

“Ideas for Treatment Improvement”

ADDICTION *Messenger*

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SERIES 28

Northwest Frontier
Addiction Technology
Transfer Center

810 “D” Street NE
Salem, OR 97301
Phone: (503) 373-1322
FAX: (503) 373-7348

A project of
OHSU
Department of Public Health
& Preventive Medicine

Steve Gallon, Ph.D.,
Principal Investigator

Mary Anne Bryan, MS, LPC
Program Manager, Editor
bryanm@ohsu.edu

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Recovery-Oriented Systems of Care - Part 1 Principles of Recovery

“What I do you cannot do; but what you do, I cannot do. The needs are great, and none of us, including me, ever do great things. But we can all do small things, with great love, and together we can do something wonderful.”

~ Mother Teresa (1910 – 1997) ~

In September 2005, SAMHSA’s Center for Substance Abuse Treatment brought together a diverse group of leaders from the substance abuse treatment and recovery fields for the *National Summit on Recovery*. Attendees included recovering individuals, treatment providers, researchers, faith-based providers and State and Federal officials. The focus of the summit was on achieving a consensus regarding a set of guiding principles of recovery and elements of a recovery-oriented system of care.

The three goals outlined and achieved during the *Summit* included:

- Developing new ideas to transform policy, services, and systems toward a recovery-oriented paradigm,
- Articulating guiding principles and measures of recovery that can be used across programs and services, and
- Generating ideas for advancing recovery-oriented systems of care in various settings and systems.

During the meeting a working definition of recovery was developed along with 12 guiding principles of recovery, 17 recovery-oriented systems of care elements, and 49 recommendations for various stakeholder groups.

Why did CSAT host such a meeting? Because a major change in thinking and practice is emerging among leaders in the addiction field. Instead of organizing services around relatively short-term episodes of acute care, increased attention is being given to sustained recovery management and longer term chronic care models. This series of the *Addiction Messenger* will summarize current thinking about recovery-oriented systems of care and what a new service paradigm might mean for counselors, treatment providers, policy makers and, most importantly, clients. First, let’s consider what we mean by recovery.

The definition of recovery developed during the *Summit* is:

“Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life”

With that definition in mind, *Summit* participants set out to develop a set of principles that could guide the development of recovery-oriented systems of care. This issue of *AM*

summarizes those principles.

Guiding Principles of Recovery

The guiding principles are intended to give general direction to the treatment and recovery fields as they move toward operationalizing recovery-oriented systems of care and developing core outcome measures and evidence-based practices.

1. There are many pathways to recovery.

Individuals are as unique as their personal needs, strengths, goals, health attitudes, behaviors and expectations for recovery. Finding the pathway to recovery is a deeply personal journey. Some pathways are grounded in cultural beliefs or traditions and involve informal community resources for supporting sobriety, others may include psychosocial and/or pharmacological treatment. Recovery for some individuals may not involve treatment. Recovery is a change process that leads an individual to make healthy choices and improve the quality of his or her life.

2. Recovery is self-directed and empowering.

While recovery may involve times when an individual's activities are directed by others, such as during treatment, recovery is essentially a self-directed process. The person in recovery is the "agent of recovery" and has the ability to make choices and decisions based on their own recovery goals that have an impact on the process. Through self-empowerment, individuals become optimistic about achieving their life goals.

Tilly and Wiener (2000, 2001) found that clients who self-directed their own care expressed greater satisfaction with the services they chose and had fewer unmet needs. Successful self-management and the resulting self-efficacy a client experiences can lead to maintaining their motivation for abstinence.

3. Recovery involves a personal recognition of the need for change and transformation.

Individuals in recovery accept that a problem exists, make a conscious choice to change, and are willing and motivated to take steps to address it. Motivation to change substance-using behaviors is an important contributing factor in the recovery process. Steps usually involve seeking help for the substance use disorder. The process of change can involve physical, emotional, intellectual and spiritual aspects of a person's life.

4. Recovery is holistic.

Recovery is a process of gradually achieving greater balance of mind, body and spirit in relation to other aspects of life, such as family, work and community.

5. Recovery has cultural dimensions.

Each person's recovery is unique and impacted by cul-

tural beliefs and traditions. A person's cultural experience often defines and shapes the recovery path that is right for him or her. Those beliefs should be acknowledged, addressed and used effectively in the recovery process. It is essential that treatment providers develop awareness, knowledge and skills appropriate to their clients' cultures. Delivering culturally competent care has significant implications on the client-provider relationship. If care is not taken to incorporate a client's cultural and language needs service difficulties are likely to emerge in:

- inaccurate or incomplete histories being taken upon which the treatment plan is based,
- decreased client satisfaction with the care provided,
- noncompliance with the treatment plan,
- premature departure from care,
- flawed or incomplete screening,
- miscommunication, and
- decreased access to providers of recovery support services.

6. Recovery exists on a continuum of improved health and wellness.

Recovery is not a linear process. It is based on growth and improved functioning and may involve cycles of relapse, readmissions, and other setbacks, which are a natural part of the continuum but not an inevitable outcome. Wellness is the result of improved care and balance of mind, body and spirit. When difficulties or setbacks occur during the recovery process clients benefit from those experiences and the resulting "lessons learned".

7. Recovery emerges from hope and gratitude.

Individuals working toward recovery often gain hope from others in recovery. They see that people can and do overcome difficulties and they begin appreciating the opportunities that each day of recovery offers them. Listening to others share their experiences about how they successfully dealt with substance-related problems can give clients confidence to deal with troubling situations they will encounter.

8. Recovery involves a process of healing and self-redefinition.

Recovery is a holistic healing process in which an individual develops a positive and meaningful sense of themselves and their life. McMillen, et al (2001) identified positive by-products for clients with regard to their struggle with substance use problems, such as:

- changes in life priorities,
- increased closeness with family members and others,
- increase in self-efficacy, and
- increased spirituality and compassion.

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9. Recovery involves addressing discrimination and transcending shame and stigma.

Stigma and discrimination have several implications for a person's ability to access care and continue on a path of recovery. Recovery is a process by which people confront and strive to overcome stigma. Stigma exists both within and outside of the health care system. Societal stigma is one of the major barriers to recovery (Perlick, 2001) and it also plays a role in affecting outcomes of treatment, access to services post-treatment, and employment.

10. Recovery is supported by peers and allies.

A common denominator in the recovery process is the presence and involvement of people who contribute hope and support for the individual and suggest strategies and resources for their recovery pathway. Peers, as well as family members, form vital support networks for people in recovery. Societal support eases and encourages the transition from the beginning of recovery to the lifelong maintenance of recovery (Jason et al, 2001). Receiving consistent abstinence support, guidance, and information from others who are committed to long-term sobriety can enhance a person's recovery. In addition, providing support services to each other and experiencing mutual healing help create a community of continual support among those in recovery.

11. Recovery involves (re)joining and (re)building a life in the community.

A basic element of recovery is the reclaiming of a normal life without substance use and the self-realization and understanding that they may have a damaged sense of their own needs which need to be restored. Recovery

involves a process of building or rebuilding what a person has lost or never had due to substance use and its consequences. Recovery involves creating a life within the limitations of sobriety. Recovery is building or rebuilding healthy family, social and personal relationships. Individuals in recovery often achieve improvements in the quality of their life, such as obtaining education, employment and housing. They also become involved in constructive roles in their communities through helping others, being productive and making other contributions.

12. Recovery is a reality.

Research and our own personal experience demonstrates that recovery can, will, and does happen. It is a continuous lifelong process.

Recovery support services are the non-clinical services that are crucial to removing barriers and providing resources to people in recovery. Such support services are most beneficial if they are readily available to clients throughout the period of their care:

- pre-treatment,
- as an alternative to treatment,
- during treatment, and
- post-treatment

Next month's *AM* will review the elements of a recovery-oriented system of care as defined during the *Summit* and identify the support services that contribute to the recovery process.

Next Issue:

"Elements of Recovery-Oriented Systems of Care"

Source:

- Center for Substance Abuse Treatment. (2007) **National Summit on Recovery: Conference Report.** DHHS Publication No. (SMA) 07-4276. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Tilly, J & Wiener, J (2000). **Consumer-Directed Home and Community Services Programs in Eight States: Policy Issues for Older People and Government.** Washington, DC: The Urban Institute.
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- Jason, AL et al (2001). **Oxford House: A Review Of Research And Implications For Substance Abuse Recovery And Community Research.** Journal of Drug Education, Vol. 31, pages 1-27.



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Recovery-Oriented Systems of Care - Part 2 Elements of the System

"Opportunity is missed by most people because it is dressed in overalls and looks like work."

~ Thomas A. Edison (1847 - 1931) ~

Some individuals recover from a substance use disorder through their own individual efforts, without engaging in treatment or using other recovery supports. Others enter recovery through mutual aid groups and/or faith communities. And still others begin recovery through some form of substance use disorder treatment. Which path is chosen often depends on the severity of the disorder, age, culture, the presence of co-occurring physical or mental health problems or involvement with the criminal justice system. A recovery-oriented system of care is designed to support individuals and families as they wrestle with changing the course of a substance use problem. The most effective systems tend to be comprehensive, flexible, outcomes-driven and individualized. They offer a coordinated menu of services and supports to maximize the choices available to a client. The menu ideally evolves over time in order to meet the changing needs of individuals as they reach milestones in the recovery process.

Elements of a Recovery-Oriented System of Care

Person-centered

Recovery-oriented systems of care are person-centered. They start with understanding and accepting the client as he/she is. Clients in such systems are presented with a menu of stage-appropriate choices that fit their needs. Choices continue to be offered as clients move along their recovery journey. Choices can include spiritual supports that fit with the individual's faith, beliefs, or values. Studies have shown that individuals become more committed to treatment if they have alternatives to choose from. Choice enhances engagement, adherence, and acceptance of treatment.

Family and other ally involvement

The important roles filled by family members, friends and other allies are acknowledged when care is focused on recovery. Family and others are incorporated, when appropriate, in the recovery planning and support process. When damaged relationships are repaired they can be a source of support for individuals entering and maintaining recovery, and often their involvement is associated with retention and more positive treatment outcomes.

Individualized and comprehensive services across the lifespan

Recovery-oriented services are characterized as being individualized, comprehensive, stage-appropriate with regard to readiness for change, and flexible. The system adapts to the needs of the client, rather than the client having to adapt to the system. Services are designed to support the client's recovery across their lifespan. The approach to substance

use disorders changes from managing acute episodes to one that manages a chronic disorder over the client’s lifetime.

Systems anchored in the community

Services that support recovery are integrated into and valued by the community. They enhance the availability and support capacities of families, social networks, community-based institutions and other people in recovery. They are not marginalized or on the fringe of the community. On the contrary, they play a facilitative role in creating recovery-oriented resources.

Continuity of care

A continuum of services, including pretreatment, treatment, continuing care and maintenance support are available on a long-term basis. Clients have a full range of stage-appropriate services to choose from at any point in the recovery process. The availability of continuing care enhances long-term recovery outcomes and decreases the rate of relapse.

Partnership-consultant relationships

Collaboration and client self-management are hallmark characteristics of the recovery-oriented system. The counselor brings expertise and knowledge of addictions to the relationship, while the client is seen as an equal partner who is an “expert in their own life” regarding what motivates them to make positive change. This type of design enables clients to feel empowered to direct their own recovery.

Strength-based

The client’s strengths, assets, abilities, resources and resiliencies are stressed in a recovery system. Clients are assumed to have the capacity to use resources, skills and motivation to focus on their strengths and make changes in their life.

Culturally responsive

Recovery-oriented systems of care are culturally sensitive, competent and responsive. They recognize that beliefs and customs are diverse and impact the outcomes of service delivery. Ignoring culture can result in missed opportunities during screening, lack of knowledge about traditional remedies, errors resulting from miscommunication and breaks in service provision.

Responsiveness to personal belief systems

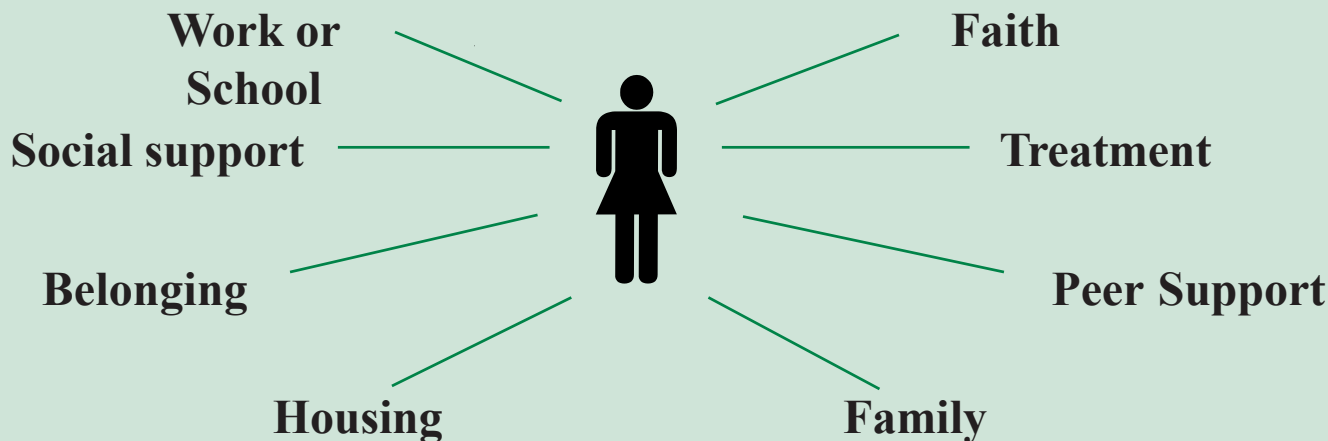
Respectful of the spiritual, religious and/or secular beliefs of clients, recovery services provide links to a variety of recovery options that are potentially consistent with client beliefs. Some individuals cite the strength acquired from their religion and spirituality as main factors that contribute to their long-term recovery.

Commitment to peer recovery support services

Support from peers who have personal experience in struggling with addiction and entering a recovery process provide reassurance, hope and guidance when an individual is beginning or renewing a recovery process. Recovering peers “foster recovery in a relational, mutually-enhancing and safe context”.

Recovery Support in the Community

In the recovery-oriented systems of care model, the treatment agency is viewed as one of many resources needed for a client’s successful integration into the community. No one source of support is more dominant than another. Various supports need to work in harmony with the **client’s direction** so that all possible supports are working for and with the person in recovery.



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Inclusion of the voices and experiences of recovering individuals and their families

The voices and experiences of people in recovery and their family members contribute to the design and implementation of recovery-oriented systems of care. People in recovery and their family members are included in decision-making and can provide oversight for service provision. Recovering individuals and family members are represented on advisory councils, boards, task forces and committees at the Federal, State and local levels.

Integrated services

Recovery-oriented systems of care coordinate and/or integrate efforts across service systems (health, mental health, social and vocational services, criminal and juvenile justice, and others) to create processes that respond to the unique strengths, desires and needs of individuals.

System wide education and training

The concepts and processes of recovery and wellness are foundational elements in the preparation of addiction professionals. Curricula, field instruction, certification and licensure, agency accreditation, continuing education and training, and site review mechanisms are all founded on the notion that the ultimate goal of the system of care is recovery.

Ongoing monitoring and outreach

Effective systems are engaging. They provide ongoing monitoring of client performance,, feedback, and assertive outreach efforts to promote continual participation, re-motivation and reengagement of clients.

Outcomes driven

Guided by recovery-based processes, the system uses outcome measures to gauge effectiveness. Measures are developed in collaboration with the client and reflect the long-term nature and impact of the recovery process on the individual, family and community. Outcomes are quantifiable and include benchmarks of quality-of-life changes anticipated in recovery.

Research based

Recovery-oriented systems of care are informed by research. Continuing research on individuals in recovery,

recovery venues and the processes of recovery, including cultural and spiritual aspects, is essential. Research designs should be informed and enhanced by the experiences of people in recovery.

Adequately and flexibly financed

Financing that permits timely access to a continuum of services, ranging from detox and treatment to continuing care and recovery support is essential to the success of the system of care. Funding and regulatory rules should be flexible enough to permit the “unbundling” of services, which enables the establishment of a customized array of services that can change over time to support an individual’s recovery. When those services are available over the lifespan and not limited to short-term acute episodes, when they are part of a disease management system not unlike those developed for other chronic illnesses, then we will have achieved a true recovery-oriented system of care.

You may be thinking that many of these 17 elements have characterized the addictions field for years. So, what’s different in this notion of a recovery-oriented systems of care? In summary the system is marked by:

- the language used,
- a broader approach that includes clinical and non-clinical supports,
- an emphasis on recovery support services,
- the use of chronic care approaches, such as recovery management,
- a greater focus on strength-based and person-centered approaches,
- shift from providing program models to offering a more individualized menu of services,
- technologies related to evidence-based practices, and
- an emphasis on developing community supports.

In essence, a recovery-oriented system of care is focused more on the experiences and perspective of the individual(s) being served, and that understanding drives the development of the system.

Next Issue:***“Recovery Management”*****Source:**

Center for Substance Abuse Treatment. (2007) **National Summit on Recovery: Conference Report**. DHHS Publication No. (SMA) 07-4276. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental health Services Administration. (2007) **Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know from the Research?**



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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 pre-

pared 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:

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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.glatc.org>)



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SAMHSA Announces Availability of

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Registration Form for Series 28

“Recovery-Oriented Systems of Care”

Name _____

Address _____

City/State/Zip _____ Phone _____

Email _____

Return your Pre-test and Registration form by mail or FAX at (503) 373-7348

Northwest Frontier ATTC
810 D Street NE, Salem, OR 97301

Name _____

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 continuum of services which enhance (fill in the blanks) _____ and decrease _____.

5. Collaboration and client self-management are hallmark characteristics of the recovery-oriented system of care.
True or False

6. Recovery-oriented systems of care coordinate/integrate efforts across service systems 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-step of 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

Mail or FAX your completed test to NFATTC
Northwest Frontier ATTC, 810 D Street NE, Salem, OR 97301 FAX: 503-373-7348
You can register for continuing education hours for Series 1 through 25.
Contact Mary Anne Bryan at 504-378-6001

