left Against Professional Advice	40.9%	25.7%†		
Terminated by Facility	15.9%	7.0%†		
Transferred to Another Treatment Program	1.5%	15.1%†		
Incarcerated	2.3%	2.2%		
Death	0.2%	0.2%		
Other	4.0%	4.9%†		

†Percentages between Indiana and the U.S. are significantly different at P < / =.05

Over time, the percentage of Indiana's discharges associated with treatment completion has increased somewhat unsteadily from 11.6% in 2006 to 35.2% in 2012 (see Figure 8).[44]

Figure 8. Indiana Treatment Discharges over Time (TEDS-D, 2006-2012)



	2006	2007	2008	2009	2010	2011	2012
Treatment Completed	11.6%	16.3%	32.3%	37.3%	39.2%	34.2%	35.2%
Against Advice	88.3%	83.5%	66.8%	54.3%	36.5%	40.6%	40.9%
Terminated	0.0%	0.0%	0.0%	3.1%	13.8%	18.9%	15.9%
Transferred	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	1.5%
Incarcerated	0.1%	0.3%	0.6%	0.7%	2.2%	2.0%	2.3%
Death	0.0%	0.0%	0.3%	0.2%	0.5%	0.3%	0.2%
Other	0.0%	0.0%	0.0%	4.4%	7.9%	3.8%	4.0%

Several demographic characteristics were associated with Indiana's treatment discharges during 2012. Men, Hispanics, and persons 55 years of age or older were significantly more likely to have been discharged for completing treatment rather than for other reasons. Outcomes were also related to the source of referral, type of service received, and the primary drug of concern. A larger percentage of persons referred from alcohol/drug counselors, employers, and the criminal justice system completed treatment compared to other referral sources. The highest treatment completion rate occurred among individuals in long-term residential settings (78.9%), while the lowest was noted for persons in rehabilitation/hospital treatment programs who were not receiving detoxification services (30.0%). A larger percentage of individuals whose substance use problems centered on alcohol completed treatment compared to individuals using other substances (see Table 6).[44]

Table 6. Demographic and Service Characteristics of Indiana Treatment Discharges (TEDS-D, 2012)

	% Completed Treatment	% Discharged for Other Reasons	x2	P
Gender			139.9	<.001
Male	38.6%	61.4%		
Female	31.0%	69.0%		
Race/Ethnicity			36.2	<.001
Non-Hispanic Black	35.6%	64.4%		
Non-Hispanic White	35.9%	64.1%		
Non-Hispanic Other Race	31.6%	68.4%		
Hispanic	44.0%	56.0%		
Age			65.2	<.001
Under 18	36.7%	63.3%		
18-24	34.5%	65.5%		
25-39	34.1%	65.9%		
40-54	38.7%	61.3%		
55 and Older	43.1%	56.9%		
Referral Source			821.7	<.001
Individual/Self-Referral	30.1%	69.9%		
Alcohol/Drug Abuse Counselor	44.8%	55.2%		
Other Health Care Provider	15.6%	84.4%		
Educational Institution	26.4%	76.3%		
Employer	41.6%	58.4%		
Other Community Referral	27.6%	72.4%		
Court/Criminal Justice	43.3%	56.7%		
Service Setting			428.9	<.001
Detox, 24 Hour Hospital Inpatient	52.3%	47.7%		
Detox, 24 Hour Free-Standing Residential	51.5%	48.5%		
Rehabilitation/Residential Hospital (Non-Detox)	30.0%	70.0%		
Short-Term Residential	52.9%	47.1%		
Long-Term Residential	78.9%	21.1%		
Intensive Outpatient	40.8%	59.2%		
Non-Intensive Outpatient	33.8%	66.2%		
Primary Drug			507.5	<.001
Alcohol	43.3%	56.7%		
Cocaine	34.8%	65.2%		
Marijuana	33.3%	66.7%		
Heroin	33.1%	66.9%		
Other Opiates	24.2%	75.8%		
Hallucinogens	22.8%	77.2%		
Methamphetamine	33.7%	66.3%		
Other Stimulants	34.1%	65.9%		
Depressants	22.8%	77.2%		
Other Drugs	25.3%	74.7%		

RECOVERY

Introduction

Treatment systems have traditionally used an acute-care approach to address SUDs. In the acute-care model, individuals with SUDs who seek care typically complete an assessment, are placed into a treatment program, helped to achieve abstinence, and then discharged after a few weeks or months of services. The acute-care model supports a view of SUDs as curable and abstinence as maintainable after a single episode of professionally-driven treatment; a view which encourages policymakers to limit funding for treatment, supports insurance companies in reducing coverage for treatment, dissuades treatment centers from offering post-discharge monitoring, and leads the public to blame persons with SUDs if they return to using.[45,46]

Research on SUDs contradicts the utility of the acute care model. People with SUDs often cycle through numerous episodes of non-use, problematic use, and treatment over many years before sustaining long-term cessation of substance use;[47-49] improvements made in treatment are best maintained among those who are stably housed, employed, and able to meet their basic needs;[48,50-52] support from people who have overcome their SUDs helps those leaving treatment continue to make gains;[53-55] formal treatment is not the only method through which persons with SUDs can become symptom free;[56-58] and persons in treatment often drop out due to dislike of abstinence goals, inflexible programming, unsupportive staff, and lack of assistance with accessing social services.[46,59-61] Taken together, these findings have generated increasing pressure from SAMHSA for states to adopt a new paradigm for addressing SUDs.

The paradigm proposed by SAMHSA and others is a continuing-care model for approaching SUDs that acknowledges the long-term nature of these conditions; emphasizes the need for ongoing access to services that can be professional and nonprofessional in nature; and which is built around the concept of recovery.[61,62]

Definitions of Recovery

Recovery from SUDs can mean different things to different groups of people. Treatment programs and researchers often define recovery from SUDs as sustained abstinence or as no longer meeting diagnostic criteria for a SUD.[63,64] SAMHSA and other recovery advocates view recovery as something that goes beyond whether someone is or is not using substances. For them, recovery is a voluntary, ongoing process that cannot be forced on anyone; is person-specific and achievable in many different but equally valid ways; involves positive changes in the use of problematic substances; promotes continuing improvement in the overall quality of one's physical, mental, social, community and spiritual life; and generates gains in one's ability to attain and maintain basic needs.[62,65-69] SAMHSA's definition of recovery, which encompasses both mental illnesses and SUDs, states that "Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations."[70]

Because definitions of recovery are varied, there are no true prevalence estimates describing how many persons in the country are in recovery. Prevalence surveys which have defined recovery as no longer meeting diagnostic criteria for a SUD indicate that 50% or more of persons with alcohol, cannabis, or cocaine use disorders will no longer meet diagnostic criteria after 14 years, 6 years, or 5 years respectively.[64] Using combined data from 2000 to 2012, White[63] reported that the lifetime prevalence of remission from SUDs among adults in the community is approximately 43.5% with 17.9% achieving complete abstinence. The recovery rate for adolescents with SUDs who received treatment is 35.0%. Only one study has attempted to estimate the prevalence of recovery from a more person-specific perspective and concluded that 23.5 million or 10.0% of Americans age 18 or older consider themselves to be in recovery from problematic alcohol or substance use irrespective of whether they did or did not have a SUD.[71]

Recovery Oriented Systems of Care

Despite the lack of a universally accepted definition or information on prevalence, persons who are in recovery not only report significant positive changes in many life areas[72] but also needed substantial support to achieve and maintain these changes.[73] To allow all persons with SUDs the best opportunity for recovery, SAMHSA is pushing states and communities to implement recovery-oriented systems of care (ROSC). ROSC is an integrated systems approach to service delivery that brings together all state and local agencies as well as service providers who work with individuals that have SUDs. The purpose of a ROSC is to allow persons with all levels of problematic drug or alcohol use easy access to a coordinated, non-overlapping set of services that target his or her unique goals and needs.[69] The ROSC approach requires agencies and providers to develop a full continuum of SUD services. This

continuum of services should include not only traditional inpatient, residential, and outpatient services but also nontraditional services such as recovery maintenance, peer services, and community-based recovery support services.[74] Recovery maintenance services provide recovering individuals living in the community with ongoing follow-up contacts to ensure that emerging issues or unmet needs are identified and resolved quickly in order to avoid an escalation of SUD symptoms.[75] Peer-based services are provided by trained, certified individuals who themselves are in long-term recovery. Peer workers may offer persons receiving other forms of treatment ongoing support and mentoring or they may work in more formal ways such as assisting persons in early recovery with getting social services, finding employment, and attending 12-step or other support groups. Within the ROSC model, peer services would be incorporated into all levels of care and be available on an ongoing basis.[61] Community-based recovery support services include such things as recovery community centers and community engagement centers. Recovery community and community engagement centers are community-based centers operated to a great extent by volunteers who are in long-term recovery. These centers help increase awareness of SUDs, give individuals with SUDs easy access to services for maintaining their recovery, allow individuals with SUDs a place to receive positive peer support, and motivate persons with substance use problems of any kind to get care.[76,77] Other community-based recovery services that a ROSC might include are recovery homes, recovery schools, and recovery industries all of which can further support people's long-term recovery efforts.[77]

RECOVERY IN INDIANA – A QUALITATIVE ANALYSIS

Introduction

On a national level, SAMHSA and other federal agencies are aggressively working to replace the traditional, acute-care, medically-oriented model of treatment for SUDs with a ROSC approach. A ROSC views SUDs as chronic illnesses, conveys the message that recovery from these illnesses is possible, emphasizes that recovery requires ongoing access to a full continuum of coordinated services that encompasses treatment and community-based recovery support services, and integrates the use of both professional and certified peer providers [69,74]. In response to the increasing federal emphasis on ROSC, Indiana is striving to incorporate recovery-based principles for addressing the many cross-system needs of individuals with SUDs into its service system infrastructure. Indiana's desire to more fully embrace recovery-oriented approaches for SUDs has highlighted the need for national and state-level data on recovery. Unfortunately, national surveys, such as the NSDUH, have yet to include questions that address recovery nor does Indiana collect state-level data on recovery indicators. As a first step in filling this knowledge gap, the Center for Health Policy (CHP), at the request of the Indiana State Epidemiology and Outcomes Workgroup (SEOW), completed a small qualitative study to explore the status of recovery in Indiana.

> *" 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. "*

Study Description

Data Collection and Analysis

In order to gather viewpoints on recovery in general as well as how Indiana is integrating recovery principles into its service infrastructure, staff members from CHP completed interviews with key informants whose organizations are involved in supporting individuals in recovery from SUDs. CHP staff used guiding questions that asked respondents to discuss how both their organization and Indiana viewed the recovery process; the facilitators and barriers for creating a recovery orientation in the state; and recommendations for what Indiana may need to do in order for recovery-guided SUD service delivery to become a reality. Key informants typically took one hour to complete the interview. CHP staff members digitally recorded and then transcribed all interviews. A senior CHP staff member reviewed the transcripts and created thematic categories that reflected and summarized key informants' responses.

Participants and Their Organizations

SEOW members provided CHP with an initial list of potential participants. CHP staff members gathered additional contacts from those individuals who participated in an interview. CHP analysts completed 10 interviews. Key informants who agreed to be interviewed were organizational leaders representing the sectors of advocacy, direct service, practitioner training and development, and service administration. All key informants described significant lived experiences with recovery as motivating their choice of career and, with one exception, had been working in the field of recovery for at least 10 years.

During the interviews, all informants supplied information about their organization's services. Four informants represented three organizations that operate recovery housing programs for men and women wanting to live in drug- and alcohol-free environments. These organizations offer short- and long-term housing, case management, access to psychotherapy, and assertive linking to community-based social services. All three organizations are 12-step-based and host or facilitate 12-step meetings on site. One informant's organization provides non-abstinence-based housing services to individuals in various socially marginalized groups, including persons in recovery from SUDs. This organization also offers relapse prevention groups open to anyone in the local community who considers themselves to be in recovery from SUDs. Many key informants stated that their organizations participate in advocacy efforts such as testifying before the legislature, serving on advisory boards, meeting with policy makers, and conducting town hall meetings in order to promote the recovery movement and the use of recovery support services. Other organizations promote recovery by training providers to work with clients from a recovery-oriented perspective, by certifying and licensing both peer and professional recovery workers, and by providing opportunities for members of the recovery community to come together, share experiences, and build stronger bonds.

Perspectives on Recovery

Organizational-Level Definitions of Recovery

Interviewers asked participants to describe how their organization conceptualized recovery and to highlight any components they viewed as essential to the recovery process. Key informants' overall descriptions of recovery reflected two common themes. First, organizations viewed recovery as a process of change that is holistic and associated with an amelioration of SUD symptoms; improvement in one's physical, mental, and spiritual health; purposeful involvement in the community; development of healthy social relationships; and a sense of hope and meaning for one's life. The director of an advocacy organization presented recovery as:

> *"…characterized by remission, meaning a decrease/disappearance of signs and symptoms [of the SUD], citizenship, and personal health…those things getting better over time, people being reconnected to the community, their relationships getting better, improving their overall health all around, holistically."*

While an informant with a direct service organization replied that in terms of recovery:

> *"…everyone needs to be able to have recovery and needs to have some hope, there is something in their future, some meaning in their lives, some purpose…just [knowing] where is it that they fit in the community."*

Second, key informants regarded recovery as a process where "I have to take some action" and which can only be maintained by continued effort on the part of the individual. In other words "Recovery is an ongoing state. It is a way of living. It is applying principles of recovery… on a regular basis."

Organizational perspectives on recovery reflected differing opinions on whether recovery could be achieved through multiple pathways and the importance of abstinence to recovery. Participants disagreed on the extent to which they supported the view that there are multiple pathways for recovery. Key informants connected to advocacy organizations were of the opinion that recovery can be achieved in many different ways and supported empowering individuals to choose their own recovery goals and the methods for achieving those goals. For example, one director related that:

> *"You get 'oh, you're one of those people, an addict, so you need to start adhering to this strict regimen'. That doesn't work for everybody. I'm an advocate for what works for you…we are more open to other methods and using whatever tools make that person's quality of life better."*

Another informant indicated that in their organization:

> *"…we try to open peoples' minds up to see that your recovery is not somebody else's recovery and to put something in there like abstinence, it may be part of somebody's recovery and it may not be."*

Key informants connected to organizations that operated housing programs typically backed the view that a person's recovery is best guided by following the 12-step structure of Alcoholics Anonymous. According to participants, their organizations adhere to the 12-step recovery model because it appears to be effective, it has clear guidelines for achieving and maintaining recovery, it provides individuals with social support, it is widely available, it is acceptable to most people, and it is free. As explained by these organizational leaders:

> *"If you can't stay stopped, then there is a program of action through these 12-step fellowships that we can introduce you to that would give you the tools and a design for living that will be greater than the need to use or drink."*

> *"It is a 12-step based model…our thinking as the 12-step model has been around since 1935, it's acceptable, it's free, and it's kind of a 24-hours a day, 7-days a week, so it seemed like a sensible model to incorporate."*

The second area of discrepancy among organizations was the relationship between abstinence and recovery. Participants whose organizations were more actively involved in advocacy and training endorsed the viewpoint that recovery should not be defined by whether or not a person is using but rather by the person him or herself. In other words, "a person is in recovery when they say they are." The model of service delivery used by these organizations reflects this person-centered perspective on recovery so that:

> *"If they are in pre-contemplation, we have them come in, have a meal, ask if they want to work on any of their [recovery] goals…people would come and they would be under the influence and we would not turn them away."*

> *"…people are in all different stages of recovery and we are not looking at an abstinence-based model because recovery for people is as varied as the individuals that we work with."*

Interview participants connected to recovery housing organizations conversely expressed that abstinence from drugs and alcohol is critical to recovery indicating that "…stating you are in recovery does not make it so…it is the removal of mind-altering substances, also taking action to stay in a recovered state" and that "…the base for recovery would be substance free, no drug use and no alcohol use." The organizations that endorsed abstinence did make exceptions for the use of Methadone, Buprenorphine, Vivitrol, as well as prescriptions drugs used to treat physical or mental health conditions as highlighted by one director:

> *"Absolutely someone on medication-assisted treatment would be in recovery, absolutely. Just like if someone was battling depression and had to take an anti-depressant."*

Organizational Views on Indiana's Definition of Recovery

Interviewers next asked key informants to discuss the definition of recovery they believed Indiana, and the Division of Mental Health & Addiction (DMHA) in particular, was using to inform policy related to SUD services. Key informants who had regular contact with DMHA stated that the agency had recently adopted the following definition of recovery which encompasses both SUDs and mental illness:

> *"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."*

Participants familiar with the newly adopted definition believed that policy makers within DMHA are trying to advance a view of recovery consistent with SAMHSA's where recovery can be attained through different pathways, that these pathways can change over time, and that all pathways to recovery are equally valid. As one director who worked with DMHA to establish the definition stated:

> *"…it says nothing about 12-steps, it talks about integrating life in a way, it does not bring any sort of spiritual or religious component into it…so I think I see this as a really good sign for DMHA."*

Another participant who reported being actively involved with DMHA indicated that what the agency is moving to do is:

> *"…strive to encourage people to meet their own needs and achieve their full potential or do the best they can. So, we have all options. We have drug-free programs, we have medication-assisted therapies, and that should be a patient choice."*

Other participants expressed less positive impressions of DMHA's and Indiana's perspective on recovery. These informants believed that DMHA's and the state's concept of recovery is "archaic"; i.e., equating recovery strictly with abstinence, including eventual abstinence from Methadone and similar drugs, and supporting termination of a person's services once abstinence is achieved. Two directors expressed their thoughts as:

> *"I gave you the example of the person on methadone…working, being a tax payer, and being able to pay for his methadone. Is that recovery? Yes, in my vision. If the state would say that was recovery I don't think so, I'm not sure…as long as I've been in the field, I've never heard them embracing other pathways of recovery."*

> *"I think that the state…is looking at recovery as substance free. Once you become substance free you should be able to just get on with your life, just go do what you need to do."*

Despite informants' contrasting opinions on the state's view of recovery, when interviewers asked key informants to express if Indiana seemed to be shifting to a more recovery-oriented service delivery system, the majority of organizational leaders thought it was. As evidence for their assertions, informants cited the following events: DMHA's recent adoption of a formal recovery definition to guide planning; DMHA's creation of a recovery advisory group containing representatives from the recovery community; DMHA's efforts to acquire grants that emphasize recovery principles such as Access to Recovery (ATR), Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS), Project PEERS, and Recovery Works; DMHA's efforts to train certified recovery coaches and other peer providers; DMHA's ongoing attempts to gain Medicaid reimbursement for recovery management services; and the Indiana General Assembly's recent decision to substantially increase funding for addiction services over the next two to three years.

Recovery Facilitators

Interviewers followed up by having key informants discuss any other factors they believed might be helping to advance recovery-based SUD service provision in Indiana. Interviewees cited three factors they saw as positive influences for recovery in Indiana.

Changing Requirements for SUD Service Grants

First, key informants observed that both state-level grants like Recovery Works, and federal-level grants from SAMHSA such as ACT, are tying dollars to the development and use of nontraditional recovery support services such as transportation and recovery coaching for persons with few resources. As reported by one agency leader:

> *"…beginning with ATR, which was done through DMHA, there was a strong emphasis by SAMHSA for connecting recovery into a continuum of addiction treatment so we have a full continuum of care instead of just abdicating to the 12-step groups."*

National-Level Policies Related to SUDs

Second, some participants believed national-level policy, specifically the Mental Health Parity and Addiction Equity Act (MHPAEA), the Comprehensive Addiction Recovery Act (CARA), and the Affordable Care Act (ACA) could help strengthen Indiana's recovery focus. Key informants suggested that CARA, if enacted, would increase Indiana's access to funding for SUD services and require the state to implement evidence-based and recovery-focused interventions with any funds it receives. Interview participants also offered that the ACA and the related Healthy Indiana Plan (HIP 2.0), if operated in accordance with the MHPAEA, would augment Indiana's recovery infrastructure:

> *"…if the ACA survives and HIP 2.0 gets running and treatment for addiction and recovery services get covered the way they should, that will help strengthen the infrastructure because it will be cost effective to integrate recovery in with the treatment side of things…as a full partner in the continuum of care."*

The Opiate Crisis in Indiana

Third, the majority of key informants cited Indiana's current opiate crisis as being the most instrumental event for raising the awareness of stakeholders, policymakers, and the population at large of the need to enhance treatment and recovery services. Informants suggested the opiate epidemic is capturing the attention of policymakers and legislatures because, unlike earlier drug epidemics (e.g., crack, methamphetamine) that primarily involved economically disadvantaged and marginalized groups, the Hoosiers currently affected are typically young adults in high school or college, living in suburban areas, who are White, and whose families have more resources and social influence. Two participants summarized the situation as:

> *"I will be real honest and I think that we all know that it is starting to change a little bit in that more faces and voices are going on because the opiate crisis is affecting 90% white, middle to upper class it is just very different than what happened with crack and meth… we are starting to look at it differently because all these parents, a lot of them influential, are starting to come out and starting to say 'listen we are from a 'good' family and we are affected' so I think it is starting to change for that reason a little bit at a time."*

> *"The prescription drug and heroin situation could have a positive effect in moving us forward. The problem has been here a long time but the current awareness comes from the fact that middle class, white kids are becoming addicted. We have politicians from areas of the state that didn't want to have anything to do with this type of thing, it was an urban problem for the big cities, the ghettos. All of a sudden, it is on their radar screen."*

Although pleased that Indiana is taking steps to incorporate a recovery-oriented structure of care and provide more support services for people in recovery, key informants voiced frustration with the pace of the process:

> *"…a lot of people talk about recovery-oriented systems of care, Indiana is trying. It is just slow…"*

> *"…Indiana seems to be behind the times, we are slow and rigid to think outside the box and try new approaches."*

Recovery Barriers

Interviewers asked key informants to describe the barriers present in the state that are keeping recovery-related reform from occurring more quickly. Respondents discussed the following barriers: stigma, funding, service availability, the structure of the SUD service system, the recovery community, and the recovery workforce.

Stigma & Conservativism

Participants expressed that Indiana's overall sentiment towards SUDs and individuals who have them is a significant factor working against recovery reform. Informants suggested that a large percentage of Hoosiers, including key elected officials, continue to uphold stigmatizing ideas about SUDs, attributing them to moral failings or character defects and branding individuals with SUDs as "bad", spiritually misguided, culpable for their disorder, lacking in willpower, and actively choosing drug use over positive life options. One interviewee summarized Indiana's viewpoint as:

> *"…we [Indiana] are in the heartland, part of the Bible belt, so minds are a little bit more closed. There is still that idea that it's a moral issue, why can't you just pull yourself up by your boot straps and just stop drinking?"*

These stigma-perpetuating views stimulate little interest among political leaders to spearhead approaches to address SUDs in ways other than those aligned with moral perspectives and which are punitive in nature, promote the use of incarceration, and that support providing individuals with treatment services but not with ongoing services for helping them maintain their recovery in the community. Two respondents described the impact of stigma by noting:

> *"I would suspect if you asked our current governor about people who suffer from addiction, he would probably come down more on the moral failing and the lack of spiritual connection component and so, there hasn't been good leadership at the political level to drive a change."*

"…the folks the state gives money to or they support [are] those systems that are very punitive. They don't look at the whole recovery process. It is all about treatment."

A few participants described Hoosiers as supporting "conservative values" which, from their perspective, promote within DMHA a fear of making changes to the existing system structure. Consequently, progress on recovery issues moves slowly because as stated by two informants:

"…there is going to have to be more direction from the Feds. It is almost like they [DMHA] don't want to do anything until they are told by the Feds to do it."

"DMHA sometimes is not very progressive. They tend to be 'well we don't want to make anybody mad.' 'We might lose our job, they will complain to the governor and the governor will fire us.'"

Lack of Awareness & Information

Key informants supplied that across Indiana, Hoosiers receive little accurate information about SUDs, addiction, what recovery from SUDs means, the types of services which are most effective for individuals in recovery, and how recovery is best achieved and maintained. Respondents described current awareness of recovery as:

"People don't know about recovery. They don't know the things that are available. They don't know how many people are in long term recovery in this country. They don't know how many of us are getting and staying well. They don't know if we get people to five years that we have a 75 to 95% chance of remaining in recovery for the rest of our lives. People need to know these things."

"I think [recovery] is still something new to them [legislatures]. When I testified two years ago, I don't think they knew a lot about substance use and the impact it had in their communities. I think they were surprised by how many people had SUDs in their communities and how many didn't have access to any care or insurance."

The limited level of knowledge about SUDs and recovery that prevails in the state maintains, in the eyes of informants, maintains misperceptions about people who have SUDs, recovery from SUDs, and the adequacy of the current SUD treatment system. Consequently, these misperceptions keep the general public and policy makers disinterested in exploring or advocating for a recovery-oriented system change.

"The [current] system spends more and more energy maintaining itself and more and more money and they don't want to look at if we had recovery coaches, recovery support services, housing, transportation, whatever it may be, that those services would improve our outcomes and we would not need to spend as much money on treatment."

"I think what is presented to the community is not accurate. I think the community envisions all these resources out there and jobs. I think they see people with [SUDs] as being lazy and they'd rather be high…I don't think the community has a clue about what is really going on."

SUD Service System Structure

The structure of Indiana's current SUD service delivery system was viewed by a number of participants as creating a challenge for recovery. A service organization's leader saw the state and local communities as "really suffering from a lack of infrastructure to support recovery of any kind. I mean good jobs, safe homes, housing. To have recovery those pieces need to be in place and if those are in place then other parts start to fall in place too." Other participants' described the state's current service system infrastructure as being "siloed", with agencies and organizations disconnected from one another, not communicating, and not working together. Per participants, the "siloed" nature of the SUD system is problematic for recovery initiatives as it prevents the development of a continuum of services that is easy for clients and providers to access and navigate and instead fosters a system characterized by confusion and delays for clients who need services and fails to support them in maintaining their recovery. Organizational leaders experienced the system as:

"…frustration when we try to collaborate with other programs…it is like we are all siloed. We are not working together. There is no continuum of care. There is no understanding that we are all on the same team."

"They [people with SUDs] encounter a lot of barriers that increase with a criminal record. Jobs are an issue. The system is siloed. There are no connections to resources and it sets someone up to revert back to survival mode [of dealing/using]."

Funding

Key informants stated that funding is an obvious roadblock to recovery. Participants voiced that the funds currently available for SUDs are simply insufficient to support the development and implementation of recovery-oriented services. As one key informant bluntly stated:

"So, those are the biggest barriers are how you pay for it and then paying for these recovery management services."

Relatedly, interviewees pointed out that recovery initiatives are further blocked as the monies DMHA has are not directed to recovery-related programming so even though "…a lot of people [at DMHA] talk recovery but if you drill down into operationally what they are doing, their policies and procedures, they are not there...if you look at their funding policies they don't mandate recovery supports as part of programming."

A third funding barrier noted by participants was Medicaid's policy of not providing reimbursement for most recovery-related services and reimbursing those it does cover at extremely low rates. The lack of proper monetary backing by Medicaid works against recovery by making it financially challenging for organizations to offer recovery services without having to rely on time-limited funding sources such as grants. A service director noted that in their organization:

"We want to be able to have outreach in our communities with our coaches, engage with high-risk, high-need individuals, do prevention, early intervention…that is not reimbursable [by Medicaid]."

Availability of Services

Participants reported that given the disconnected nature of the SUD service system and the lack of financial support for recovery, gaps currently exist within Indiana's array of SUD services. These gaps present a barrier for Indiana as recovery-oriented systems require a complete continuum of both treatment and recovery-related services for individuals to be successful. The service gaps noted by informants were insufficient detoxification services; residential treatment services, particularly for women; recovery housing services; medication-assisted recovery services; recovery support services to assist individuals with housing, transportation, job training, and employment; community engagement and outreach services; recovery management services; and peer-provided services for individuals living in community and correctional settings. Key informants struggle with helping clients to start and stay in recovery because:

"…we got 25 detox beds in this city, you've got a better chance of winning the lottery than getting a detox bed."

"…the biggest barriers we have when they get ready to leave are housing, housing is horrible even if they qualify; transportation is not much better; unemployment is an issue; being able to support themselves…"

Recovery Workforce

Respondents reported that Indiana's recovery efforts are held back by issues related to its recovery labor force. While several key informants applauded DMHA's commitment to growing a peer workforce, they were unaware of parallel efforts to increase employment opportunities for peer workers. The lack of peer recovery jobs hinders implementation of what informants view to be an essential component to any recovery-oriented system of care. Low pay, the use of peer workers in clerical rather than service positions, and organizational policies that deny employment to peer workers with drug-related criminal convictions are additional factors that participants believe are helping to further limit the expansion of peer-provided care. The situation for peer workers was expressed as:

"You've got these recovery coaches trained but there is not the infrastructure to go work and practice being recovery coaches."

"We were talking about getting peers hired, a lot of them have a criminal offense and it is policy at some providers that they won't hire somebody with a criminal offense."

"Recovery coach salaries are from minimum wage to about $15.00 per hour. How can you make a living on minimum wage?"

In terms of the broader recovery workforce, interview participants cited the state's overall shortage of addiction/recovery professionals as a barrier to recovery efforts. Despite the high need for professionals, key informants suspected that Hoosiers interested in pursuing a career in addiction/recovery are often dissuaded from doing so as the stigma tied to SUDs along with the limited funding for services, create an environment where addiction/recovery workers are devalued and often poorly compensated. Two informants supplied that:

"If you tell them you work in a methadone program it is like "Oh man, how could you work in a methadone program?" So, there is a lot of stigma even for folks who work in the field. It is not high status…"

"You can have an MSW and start out at $23,000 a year. Many [providers] work at one agency all day and then have a part-time job with another one just to stay above the poverty line."

Lack of Recovery Advocates

Respondents identified that two critical assets for advancing recovery initiatives are lacking in Indiana. These assets are a well-organized group of people who are openly in recovery and willing to aggressively advocate for change in how Indiana serves people with SUDs and strong recovery allies within the state's government. Informants suggested that by Indiana not having these prominent "recovery champions", policy makers can easily overlook the needs and wants of the recovery community. Two informants related that:

"We don't have a constituency that can really put pressure on the legislature… We don't have a lot of champions at the legislative and political side of things. We have got to develop those."

"So, these folks who are in positions of public service if the only thing they are hearing is the loudest noise, they may be responding to the loudest need but maybe not the appropriate need, the one that could best suit everybody."

Policy Recommendations

In light of the barriers which key informants highlighted as holding back statewide implementation of recovery-oriented services and system level modifications, interviewers next asked them to discuss policy recommendations that might address the existing barriers and allow for a recovery-oriented system of care to emerge more rapidly within Indiana.

Spread Accurate Messages about Addiction & Recovery

In order to help negate stigma and increase interest among the public and politicians around recovery issues, informants voiced a strong need for all organizations, agencies, and groups involved in recovery work to develop policies that promote the dissemination of accurate information about SUDs and recovery. Respondents agreed that more concerted efforts need to be made by all sectors to communicate through the use of recovery-affirming language that SUDs are chronic medical conditions tied to a person's genetic makeup, not to his or her morals or character; the social and economic benefits that can be gained by helping individuals with SUDs have easy access to early intervention and ongoing community-based services; and precisely what each sector in the state, including the general public, can do to be part of a recovery-based answer for SUDs. Interviewees summarized the need for these policies as:

"…we need to convince the world that it is an illness and that people do get better."

"…when I go to these meetings, I am essentially the only voice saying we are letting the public off the hook…the public health crisis that is addiction is the only public health crisis that is not telling the public what they can be doing, giving them something to do as part of the solution."

"…just promoting, having a bit more emphasis on the positive message of recovery and having the spokesperson [for the state] use the language of recovery versus the language of addiction."

Relatedly, key informants pressed for policies that would expand and set standards for education and training on substance use, SUDs, treatment, and recovery that is provided to young people in schools, to addiction and mental health professionals, to the criminal justice workforce, to healthcare providers and to other professionals who engage with individuals that are affected by SUDs.

> *"…so there is a need to get education and awareness, treatment, recovery all those disciplines dealt with as a continuum so we need to go into the schools in the formative years when kids are beginning to be introduced [to alcohol and drugs…"*

> *"…all the training these different professions get, what are they getting around addiction? Are they getting anything? If they are, what is the focus on recovery?"*

> *"…the messages around fear, striking fear into our kids is not the best model for teaching prevention, [like] if you use, you are bad and you will go to Hell and burn."*

Although not a policy recommendation per say, respondents did identify a need for more effort from within the local recovery community to support people to come forward, be open about their recovery, and share their stories. Informants suggested that showing Hoosiers the entire range of people who are in recovery from SUDs can lessen the stigma held by individuals in recovery, help those in recovery become more vocal proponents for change, positively shift public opinion around recovery, and encourage public support for system change. For example, one key informant believed:

> *"We need to put a face on it. These are the people in your neighborhoods, the people you work with, the people you go to school with, you sons and daughters, your grandparents. These aren't just what you seen TV, they are not just the homeless people living downtown. I think that is going to be where the big shift comes into play."*

Involve the Recovery Community in Policy Making

Participants cited that if the recovery initiatives are to move forward, policies are needed that ensure that the recovery community has a significant role in shaping policy and services across the entire continuum of care for persons with SUDs. Informants argued that recovery community involvement is essential in creating a system that will effectively meet their needs and which they will support. Otherwise, as one respondent supplied:

> *"…you build something and think it is amazing and say 'hey, look what I built for you' and they say 'wrong way, wrong approach.' You must assume that they are going to be grateful, no! Include them from the beginning so they are building it."*

Key informants noted that currently, provider organizations, local and state agencies, and other groups who work with individuals in recovery typically have few if any recovery representatives on their boards, questioning "Why isn't there someone from the recovery community at the table and not just your token addict or alcohol? Someone who is able to have the appropriate conversations and pull some of those resources?" To solve the problem of recovery community involvement, participants suggested that one solution would be to have policies that mandate that members of the recovery community sit on all boards and in policy-making positions within all levels of organizations and agencies:

> *"…somehow we need to get a greater recovery voice in policy making and I think one way to do that is mandate instead of say one person [on a board or committee] 5 or 10 or whatever."*

Promote Recovery-Oriented Systems Change

Survey participants were of the opinion that Indiana would benefit from a recovery-oriented SUD service system; however, for the state to move in that direction advocacy is needed for policies that will generate a stronger interest in a recovery-based structure. As one participant saw it:

"…the recovery model would be cheaper and more efficient…we are talking about a way that changes the structure, so I think they can look at promoting and training and getting folks to build the infrastructure."

The infrastructure proposed by informants reflected SAMHSA's recommendation for shifting Indiana from a system, where agencies involved with substance use issues are disconnected from each other, to a recovery-oriented system of care where agencies are coordinated, integrated, and can better address the multi-system needs of individuals in recovery. Two respondents believed:

"…there is a need to get education and awareness, treatment, recovery, all those disciplines dealt with as a continuum… this [SUDs and recovery] is a multi-pronged issue that recovery is the hum of, but all these pieces need to be addressed simultaneously…"

"Everyone is so busy, caught up in their own little silo. Nobody has the person or the time or the resources to stand back and say 'wait a minute, we need an expert that is going to look at a systems approach and bring everybody to the table: mental health, and addiction, and housing, and employment.' We need everybody at that table to work together and play together. It would benefit us in the long run and get so much more for our dollars."

An integrated system of care would facilitate the development of an inclusive array of recovery services ranging from low- to high-intensity intervention options as well as ongoing recovery maintenance. Respondents believed that a complete continuum of services which is supported by insurance is vital for Indiana to have in place in order to most effectively support Hoosiers' long-term recovery efforts. Participants summarized the need as:

"…it comes back to integrating recovery as a full partner, insurance-wise, philosophy-wise, medical-wise, and creating that continuum of care. If we don't do that we are not going to allow recovery to mature and become a full partner of the continuum in the way it needs to be so people can be successful and stay in recovery."

"…there are a lot of different aspects to recovery and they all need to be identified and given appropriate attention and there is a continuum of care in recovery that starts from maybe detox all the way through permanent housing and support 10 years out…"

Support Expansion and Use of Recovery Services

For Indiana to be effective in working with individuals from a recovery-oriented perspective, informants stated that a wider range of recovery support, recovery management, and peer recovery services not only need to be offered but also used by organizations that serve people in recovery. Respondents reiterated that DMHA continues to direct available monies to treatment over recovery-related services. One informant described the situation at DMHA as:

"The community mental health centers run DMHA. They are the biggest recipients of the money. For DMHA to make a policy change they [the mental health centers] have to approve it and their focus is on treatment so their belief is any new money that comes in should go to treatment. That keeps recovery supports from moving forward…"

In the eyes of two informants, the obvious policy recommendation to address the money barrier was for DMHA to "…fund recovery supports" and provide a "stream of funding that we just could totally focus on recovery coaching, counseling, and long-term recovery for individuals." Other informants noted that for such a change to happen DMHA would first need policies that support recovery services because "…recovery needs to be included more and drilled down into their [DMHA's] operational levels" and that "…it is going to require RFPs, whether from the division, the CJI, and other people to start writing things that are more recovery oriented, that is really the direction that it needs to be." Once there is clear support for recovery services at the state level, informants believed that then it would be incumbent upon DMHA to have policies that tie the receipt of state funds to the use of recovery services perhaps in the form of "…a mandate that if you are getting state money you have to have recovery supports in your program and they have to be accredited or approved." In general, informants suspected that policies linking funds to recovery services will be critical for advancing their use as:

"It's not just going to magically happen because the providers out there are going to do the things that the state funds. They've got to survive, they've got to eat. If the state starts making these [recovery services] a priority I think it would make a big difference."

Follow Best Practices for Recovery

Interview participants discussed the need for policies to ensure that in creating the continuum of services, the state, DMHA, and provider organizations follow best practice guidelines. The policies which key informants proposed are ones which would: require support for all pathways to recovery, remove barriers for harm reduction strategies such as syringe exchange programs, require the use of evidence-based practices, mandate that individuals receive recovery management for up to five years post-treatment, and increase the use of early intervention strategies to link high-risk individuals to community-based and other services more quickly.

Respondents cited methadone clinics as one service area where change is critically needed to make them recovery-oriented as "…it is one of the most regulated things in the state to where some places they fund, I wouldn't send my dog there…I think it is time for the language of recovery to pick up." Key informants suggested that in order to shift the punitive nature of methadone clinics, policies are required that would support long-term use of methadone, have clinics endorse recovery principles, and mandate that clinics offer peer recovery services along with medication.

"The legislature has not mandated a recovery focus. Somehow we need to move to medication-assisted recovery and if they want to add regulations to the clinics, put something measurable in their about recovery."

Support Recovery for Individuals who are Incarcerated

Informants related that incarcerated individuals who have SUDs are currently underserved, typically have post-release recovery challenges related to obtaining employment, following probation requirements, and meeting their basic needs. To help recovering individuals from cycling in and out of prison, one respondent noted "I would love to see policy change a lot in our criminal justice system and have more innovative approaches there." Respondents suggested policies that would support expunging criminal records of certain drug-related crimes; create skills training programs for inmates that can lead to post-release employment; develop therapeutic communities; incorporate peer services directly into correctional settings; and create job opportunities for individuals who receive recovery coach training while incarcerated to work as coaches upon release.

Enhance Employment Opportunities for Peer Workers

Interviewees reported that peer services which offer role-modeling, emotional support, education, and linkages to community resources are essential for helping individuals achieve and maintain recovery. Participates believe that as DMHA expands the pool of peer workers who can provide these services they also need to create policies that mandate the use of peer workers so they can find employment. Policy recommendations that informants suggested were "if I had a treatment program I would want everybody there to have a recovery coach… just helping people out," "partnering with all the access points, coaches could be going in and training access points to create environments for people to get help sooner," and "there needs to be more emphasis on this peer model, if DMHA could just take a strong stance on it."

CONCLUSION

Key informants' thoughts and opinions about the nature of recovery highlight the many ways that it can be conceptualized. Though participants agreed that recovery from SUDs is an active change process that is characterized by ongoing improvement in mental and physical health, social relationships, community involvement, spirituality, and SUD symptoms, they disagreed on other aspects of recovery. Some participants' organizations upheld the view that many pathways exist to recovery and the choice of path should be up to the individual while informants in other organizations maintained that recovery can best be achieved by following a 12-step approach. Views on abstinence from drugs and alcohol also varied among organizations with several viewing it as a requirement for recovery and others believing that a person can be in recovery regardless of whether or not they choose to be abstinent.

In terms of Indiana, participants familiar with DMHA reported that the agency recently adopted a definition of recovery to guide their service planning which emphasizes improvement in quality of life as the goal and allows for flexibility on how that goal is reached. Despite this move by DMHA, many respondents were of the opinion that the state continued to define recovery in terms of achieving abstinence, including abstinence from drugs used in medication-assisted recovery, and not as an ongoing process requiring long-term, community-based support services. In spite of how several participants believed Indiana viewed recovery, most informants thought that there was some movement within DMHA to be more recovery-oriented citing DMHA's interest in recovery-based grants and its efforts to train peer recovery workers. Respondents suggested that changing guidelines for the use of grant funds at the federal level, national policies supporting recovery-oriented care, and the attention Indiana's opiate crisis has raised around services for persons with SUDs have helped push both DMHA and the state in a more recovery-oriented direction.

Despite the changes taking place, key informants cited several barriers that they believe are holding Indiana back from fully embracing a true recovery-oriented service delivery system. Participants noted that stigma and lack of accurate information about addiction and recovery promote negative perceptions about individuals with SUDs and create little interest in the public or the legislature to do things differently. Key informants cited Indiana's overall lack of a recovery infrastructure and the siloed nature of its current service delivery system as impeding the development of a coordinated system of care that can provide a full continuum of treatment and recovery services. The limited funding for SUD services, DMHA's policy to direct available funds to treatment programming, and the resulting service gaps all act as barriers to creating the array of services necessary for supporting individuals in recovery. Respondents noted that the lack of employment opportunities for peer providers is inhibiting the expansion of peer-based services, services which are central to recovery-oriented care. The final barrier to recovery-oriented system change respondents addressed was the absence in Indiana of both a powerful recovery advocacy group and "recovery champions" in state government that can argue for and bring about change.

Key informants made several policy recommendations that they thought could address Indiana's recovery-related barriers and move it more rapidly towards embracing recovery-oriented care for persons with SUDs. First, in order to reduce the stigma associated with SUDs, participants proposed that agencies and organizations have policies that promote accurate information about SUDs written using the language of recovery. Second, to ensure a recovery voice in policymaking, key informants stressed the need for policies that mandate inclusion of representatives from the recovery community in all aspects of recovery-related planning. Third, to move Indiana away from its disconnected system structure, participants suggested having policies that promote a recovery-oriented system of care and support integration of the agencies who serve individuals with SUDs. Fourth, so that Indiana is able to have a complete continuum of recovery services and ensure that they are used, respondents proposed that existing funding policies and funding mechanisms would be revised so that dollars are tied to the use of recovery services. Fifth, participants related that in order to guarantee that Indiana implements recovery services appropriately, policies requiring the use of best practices for recovery would be essential. Sixth, respondents related that shifting to a recovery focus would require Indiana to address the needs of recovering individuals in the correctional system and proposed having policies in place that would provide recovery services for these individuals during their incarceration and after they return to the community. Finally, to address the limited employment opportunities for peer workers and enhance the use of this vital resource, key informants recommended policies that would require their use and would integrate them into all organizations that in some way connect with individuals who are or would like to be in recovery from SUDs.

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