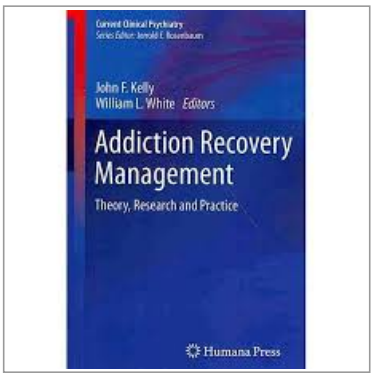
BLOG & NEW POSTINGS

December 18, 2015 | Bill White

RUSH TO RECOVERY: RHETORIC VERSUS REALITY



Does *recovery*, as a claimed new organizing paradigm within the addictions field, constitute a positive and fundamental shift in the resolution of alcohol and other drug (AOD) problems in the U.S., or is it an ephemeral "flavor of the month" that simply puts a new rhetorical face on unchanged service philosophies and practices? It has the potential to be either.

Two decades ago, a new generation of recovery advocates and a small group addiction professionals began calling for the addiction field to extend its focus beyond cataloguing the sources and patterns of addiction-related pathologies and the methods of brief interventions into such problems. What they proposed was an intensified focus on long-term personal and family recovery and the lessons that could be drawn from studies of the prevalence, pathways, processes, stages, and styles of such recoveries. A resulting vision emerged of extending acute care models of addiction treatment to models of sustained recovery management nested within larger recovery-oriented systems of care to serve those with the most severe, complex, and chronic substance use disorders. In the ensuing years, the recovery concept emerged as a new policy paradigm, a new recovery advocacy movement was born, new recovery support institutions and roles flourished, recovery research emerged as a specialty among addiction scientists, and *recovery*, *recovery management* (RM), and *recovery-oriented systems of care* (ROSC) became extolled as new organizing frameworks for addiction treatment and the expansion of peer-based recovery support services.

As this shift unfolded at national, state, and local levels, addiction treatment providers and allied health care institutions responded in quite varied ways. Some re-evaluated their treatment protocol and launched a radical redesign of their service philosophies, service practices, and service relationships. Others defensively claimed that they were already recovery-oriented and that there was nothing to this new recovery rhetoric. Still others responded by showcasing a new program as evidence of their recovery orientation—a loosely attached appendage that gave the veneer of recovery orientation while their mainstream services practices remained unchanged. Many programs adopted recovery language in their names and service descriptions—some out of a deep commitment to this new orientation and others out of political or financial expediency. This variability left individuals and families seeking help and purchasers of addiction treatment services in a quandary over how to identify the degree of such recovery orientation as a potential indicator of quality of treatment services.

As one of the early advocates of this recovery-oriented transformation of addiction treatment in the United States, I am frequently asked: "How does one separate recovery orientation in substance from superficial recovery rhetoric?" Here is my answer: An addiction treatment program reflects alignment with RM/ROSC principles if, and only to the extent that, such programs:

Can document authentic recovery representation at all levels of institutional governance, service planning and delivery, and service evaluation;

Assertively identify, engage, and assure service access for individuals and families at the earliest stages in the development of AOD-

related problems;

Exemplify multidisciplinary and multi-agency service models focused on supporting long-term recovery for those individuals, families, and neighborhoods experiencing severe, complex, and enduring AOD problems;

Conduct individual, family, and community needs-assessment protocols (including recovery resource mapping of served communities) that are comprehensive, strengths-based, and ongoing;

Shift the core service relationship from an expert model to a partnership model involving a long-term recovery support alliance and extend this partnership model to all system component relationships;

Increase treatment retention rates and adopt policies that prohibit extruding people from treatment (via administrative or "therapeutic" discharge) solely for exhibiting symptoms of the disorder being treated;

Offer an extensive service menu, with an emphasis on evidence-based and promising recovery-linked service practices;

Promote a "philosophy of choice" that recognizes the legitimacy of multiple pathways and styles of long-term addiction recovery;

Ensure each client and family an adequate dose and duration of pre-treatment (*recovery priming*), in-treatment, and post-treatment clinical and recovery support services;

Exert influence on the post-treatment recovery environment by shortening the physical and cultural distance between the treatment institution and the natural environments of those served and offering services aimed at increasing family and community recovery capital;

Assertively link clients and families to available recovery mutual aid groups and other indigenous recovery support institutions;

Provide post-treatment monitoring (recovery check-ups for up to five years following discharge from primary treatment), stage-appropriate personal/family recovery education, sustained recovery coaching, and, when needed, early re-intervention; and

Systematically collect and publically report long-term post-treatment recovery outcomes for all admitted individuals and families by level of care, discharge status, and key clinical characteristics.

Few, if any programs, currently meet all of the above aspirational criteria of the RM/ROSC model of supporting long-term recovery, but a program claiming a high level of recovery orientation is most disingenuous if it cannot describe the progress it is making in these thirteen areas.

Those interested in evidence-based and promising practices to help programs achieve these critical elements are encouraged to explore the following monographs developed by the Center for Substance Abuse Treatment / Great Lakes Addiction Technology Transfer Center, the Philadelphia Department of Behavioral Health and Developmental disAbilities, and the Institute for Research, Education, and Training in Addictions.

Recovery Management and Recovery-oriented Systems of Care: Scientific Rationale and Promising Practices.

Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches.

Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation.

Recovery-oriented Methadone Maintenance

Other papers related to recovery management and recovery-oriented systems of care are posted here and here.

Policy leaders, purchasers of care, system administrators, addiction professionals, recovery advocates, and recovery support specialists share the responsibility of building recovery-oriented systems of care that reflect these critical changes in traditional addiction treatment practices.

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