"Ideas for Treatment Improvement"

ADDICTION Messenger

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SERIES 28

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Recovery-Oriented Systems of Care- Part 3

Recovery Management

"A wise man will make more opportunities than he finds."

~ Sir Francis Bacon (1561 - 1626) ~

An article written by William L. White titled *"Recovery Management: What If We Really Believed That Addiction Was A Chronic Disorder?"* appears in "Recovery Management", published in 2006 by the Great Lakes Addiction Technology Transfer Center. That article is used as the focus of this issue of the Addiction Messenger which continues to explore aspects of recovery-oriented systems of care with information on the definition, principles and practices of the Recovery Management model. Mr. White's entire monograph can be downloaded at: http://www.glattc.org.

Recovery Management Definition

The recovery management model of addiction treatment shifts the focus of care from episodes of acute symptom stabilization toward a client-directed management of long-term recovery. Traditional interventions are combined with a sustained continuum of:

• pre-recovery support services to enhance recovery readiness,

• in-treatment recovery support services to enhance the strength and stability of recovery initiation, and

• post-treatment recovery support services to enhance the durability and quality of recovery maintenance.

The shift from acute intervention models to models of sustained recovery support are reflected not only in the federal government (particularly in CSAT's Recovery Community Support Program at http://rcsp.samhsa.gov) but also in the policy agendas of new grassroots recovery advocacy organizations (at http://www.facesandvoiceofrecovery.org). Describing the emerging "model" of recovery management is difficult because it is still being created. But its' broad principles and early changes in clinical practices are becoming visible. The information in the following paragraphs represent what is increasingly being characterized as a model of *Recovery Management (RM)*.

Basic Principles

The cornerstone beliefs that distinguish the recovery management model from acute models of addiction treatment include:

• emphasizing the client's resilience and recovery processes (as opposed to pathology and disease processes),

• recognizing and honoring that there are multiple long-term pathways and styles of recovery,

• empowering the client in recovery and their families to direct their own healing,

• developing highly individualized and culturally appropriate services,

• increasing collaboration with diverse communities of recovery, and

• committing to best practices as identified in the scientific literature and through the collective experience of people in recovery. (http://www.bhrm.org/papers/principles/BHRMprinciples.htm and http://www.dmhas.state.ct.us/corevalues.htm)

Model Practices

White, Boyle and Loveland's (2003a/b) review of recovery management pilot programs highlights critical differences between the RM models and traditional acute care models. The differences span several areas of clinical practice.

Engagement and Motivational Enhancement:

RM models place an emphasis on engagement and motivational enhancement. This emphasis is reflected in low thresholds of engagement, investment in outreach and pre-treatment support services, high retention and low post-admission administrative discharge rates. Motivation as something that emerges within the service relationship rather than a precondition for service initiation. RM models reach out to people prior to a crisis and sustain contact with them, while Acute Care models are reactive in their wait for individuals to enter a crisis state that brings them to treatment.

Assessment and Service Planning:

Clinical assessment is usually focused on substance use and its consequences, is pathology-based, and is an intake activity. Problem severity dictates the level of care, and the problems list drives the treatment plan. In RM, assessment is focused on the whole life of the recovering person, is asset-based (a client's "recovery capital"), and is continual over the span of the service relationship. This view is based on three propositions:

• Chronic disorders can lead to other acute and chronic problems, so all aspects of the recovering person's life must be assessed and incorporated into the recovery process.

• Service intensity and duration should be dictated by the interaction of problem severity and recovery capital. Problem severity alone is not adequate and is a disempowering basis for service planning,

• There are developmental stages of long-term recovery. Service and support needs can shift significantly in the transition from one stage to another. Therefore stage-dependent service needs must be continually reevaluated.

The traditional professionally-directed, short-term treatment plan of the acute care model is replaced in the RM by long-term and short-term recovery plans prepared by the person seeking recovery and focused on building recovery capital and a meaningful life.

Service Duration and Emphasis:

Acute care models often fail to facilitate the transition between recovery initiation and recovery maintenance. RM focuses on factors needed to sustain recovery over a lifetime. RM emphasizes four post-treatment service activities:

• sustained post-stabilization monitoring,

• stage appropriate recovery education and coaching,

• assertive linkage to local communities of recovery, and,

• early reintervention when needed.

Detoxification and traditional treatment exist in RM models, but the focus of service shifts from crisis intervention to post-treatment recovery support services.

Locus of Services:

The focus of the acute care model ("How do we get the addicted person into treatment?") shifts in the RM model to the larger community ("How do we facilitate the process of recovery within the client's natural environment?"). With this shift, there is greater emphasis on home and neighborhood based services and in direct monitoring/communicating via telephone, mail, and Internet. Providing recovery support services within the client's physical/social environment are also emphasized. RM encourages treatment agencies to develop greater advocacy responsibilities regarding stigma and discrimination, to decrease obstacles to recovery and to create recovery support resources within their local communities.

Role of the Client:

The person entering treatment is sometimes viewed as the major obstacle to their own recovery in the acute care model, and therefore, seen as dependent upon an expert who will take responsibility for their diagnosis and treatment. RM models honor and champion the right of the client to self-manage their own recovery process. Each client must become an expert on their condition and its management. This philosophy can be seen in the client's role in treatment planning, evaluation, and the inclusion of recovering people and family members.

Service Relationship:

The service relationship in RM is less hierarchical than within the acute care model. The service provider role is more that of a consultant and ally participating in a long-term health care partnership. RM models are pioneering new approaches to peer-based recovery support services that utilize new service roles, e.g., peer counselors, recovery coaches, and recovery support specialists (White, 2004). The importance of a sustained continuity of contact in the recovery support relationship is emphasized. This relation-

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ship would be similar to the long-term alliance between a physician and a diabetic patient.

Model Evaluation:

Evaluation within the RM models focuses on measuring the long-term effects of multiple service interventions rather than measuring the short-term effects of a single, brief episode of intervention such as in acute care models. The goal is to identify combinations of clinical and recovery support services that improve recovery outcomes within particular populations of people. It also balances science-based evaluations of outcomes with consumer and community/tribal evaluations of service processes and recovery outcomes.

Elements of RM exist in many traditional treatment programs that have focused more on client-responsive clinical policies and practices. The model also exists in CSAT's Recovery Community Support Program and RWJ's Paths to Recovery grantee sites. It is also being used in networks of recovery homes and recovery support centers. The RM model of intervening with substance use disorders is a significant change in the design of addiction treatment.

Examples of Recovery Oriented Systems of Care

State of Washington

The State of Washington funded six counties to implement Access to Recovery (www.atr.samhsa.gov), a grant program funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. ATR provides vouchers to clients for purchase of substance abuse clinical treatment and recovery support services. The goals of the program are to expand capacity, support client choice, and increase the array of faith-based and community-based providers for clinical treatment and recovery support services. The beneficial effects include a more person-centered approach to services where individual choice and preference are important, an emphasis on culturally specific services and an acceptance of spiritual support and services that have not traditionally been funded. Washington's ATR reflects several elements of recovery-oriented systems of care: person-centered, partnership-consultant relationship, culturally responsive, and responsive to personal belief systems.

The Wellbriety Movement

The term "Wellbriety" means to be both sober and well. For American Indians and Native Alaskan populations, the term describes a natural evolution of the recovery process and combines Native American cultural values with the traditional 12-steps of AA. It is based on the Four Laws which involve family and are anchored in the community, which ensures that the community is a centerpiece and an ongoing support network for individuals and families seeking recovery. The Wellbriety Movement meets the following elements of a recovery-oriented system of care: person-centered, family involvement, services across the lifespan, anchored in the community, partnership-consultant relationships, culturally responsive, peer recovery support services, education and training, and ongoing monitoring and outreach. For more details go to: www.whitebison.org/about/index.html.

Next Issue:

"Interventions with Families of Adolescents"

Source:

White, W., Boyle, M. & Loveland, D. (2003a) Addiction As Chronic Disease: From Rhetoric to Clinical Application. Alcoholism Treatment Quarterly, 3/4: 107-130.

White, W., Boyle, M. & Loveland, D. (2003b) Recovery Management: A Model To Transcend the Limitations of Addiction Treatment. Behavioral Health Management 23(3):38-44.

White. W. (2004) The History and Future of Peer-Based Addiction Recovery Support Services. Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC. (Available at www.bhrm.org).

White, W. Recovery Management: What if we really believed that addiction was a chronic disorder? In Great Lakes ATTC (2006) *Recovery Management*, (available at http://www.glattc.org)

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- ☐ **Series 2** Vol. 4, Issues 4-6 "What Works for Offenders?"
- ☐ **Series 3** Vol. 4, Issues 7-9 "Manual-Based Group Skills"
- ☐ **Series 4** Vol. 4, Issues 10-12 "Preparing Clients for Change", "What Is A Woman Sensitive Program?" and "Naltrexone Facts"
- ☐ **Series 5** Vol. 5, Issues 1-3 "Methamphetamine: Myths & Facts"
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Registration Form for Series 28
"Recovery-Oriented Systems of Care"

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TEST Series 28

1.
Recovery-oriented systems of care are:
a. Client centered
b. Short-term interventions
c. Hierarchical
d. a and c.

2.
Family and others are never incorporated into the recovery process

True or False

3.
Providing individualized, comprehensive, stage-appropriate services means that the care system:
a. adapts to the needs of the client
b. supports the client across the lifespan
c. uses the Stages of Change
d. a and b

4.
The continuity of care in a recovery-oriented system of care provides a contiuum of services which enhance (fill in the blanks)____________________
and decrease ______________________________.

5.
Collaboration and client self-management are hallmark characteristics of the recovery-oriented sysem of care.

True or False

6.
Recovery-oriented systems of care coordinate/ integrate eforts across service sytems such as:
1. __________________ 2. __________________
3. __________________ 4. __________________
5. __________________

7.
Evaluation in recovery management focuses on the long-term effects of multiple service interventions without identifying the combinations of clinical and support services used.

True or False

8.
A recovery process that combines Native American cultural values along with traditional 12-stepof AA is called (fill in the blank)
______________________________.

9.
Name five of the guiding principles of recovery:
1. ____
2. ____
3. ____
4. ____
5. ____

10.
Peers as well as family members, form vital support networks for people in recovery. Receiving support, guidance and information from others who are committed to recovery can enhance a person's recovery

True or False

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What was your reaction to the concepts presented in Series 28?

How did you react to the amount of information provided?

How will you use this information?

Have you shared this information with co-workers?

What information would you have liked more detail about?

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