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Recovery Management Service Design Matrices

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The acute care (AC) model of intervention has dominated specialized addiction treatment since its inception in the mid-nineteenth century. According to White & McLellan (2008), the AC Model is distinguished by the following characteristics:

- Services are delivered "programmatically" in a uniform series of encapsulated activities (screening, admission, a point-in-time assessment, a short course of minimally individualized treatment, discharge, and brief "aftercare" followed by termination of the service relationship).
- The intervention is focused specifically on symptom elimination of the substance use disorder.
- Professional experts direct and dominate the assessment, treatment planning, service delivery, and service termination decision-making.
- Services transpire over a short (and historically ever-shorter) period of time, usually as a function of a pre-arranged, time-limited insurance payment designed specifically for substance use disorders and "carved out" from general medical insurance.
- The individual/family/community is given the impression at discharge ("graduation") that long-term recovery is personally self-sustainable without ongoing professional assistance.
- The intervention is evaluated at a short-term, single point-in-time follow-up that compares pre-treatment status with discharge status and post-treatment status.
- Post-treatment relapse and re-admissions are viewed as the failure (non-compliance) of the individual rather than as potential flaws in the design or execution of the treatment protocol.

There are increasing calls to extend this AC model into more encompassing models of sustained recovery management (RM) and to nest these RM models within larger recovery-oriented systems of care (ROSC).

Recovery management is a philosophy of organizing addiction treatment and recovery support services to enhance pre-recovery identification and engagement, recovery initiation and stabilization, the transition to long-term recovery maintenance, and the quality of personal/family life in long-term recovery as well as break intergenerational cycles of problem transmission via

the integration of prevention, early intervention, treatment, and recovery support activities (White, 2008b).

The phrase r*ecovery-oriented systems of care* refers to the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes. The "system" in ROSC is not a federal, state, or local agency, but a macro level organization of the larger cultural and community environment in which long-term addiction recovery is nested (White, 2008b).

The AC and RM models are not mutually exclusive; RM incorporates AC expertise in biopsychosocial stabilization and recovery initiation, and many AC models, when called upon to increase their recovery orientation, respond by developing an isolated RM-oriented service component (additive approach) or applying RM principles and methods to only one particular program or level of care (selective approach) rather than fundamentally redesigning the service system (transformative approach; Achara-Abrahams, Evans, & King, 2011).

The authors are often asked what system characteristics and service practices change in the transition to RM and ROSC. The purpose of this paper is to chart such changes in a series of brief tables that can be used for easy reference.

Service Infrastructure

There are many infrastructure elements needed within and shared in common between AC and RM/ROSC models of care. For example, both AC- and RM-oriented organizations operate best with a foundation of organizational health and stability, adequate capitalization and funding diversification, recognized status as a local service institution, and technological sophistication (White, 2008b). But there are distinct differences when we compare the service infrastructures of AC- and RM/ROSC-oriented organizations. Examples of these differences are highlighted in Table 1.

Table 1: RM & ROSC Changes in Service Infrastructure

Service Infrastructure Dimension	Prevailing AC Model	Emerging RM Service Model
Recovery Representation & Orientation	Low recovery representation (e.g., eroding recovery representation among board, management, staff, & volunteers) and recovery orientation (decreased focus on <u>long-term</u> recovery processes and outcomes) through era of modern addiction treatment; recent efforts to revitalize recovery orientation.	Emphasis on authentic recovery representation at all levels of system: governing boards, advisory councils, leadership roles, staff, and volunteers. Recovery orientation evident by recovery-focused mission statements, recovery-focused service practices (e.g., practice guidelines), and relationships with local recovery communities.
Service Integration	Categorical service segregation (specialized addiction treatment services with weak linkages to broader health and human service network) & weak relationships with culturally indigenous	Reciprocal integration of mental health services, primary health care, and addiction treatment; focus on developing other cross system partnerships; emphasis on nesting recovery within natural community environments of those served via strong

	(non-professional) institutions & healers.	relationships with indigenous institutions/healers.
Service Design	Discrete, disconnected system initiatives (e.g., evidence-based practices initiative, trauma informed care initiative, behavioral health primary care integration) and programs, with no over-arching framework to tie them together.	ROSC serves as the overarching framework for the development of everything in the service system. The values and principles embedded in the RM approach inform all initiatives and services so that they are part of a larger recovery-oriented context. Strong emphasis on connecting and integrating initiatives.
System Leadership	Strong emphasis on management and hierarchy. Management processes focus on ongoing operations, budgeting, coordinating, monitoring, and problem solving.	Leadership is emphasized and viewed as distinct from management processes. Leadership focuses on developing a vision of the future; aligning people, practices, and processes with that vision; and inspiring people to embrace and pursue the vision.
Service Funding	Service designs dictated by funding restrictions of private managed behavioral health care organizations and public funders; categorical funding of clinical services delivered by traditional addiction treatment providers. Funding is allocated based on historical funding patterns. Almost all service dollars are focused on treatment to traditional providers. Non-clinical supports and alternative services not viewed as important.	Newly developed recovery-focused service guidelines of public managed behavioral health care organizations; expanded funding to deliver recovery support services through non-traditional service providers, e.g., recovery community organizations, health clinics, faith ministries; mini-grants specifically to enhance recovery orientation of treatment programs. Funding is allocated based on the expressed needs and desires of people receiving services and those practices identified as supporting recovery.
Systems Relationship	Hierarchical influence based on authority, control, and fear (e.g., threatened loss of funding); we-they polarizations at multiple systems levels.	Influence based on mutual respect and partnership; efforts to transition historically conflicted/competitive relationships to collaborative relationships.
Workforce Development	Minimal investment in workforce development, high workforce turnover; replication of abandonment & loss experiences of clients.	Considerable recovery-focused education, training, and supervision provided; emphasis on workforce retention & leadership development;

		investment in leadership development for people in recovery.
Performance Improvement (PI)	PI processes not a focal point of the system. When they are used, they are limited to typical utilization data (e.g., access, retention, graduation rates). Data is used primarily for reporting. Emphasis is on symptoms of addiction (i.e., recidivism, arrests, etc). Data is not used to improve the service system's capacity to support sustained recovery. Data collection is limited to quantitative service system data with minimal direct feedback from people in recovery and families, and there are few feedback loops with the providers. Performance improvement focuses on the process of treatment (e.g., numbers served) and symptom management as the primary outcome.	PI processes are used to shape provider practices. What you look at is different (e.g., in addition to typical utilization data, also include recovery-oriented practices, e.g., extent to which people involved in directing their treatment and recovery plans, existence of service menus, and also improvements in global health). Why you look at certain data points is different (e.g., recidivism is used not as a marker for engagement in treatment, but engagement in long-term recovery), and how you collect the data is different (e.g., in addition to quantitative service data, also collect qualitative data via focus groups with people in recovery). PI processes incentivize and support RM approaches through pay for performance initiatives and continuous feedback loops, etc.
Systems & Service Evaluation	System evaluation focuses primarily on process measures, e.g., the number of units of service, or the number of people served. Limited outcome evaluations focus on the short-term evaluation of degree to which services can subtract from lives of those served, e.g., reduction in drug use, crime, social costs, threats to public health. People in recovery and family members are minimally involved in system evaluation processes.	Focus on long-term outcomes that evaluate what services can add to individual, family, and community life, e.g., sobriety, global health, community reintegration, and social contribution; quality of personal/family life; cost-offsets seen as by-products of recovery not primary purpose of service provision. The perspectives of people in recovery and family members are actively sought and they play a central role in evaluation processes (e.g., conducting focus groups, etc.). To the extent that process is evaluated, the emphasis is on known correlates of successful recovery initiation and management.

Changes in Service Practices

       Following brief presentations of the authors on RM/ROSC, we often hear comments like "We're already recovery-oriented" or "This recovery stuff is just new buzzwords for the same thing we've always been doing." The more detailed the comparison between AC and RM/ROSC models, the less we hear such comments. Table 2 illustrates some of the fundamental changes that occur in frontline service practices in the transition between an exclusively AC model of care and an RM/ROSC approach to service design.

Table 2: RM and ROSC Changes in Service Practices

Service Dimension	Prevailing AC Service Model	Emerging RM Service Model
Attraction	Passive reliance on referrals from formal community organizations, marketing aimed primarily at service institutions.	Assertive outreach (e.g., hospitals, jails, street outreach teams, faith-based organizations, natural healers, etc.).
Access	Restricted by waiting lists, layers of administrative intake, limited hours of service provision, geographical inaccessibility.	Assertive lowering of barriers to access (e.g., waiting list management, co-location of services, pre-treatment peer support groups, education of natural supports to promote early identification, etc.).
Engagement	High rates of service attrition via exclusion, early disengagement, and extrusion (more than 50% not completing a course of treatment).	Emphasis on engagement, retention, and outreach and re-engagement of those who disengage from service. Lower thresholds of engagement; warm welcome; assertive service prompts. Continued AOD use during treatment results in reengagement and altering service plan rather than administrative discharge.
Assessment	Problem-specific, problem-focused, conducted as an intake or initial service planning function; unit of service is the individual entering treatment.	Focused on multiple life domains, strengths-based (recovery capital—assets as well as challenges), emphasis on self-assessment, continual; unit of assessment is person, family, and community.
Service Planning Format	Professionally directed Treatment Plan; emphasis on need for professional control and direction; limited choice; limited variation in treatment plans.	Rapid transition from treatment plan to person-directed recovery plan; or development of person-directed recovery plan that includes a treatment plan; emphasis on philosophy of choice; considerable variation in recovery plans.
Level of Care Placement	Decided primarily by problem severity, duration, and complexity.	Decided based on ratio of recovery capital to problem severity, duration, and complexity and

		expressed preference of person/family.
Composition of Service Team	Composed primarily of addiction counselors.	Expanded to include much greater role for physicians, psychologists, social workers, recovery support specialists, family, and indigenous healers from the community (e.g., spiritual advisors); much greater use of alumni and recovery volunteers.
Service Relationship	Professional model, e.g., professional diagnoses and treats; person's role is treatment adherence; relationships hierarchical, transient, and highly commercialized.	Partnership model, e.g., person forges their own long-term recovery plan with professional serving as consultant in each person's development and execution of the recovery plan; focus on helping each person/family develop recovery support relationships that are natural, reciprocal, and potentially enduring.
Service Scope	Set "program" (fixed sequence of addiction-specific services) with limited individual variation. The services are determined by the professionals.	Ever-expanding service menu that is combined and sequenced with considerable variation from person to person. The menu of services is informed by and frequently modified based on the expressed needs, interests, and preferences of the people being served.
Service Duration	Brief intervention focused primarily on the stage of recovery initiation and stabilization followed by termination of the service relationship.	Sustained recovery support potentially spanning pre-recovery identification and engagement, recovery initiation and stabilization, transition to stable recovery maintenance, enhanced quality of personal/family life in long-term recovery, and efforts to break intergenerational cycles of problem transmission.
Service Quality	Efforts underway to implement evidence-based practices (EBP). The implementation of EBPs is often focused around symptom reduction and stabilization.	Emphasis on evidence-based practices and practice-based evidence with service participants having a major voice in definitions of quality. EBPs implemented and embedded in the context of a recovery management approach. They are viewed as tools in a more comprehensive toolkit and the focus of implementation is on sustained recovery and increased quality of life.

Locus of Service Delivery	Services primarily institution-based—person must leave his/her world and enter professional milieu.	Greater emphasis on reaching people in their natural environments, e.g., home-based, neighborhood-based service delivery; greater use of technology for service delivery and long-term recovery support.
Linkage to Recovery Community Resources	Ranges from no linkage to passive linkage (e.g., verbal encouragement to attend recovery mutual aid meetings, provision of a meeting list).	Assertive linkage to a broad spectrum of recovery support institutions and activities, including opportunities for recovery advocacy. Assertive efforts to identify the best fit between individuals and the available recovery community resources. Close organizational ties between treatment institution and indigenous recovery community institutions, e.g., recovery mutual aid service committees, recovery community organizations, recovery homes/schools/industries/ministries, etc.
Post-treatment Contact	Passive continuing care, e.g., weekly continuing care group available at treatment institution for persons who successfully completed treatment, discharge planning towards the end of a treatment episode.	Assertive continuing care (post-treatment monitoring & support—recovery checkups, stage-appropriate recovery education, linkage to recovery support resource, and if needed, early re-intervention) for all persons admitted to treatment, regardless of discharge status. Planning for continuing support initiated early in the treatment process. Building connections to community recovery capital becomes a focus of the treatment process based on identified needs.
Service Evaluation	Focus on short-term abstinence outcomes and reduction in social costs outcomes.	Focus on long-term recovery outcomes as measured by abstinence or remission, improvements in global health, and positive community reintegration.

The Community as Client: Integration of Clinical Models of Intervention with Cultural Revitalization and Community Development Models

AC models of intervention into AOD problems are based exclusively on clinical interventions primarily with the individual and, at their best, with families. RM/ROSC models of care seek not only to target interventions at the community level to support personal/family

recovery but also to heal wounds within the larger community that have been inflicted by AOD-related problems. Within RM/ROSC approaches, the community is also a client. Table 3 illustrates some of the goals and representative activities within this community-level intervention process.

Table 3: Community Mobilization Strategies within RM & ROSC

Recovery-focused Community Mobilization Goals	Representative Activities
Mobilize local recovery communities as a force for education, advocacy, peer recovery support, and community service.	• Establishing a Recovery Advisory Council. • Hosting national speakers for recovery community events; public recovery celebration events (e.g., annual recovery walk). • Sponsoring storytelling, recovery coaching, and leadership training workshops. • Supporting development of community recovery centers as hubs for education, advocacy, peer support, and community service. • Encouraging development of treatment alumni associations. • Offering technical assistance to local organizations on how to recruit, select, orient, train, and supervise recovery volunteers. • Inviting participation in public advocacy by people in recovery who are temperamentally suited for this role and whose life circumstances minimize the risk of personal/family harm that might accrue from this activity.
Enhance diversity and quality of recovery support resources.	• Inventorying and mapping local recovery support resources. • Measuring and reporting changes in community recovery capital over time. • Ensuring recovery support resources are located in geographical areas of greatest need. • Strengthening relationships between local treatment programs and mutual aid group service committees. • Supporting the development of indigenous recovery support resources across diverse ethnic and cultural communities. • Providing seed money and technical support for development of new recovery support institutions, e.g., recovery homes/schools/industries/ministries.

	• Developing and disseminating educational materials that affirm the legitimacy of diverse secular, spiritual, and religious pathways of recovery. • Creating pathways of involvement for people in medication-assisted recovery to participate in recovery-focused community activities, e.g., recovery newsletter for people in medication-assisted recovery. • Developing a Consumer's Guide to Medication-assisted Treatment & Recovery.
Support development of an inclusive, "non-denominational" (not linked to a single treatment or recovery mutual aid resource) culture of recovery.	• Ensuring diversity of pathways and styles of recovery in all structures (e.g., advisory groups, event planning groups) and activities. • Encouraging development of recovery-focused activities in art, music, theatre, sports, and leisure.
Raise recovery consciousness at the community level.	• Creating task forces to address social and professional stigma attached to treatment and recovery. • Hosting meet and greet meetings between recovery community organization leaders and local social/political/business/religious/media leaders. • Involving community leaders and leading community institutions in recovery-focused public events. • Promoting recovery-related stories through mainstream media channels. • Challenging any media story that contains misinformation about addiction and recovery or that objectifies or stigmatizes people in recovery from alcohol and other drug problems. • Using recovery mural and poster projects to elevate hope for and visibility of recovery in the community. • Conducting and publicly disseminating results of recovery prevalence surveys (imbedded within existing public health surveys).
Build pathways of community reintegration for people with the most severe, complex, and enduring AOD problems.	• Strengthening linkages between addiction treatment and recovery community organizations and local educational and employment resources. • Conducting skill training programs within the community recovery center.

	• Operating a job bank within the community recovery center for people in recovery seeking employment. • Encouraging people in recovery to hire and mentor people in recovery. • Creating special recovery support programs for people re-entering the community from prison.
Integrate primary prevention (PP), early intervention (EI), treatment (Tx), and recovery support (RS) programs.	• Developing conceptual models for PP, EI, Tx, & RS integration. • Ensuring inclusion of children and adolescent services representatives and prevention specialists in all governance and advisory bodies. • Integrating discussions of PP/EI strategies for children of parents in treatment into treatment and post-treatment recovery education.
Increase the readiness of the broader health and human services network to embrace and integrate recovery support services.	• Training providers to enhance organizational readiness for integrating peer-based recovery support services (P-BRSS). • Educating and training primary care providers on RM and the potential roles and benefits of P-BRSS. • Advocating for the inclusion of SUD and related services to be a part of any community-wide health reform initiatives. • Implementing demonstration projects that highlight the potential impact and relevance of RM approaches within other social services and healthcare arenas, e.g., child welfare and criminal justice systems.

Those wishing additional information are encouraged to explore the following resources.

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