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Traditional frameworks of addiction recovery and addiction treatment recognize long term supports play an important role following formal treatment. What further elements of recovery orientation in clinical practice have been developed?

This presentation will provide an updated look at substance use disorder treatment and supports for ongoing recovery by reviewing the principles of behavioral health recovery management (BHRM) that later became formalized as recovery oriented systems of care (ROSC).

The resulting continuum from a traditional orientation to a newer recovery orientation will be applied to innovating in our systems and also in our approaches to helping individuals. Opportunities for recovery-oriented organizational change and related leadership practices supportive of change at the organizational level will be discussed.

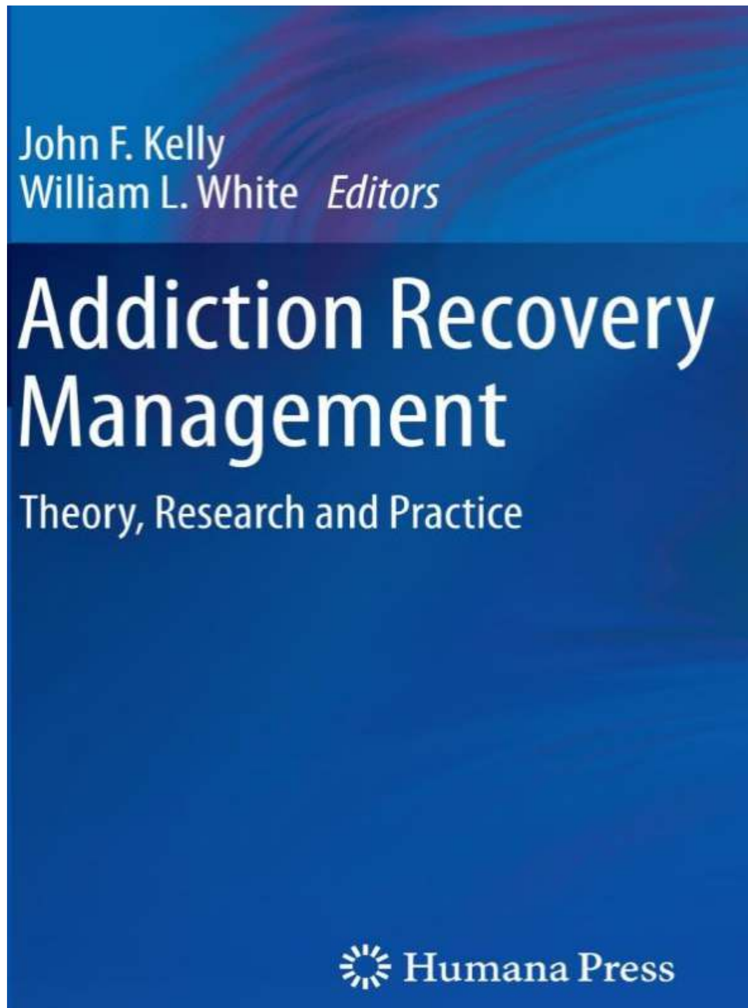
Workshop Objectives

By the end of the presentation, the attendee will:

- Describe the shift from a pathology orientation to a long-term recovery-oriented paradigm.
- List the recovery management principles that can help inform development of clinical services with a recovery orientation.
- Discuss individual care and systems of care from a recovery-oriented perspective, including innovative practices to better serve individuals.
- Understand opportunities for recovery-oriented organizational change and supportive leadership practices specific to making organizational change

- **bhrm.org** – the website home of the BHRM project
  - *BHRM Statement of Principles*
  - And practice guidelines by leading national authors
- **mobilewellnessandrecovery.com**

Recovery Management



Chapter 13: Implementing Recovery Management in a Treatment Organization

Michael Boyle

David Loveland

Susan George

General Suggestions

- Ask the person what to change, and how.
- "Recovery" model is not "good", and "Traditional" model is not "bad".
- Be aware of the *continuum* for each of the 16 points.
- Innovate according to the person's presentation, rather than use a fixed approach of one model or the other.
- Example: "If they show up distressed by hearing voices, while in objective alcohol withdrawal, you better use a Traditional Model".
- "Don't be afraid of change; you can always change back."
- "If you think your system change is too slow, slow down."

BHRM Statement of Principles

1. Recovery Focus
2. Client Empowerment
3. The Destigmatization of Experience
4. Evidence-based Interventions
5. Development of Clinical Algorithms
6. Application of Technology
7. Service Integration
8. Recovery Partnership
9. The Ecology of Recovery
10. Monitoring and Support Emphasis
11. Continual Evaluation

1. Recovery Focus

- Full and partial recoveries from severe behavioral health disorders are living realities evidenced in the lives of hundreds of thousands of individuals in communities throughout the world.
- Where complete and sustained remission is not attainable, individuals can actively manage these conditions in ways that transcend the limitations of these disorders and allow a fulfilled and contributing life.
- The BHRM model emphasizes recovery processes over disease processes by affirming the hope of such full and partial recoveries and by emphasizing patient strengths and resiliency rather than patient deficits.
- Recovery re-introduces the notion that any and all life goals are possible for people with severe behavioral health disorders.

2. Client Empowerment

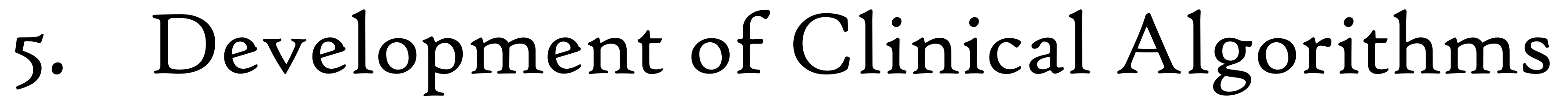
- The patient, rather than the professional, is at the center of the BHRM model.
- The goal is the assumption of responsibility by each patient for the management of his or her long-term recovery process and the achievement of a self-determined and self-fulfilling life.
- patient empowerment involves not just self-direction of one's own recovery, but:
  - opportunities for involvement in the design, delivery and evaluation of services provided by behavioral health organizations and
  - involvement in shaping public attitudes and public policies regarding behavioral health disorders.

3. Destigmatization of Experience

- The BHRM model seeks to "normalize" or otherwise respect a person's experiences with behavioral health disorders and subsequent services.
- In this way, the person escapes attacks on self-esteem and self-efficacy that often accompany the stigma of mental illness.
- Moreover, the public begins to endorse positive images of behavioral health that undermine the prejudice and discrimination that frequently accompanies services.

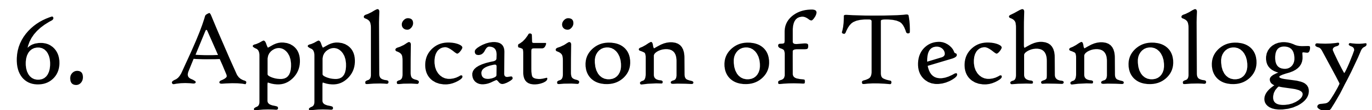
4. Evidence-based Interventions

- The BHRM model emphasizes the application of "evidence-based" interventions at all stages of the disease stabilization and recovery process.
- The "evidence" under girding such interventions includes scientific studies (randomized clinical trials, clinical field experiments) and inter-disciplinary professional consensus regarding promising approaches,
- but the ultimate evidence is the fit between the intervention and the patient at a particular point in time as judged by the experience and response of the patient.



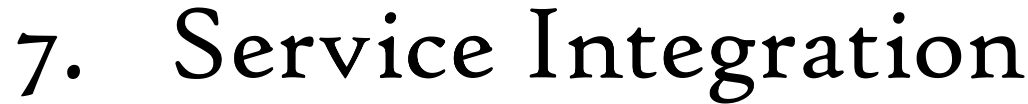
5. Development of Clinical Algorithms

- As knowledge and application of evidence based practices advance, the challenge becomes knowing what treatment approaches to use with specific individuals as they progress through the stages of change and stages of treatment.
- Medication algorithms have been developed that specify preferred first line prescriptions for specific diagnoses, dosing and time frames for evaluating the effects.
- Similar practice support algorithms are needed for clinicians utilizing psychosocial treatments.



6. Application of Technology

- The rapid advances in technology must be applied to recovery from serious mental illness and addictions.
- Technology being utilized in other fields may be adopted or adapted to addressing behavioral health issues.
- While web based services and supports are currently being explored, what other technologies could be made available for treatment and recovery support? Is there an application for GPS, nanotechnology or other developing scientific advances?
- Many technologies could be applied today while we await the miracles that will arise from the human genome project through fields such as genetic engineering and bioinformatics.



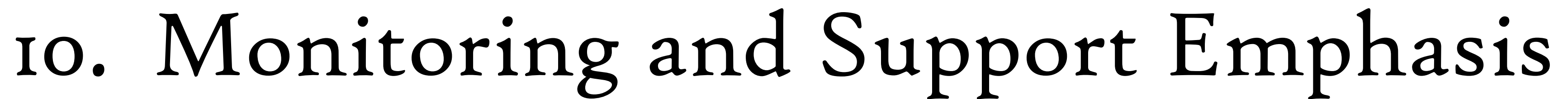
7. Service Integration

- Based on the recognition that severe disorders heighten vulnerability for other disorders and problems, the BHRM model seeks to coordinate categorically segregated services into an integrated response focused on the person rather than territorial ownership of the person's problems.
- The goal is to mesh these historically isolated services into an integrated, recovery-oriented system of care.
- The BHRM model advocates multi-agency, multidisciplinary service models that can provide less fragmented and more holistic care.

8. Recovery Partnership

- In the BHRM model, the traditional professional role of "expert" and "treater" progressively shifts to a recovery management partnership with the patient.
- Within this partnership, the professional serves primarily as a "recovery consultant."
- The service relationship within the BHRM model is marked by continuity of contact in a primary service relationship (with a recovery consultant) over time--a relationship analogous to that between a physician and patient managing any health care problem characterized by chronicity and episodic acuity.

- The family (as defined by the patient) and community constitute a reservoir of support for long-term recovery from behavioral health disorders.
- The BHRM model seeks to enhance the availability and the support capacities of family, intimate social networks and indigenous institutions (e.g., mutual aid groups, churches) to persons recovering from behavioral health disorders.
- The BHRM model also extends the locus of service delivery from the professional environment to the natural environment of the patient.
- One of the major goals of the BHRM model is to create the physical, psychological and social space within which recoveries can flourish in local communities.



- The BHRM model emphasizes the need for on-going monitoring, feedback and encouragement, linkage to indigenous supports and, when necessary re-engagement and early re-intervention.
- This model of sustained monitoring and recovery support services contrasts with models that provide repeated episodes characterized by "assess, admit, treat, and discharge," as is traditional in the treatment of substance use disorders.
- It also contrasts with mental health programs that focus on stabilization and maintenance of symptom suppression rather than on recovery and personal growth.

- Service and support interventions must be matched not only to the unique needs of each patient but to the stage-specific needs of each patient as these needs evolve through the stages of recovery.
- In the BHRM model, both assessment and evaluation become continual activities rather than activities that mark the beginning and conclusion of a service episode.
- There is also a shift from evaluating single episodes of care to evaluating the effect of particular combinations and sequences of interventions on the course of behavioral health disorders and on recovery careers.

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Traditional Model to Recovery Model

16 points of service

1. View of Motivation
2. Engagement
3. Service Timing
4. Service Emphasis
5. Locus of Services
6. Screening Assessment
7. Service Goals
8. Service Roles
9. Service Relationship
10. Consumer Involvement
11. Relationship to Community
12. Management of Comorbidity
13. Service Technologies
14. View of Aftercare
15. Service Evaluation
16. Advocacy

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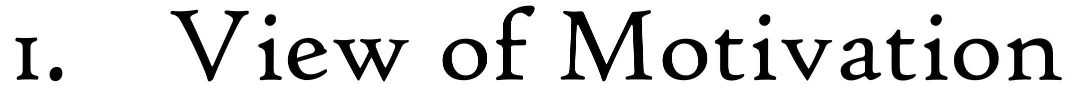

1. View of Motivation

Traditional Model

- precondition for treatment
- absence defined as resistance
- responsibility/blame – patient

Recovery Model

- seen as outcome of services
- emphasis on pre-action stages of change
- recovery priming
- responsibility/blame – service milieu

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Traditional Model

- high threshold
- crisis intervention
- isolated outreach
- high extrusion

Recovery Model

- low threshold (and welcoming)
- emphasis on outreach

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Traditional Model	**Recovery Model**
☐ focus on crisis/problem resolution	☐ focus on post-crisis recovery support activities
☐ reactive	☐ proactive
	☐ commitment to continued availability

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4. Service Emphasis

Traditional Model	Recovery Model
stabilization	recovery coaching monitoring with feedback and support early re-intervention

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5. Locus of Services

Traditional Model	Recovery Model
Institution-based “How do we get the patient into treatment?”	“How do we nest the process of recovery within the patient’s natural environment?”

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6. Screening Assessment

Traditional Model	Recovery Model
- categorical - intake activity - deficit based (problems to treatment plan)	- global - continual (stages of change assumptions) - strengths based (assets to recovery plan) - inclusion of family/kinship network - consumer defines family

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Traditional Model	**Recovery Model**
- professionally defined in treatment plan - focus on reducing pathology	- consumer-defined in recovery plan - focus on building recovery capital - recovery vision reflected in mission

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8. Service Roles

Traditional Model	Recovery Model
specialization of clinical roles	a-disciplinary
emphasis on academic/technical expertise	role cross-training
resistance to the prosumer movement	pro-consumer in paid and volunteer support roles
	emphasis on mutual aid
	role of primary care physician

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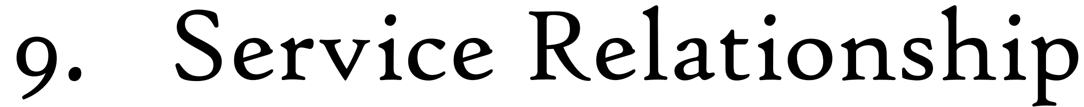

Traditional Model

- dominator-expert model; hierarchical
- time-limited
- transient – staff turnover
- commercialized

Recovery Model

- partnership-consultant model
- less hierarchical
- potentially time sustained
- continuity of contact
- less commercialized

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10. Consumer Involvement

Traditional Model

- passive role – professionally prescribed
- consumer dependency

Recovery Model

- consumer involvement/direction of service policies, goal setting, delivery & evaluation
- focus on illness self management
- consumers as volunteers & employees
- consumer led support groups & activities

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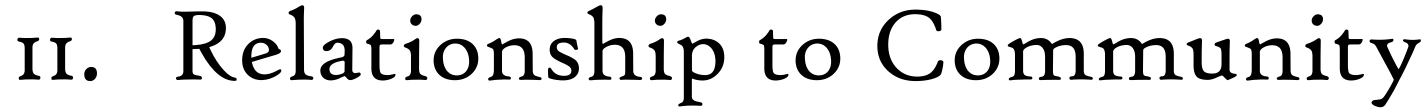

Traditional Model	**Recovery Model**
- community defined in terms of other agencies	- focus on how to diminish need for professional services - emphasis on hospitality and supports within the natural community - emphasis on indigenous supports

TM … **RM**

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12. Management of Comorbidity

Traditional Model	Recovery Model
exclusion, extrusion	serial recovery
recidivism, iatrogenic	integrated care
experiments with parallel or sequential treatment	multi-unit/agency
	indigenous resources

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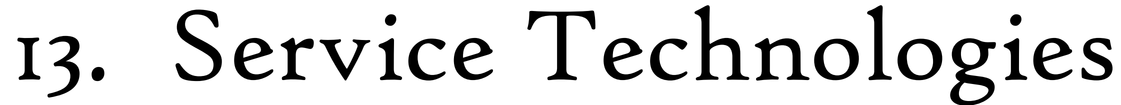

Traditional Model

- focus on programs
- limited individualization
- biomedical stabilization

Recovery Model

- focus on service and support menus
- high degree of individualization
- greater emphasis on physical/social ecology of recovery

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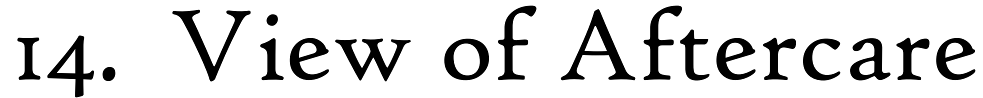

14. View of Aftercare

Traditional Model	Recovery Model
aftercare as an afterthought or maintenance for life	eliminate concept of aftercare
	all care is continuing care
	emphasis on community resources
	role of guide or recovery coach

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15. Service Evaluation

Traditional Model

- focus on professional review of short-term outcomes of single episodes of care
- recent emphasis on social cost factors – impact on hospitalizations, arrests, etc…

Recovery Model

- focus on long term effects of service combinations and sequences on patient/family/community
- consumer defined outcomes and review

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16. Advocacy

Traditional Model	Recovery Model
advocacy often limited to that related to institutional funding	emphasis on policy advocacy
marketing and PR approach	community education (stigma) and community resource development
	activist/community organization approach

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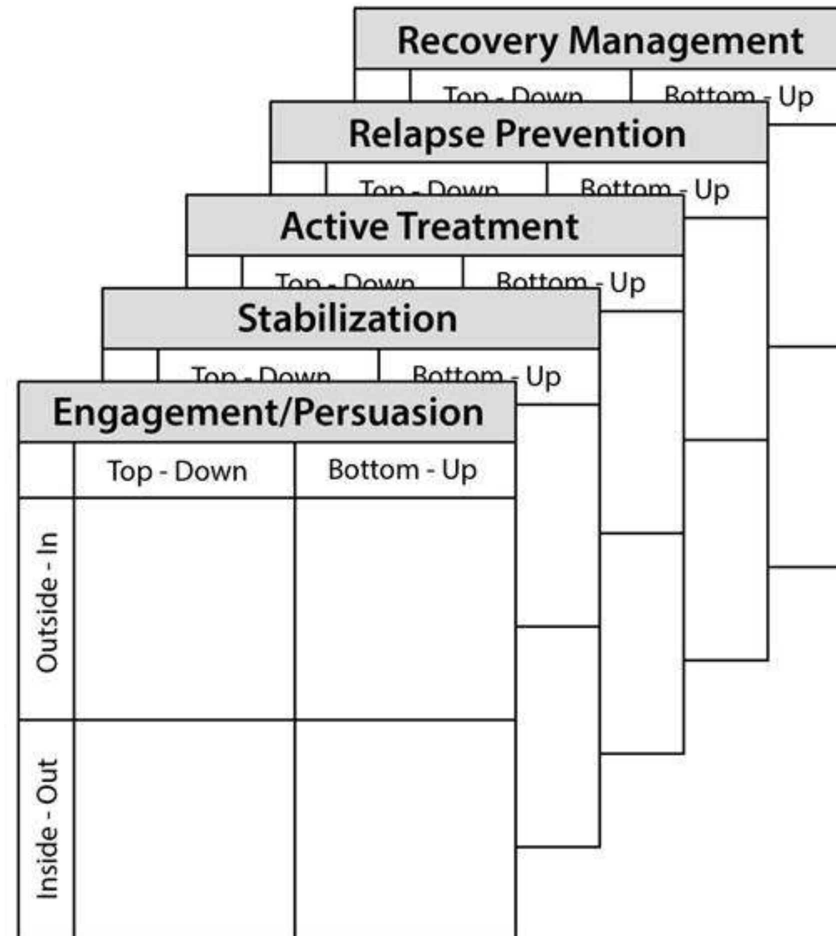
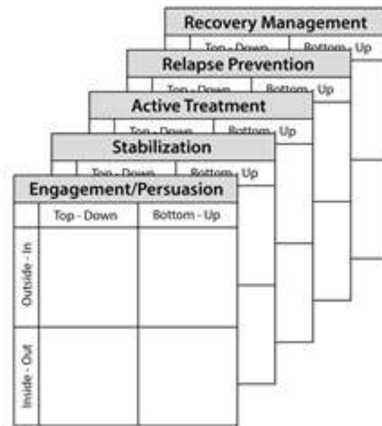
Recovery Management

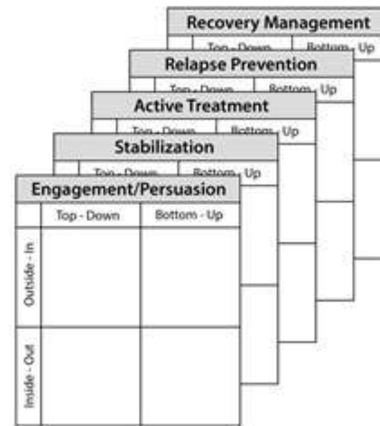
Zones	Stages	Levels
• Physical • Psychological • Relational • Lifestyle • Spiritual	• Engagement/Recovery Priming (pre-recovery & treatment) • Recovery initiation & stabilization (recovery & treatment) • Recovery maintenance (post treatment)	• Low service involvement (annual check-up or quarterly phone calls) • High service involvement (recovery home with intensive monitoring and coaching)

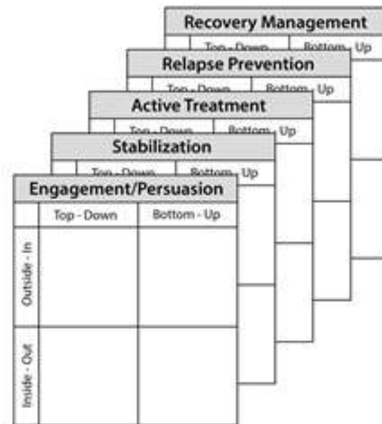
Stages of Treatment (Osher)

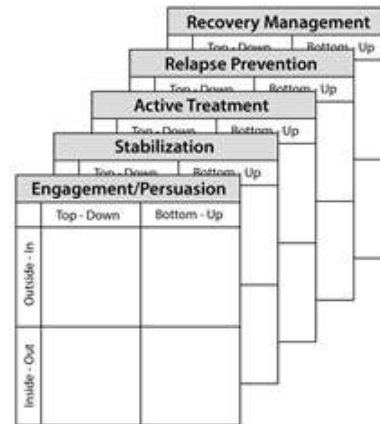


Stages of Treatment by Problem Area









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