Long Term Recovery

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Pathology and Treatment Paradigms versus a Recovery Paradigm in SUD

Pathology Paradigm

- Focuses on SUD as a disease
- It created a need for studies about addiction
- Sparked the search for the etiology of addiction
- Also sparked research into the incidence, prevalence and personal/social costs of SUD problems.
- Looking for specific solutions
- As a result, we have learned much about the initiation and maintenance of addiction.

Treatment Paradigm

- Acute, time limited interventions for a chronic condition
- Evidenced based practices; professionally driven
- Strategies and techniques to intervene (social and personal)
- Relatively short duration (90 days or less)
- Expectation: The person 'graduates' the program; recovery is self sustainable at this point without professional help.

Treatment works!

- Significant decrease in SUD use post treatment
- SUD problems decrease significantly as well
- Lives of individuals and families are transformed.

Problems with current treatment

- Low attraction
- High attrition
- Low service dose
- Lack of or inadequate continuing care
- Post treatment relapse

“If addiction is best considered a chronic condition, then we are not providing the appropriate treatment for many addicted patients.”

Dr. Tom McLellan, 2002

The Recovery Paradigm

- Solution focused as opposed to Problem focused.
- Solutions to SUD problems already exist in the lives of millions of individuals and families.
- Improved strategies can come from the experience, strength and hope of those already in recovery.
- Recovery as a community wide organizing concept in SUD and mental health treatment.

Recovery definition

- "Recovery defined as a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship."
  - 2007 Betty Ford Institute Consensus Panel
- "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."
  - SAMHSA Jul 24, 2015

Recovery Management

- Is a philosophical framework for organizing addiction treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality of life enhancement for individuals and families affected by severe substance use disorders.

Five Year Recovery Model for TX (DuPoint, et al, 2015)

- "A need for regular monitoring of patient symptoms, function, and risk faction combined with individualized combinations of medications, social services and patient/family educations to detect incipient relapse and intervene rapidly to prevent escalation of illness" (DuPoint, 2015)
- Advocating for TX shift from a model of acute biopsychosocial stabilization to a model of sustained recovery that would emulate the TX of other chronic health conditions
- Integration of health services
- "Focus on the ecology of addition recovery: relationships between individuals and their physical, social and cultural environments promote or inhibit the long-term resolution of severe AOD problems"-(White, 2008)

Pre recovery identification and engagement

- Screening, Brief Intervention and Referral to Treatment in Primary Care settings (SBIRT).
- Use of screening instruments such as the AUDIT C
- Identify and engage the other 90% that don't access specialty SUD care before many losses and consequences.
- Aggressive outreach in the community
- Peer Recovery Specialists in ED's and shelters
- Motivational Interviewing

Entering Recovery (motivation….)

- Use of Motivational Interviewing, gauging and establishing motivation:
- Implementing Change Talk
  - Commitment (I will make changes)
  - Activation (I am ready, prepared and willing to change)
  - Taking Steps (I am taking specific acts to change)

-The use of simple tasks is very effective at this point and using several tools to gauge the commitment can be used effectively.

- "people with internal motivation understand causality and tend to act on their own choosing, mainly based on their values and beliefs, whereas people with external motivation understand it differently and tend to view themselves as pressured by external forces, such as interpersonal, occupational, scholastic, medical and legal pressures"-(A. Milllere, et al, 2014)
- ecology of addiction recovery—how the relationships between individuals and their physical, social, and cultural environments promote or inhibit the long-term resolution of severe AOD problems" (White, 2008)

Three types of recovery initiation

Natural Recovery

- Shown by some studies to be the most common recovery pathway
- Using one's own intrapersonal and interpersonal resources to resolve SUD problems without the benefit of professional interventions.
- Prevalence declines as problem severity and problem duration increases.
- Associated with higher incomes and stable social/occupational supports.

Treatment Assisted Recovery

- Approximately 10% of those with an SUD seek tx in a given year (problem with acute care model)
- Addiction treatment is heterogeneous, with differences in treatment philosophies and effectiveness.
- Usually people who seek treatment have greater problem severity, early age of onset, family history, less social supports.
- Outcomes are compromised by high treatment dropouts and inadequate doses of treatment.

Peer Assisted Recovery

- Uses the mutual aid groups to initiate and maintain sobriety.
- AA is the most utilized of these
- Can play a significant role in moving from addiction to recovery.
- The positive effect extends to wide variety of people including dually diagnosed, atheists/agnostics, adolescents, women and historically disempowered groups.
- The probability of stable remission rises in tandem with the number of meetings attended in the first three years.
- Recovery homes are also included in this pathway of initiation.

Recovery Initiation Frameworks

Religious

- Uses religious experience, religious beliefs, prescriptions for daily living, rituals of worship and the support of a community with shared faith for support.
- There is a religious rationale for the roots of addiction.
- There is a religious rationale for restraint and temperance.
- Rituals of confession, restitution and forgiveness help with psychological reconstruction.
- Religious can overlap with the Spiritual initiation framework
  - Both flow out of the human condition of wounded imperfection.

Spiritual

- The experience of connection with resources both within and beyond the self
- Core values such as humility, gratitude and forgiveness.
- Focuses on defects of character such as self-centeredness, selfishness, dishonesty, resentment, anger as the root of addiction.
- Work inside of oneself on developing the traits of honesty, humility and tolerance.
- Work outside of oneself with reliance on a Higher Power, acts of service, prayer, confession, acts of restitution and participation in community.
- Embraces the paradox of “sober alcoholic”.
- Vacuum inside of oneself craves meaning; SUD filled that void in active use.
- More authentic and lasting meaning can be had through spirituality.

Secular

- Rests on the belief in the ability of each individual to rationally direct his or her own self change processes.
- Root of addiction is irrational beliefs about oneself and the world
- Also, views SUD as coming from ineffective coping strategies instead of viewing it in terms of biology, morality, character or sin.
- Involves assertion of self.
- Teaches behavioral and cognitive self-change techniques.
- Emphasizes recovery knowledge
  - Scientific evidence, self mastery through knowledge of self and knowledge of one's problems and strength flowing from personal competence.

Religious, Spiritual and Secular frameworks have in common:

- Re-visioning of self
- Re-visioning of one's life context
- Restructuring of life stance and lifestyle.
- A three part story-style
  - What it was like
  - What happened
  - What it is like now

Religious and Spiritual

- Active participation in communal religious activities helps build support that helps with identifying illness, provides community identity, encourages a healthy lifestyle, lower levels of depression and an improvement in overall health (McCullough, 2009)

Recovery Capital
(White and Cloud, 2008)

- "*Recovery Capital* is the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from severe AOD problems" (Granfield and Cloud, 1999)

Personal Recovery Capital

- Physical health, financial assets, health insurance, safe/recovery supportive shelter, clothing, food, transportation. Also includes values, knowledge, educational/vocational skills/credentials, problem solving capabilities, self awareness and self esteem, self efficacy, hopefulness/optimism, perception of past/present/future, sense of meaning and purpose in life and interpersonal skills.

Family/Social Recovery Capital

- Intimate relationships, family/kinship relationships as defined by the person, social relationships that are supportive of recovery. This includes family willingness to be involved in treatment, presence of others in the family in recovery, access to sober social outlets (school, workplace, church, other).

Community Recovery Capital

- Attitudes/policies/resources related to addiction and recovery that promote the resolution of alcohol and other drug problems. This includes
  - Active efforts to reduce stigma
  - Visible and diverse recovery role models
  - Full continuum of addiction treatment resources
  - Local recovery community support institutions
  - Sources of sustained support and early re-intervention
- Learning new behaviors needs a fertile and safe environment to happen, 12-step groups, supportive family, counselors, spiritual support, educational environments and exercise are all key ingredients.

Cultural Recovery Capital

- A part of Community Recovery Capital. This includes
  - Culturally prescribed pathways of recovery
  - Native Americans treatment programs/self help
    - Red Road; Indianization of AA
  - African American treatment programs
    - Africentric Personal Development program
    - Bell Center

Recovery Capital

- In both quality and quantity, play a major role in determining success or failure of natural or assisted recovery.
- Increases in recovery capital can spark turning points that end addiction careers, trigger recovery initiation, elevate coping abilities and enhance quality of life in long-term recovery.
- Elements of recovery capital vary in importance within a particular stage of recovery
- Disempowered groups lack recovery capital that other groups take for granted.
- Post treatment recovery check ups help preserve recovery capital

Recovery Capital

- Most clients with severely depleted family and community recovery capital gain little from individually focused addiction treatment that fails to mobilize family and community resources.
- Long term recovery outcomes for those with the most severe AOD problems may have more to do with family and community recovery capital than the attributes of individuals or a particular treatment protocol.
- Environmental factors can augment or nullify the short term influence of an intervention.
- Strategies that target family, community recovery capital can elevate long-term recovery outcomes as well as elevate the quality of life for both individuals and families in long term recovery.

Recovery Capital

- "The upward spiral revolves around the drug in ever-widening circles, expanding away from the drug. This spiral grows to include health relationships, an expanded self-concept and a richer sexual and spiritual life" (Hammond-Clark, 2011 & Covington, 1999)

Recovery Capital in Clinical Practice

1. Support Screening, Brief Intervention and Referral to Treatment (SBIRT) in Primary Care settings before someone's recovery capital is depleted and SUD becomes even more severe.
2. Aggressive Community outreach programs to engage those with the least recovery capital.
3. Assess recovery capital at the start and throughout treatment
4. Use recovery capital to help determine level of care placement decisions.
5. Target all 3 spheres of recovery capital in both professional treatment plans and client devised recovery plans.

Recovery Capital in Clinical Practice

6. Support recovery linked cultural revitalization and community development movements. Outcomes will include the creation of a community milieu where those in recovery can flourish and recovery support services will increase.
7. Evaluate your program and practice regarding recovery capital
8. We have done well at measuring what is subtracted from our clients lives; we need to start focusing as well on what has been added to their lives

Barriers to implementing recovery oriented treatment

- Conceptual difficulties (moving from problem focused to solution focused; difficulty thinking outside of the acute care model.
- Potential loss of professional pride – difficulty acknowledging the collective wisdom of the recovery community.
- Lack of financing/staffing models for the changes
- Lack of an evidenced based recovery support protocol
- Potential ethical concerns
- Potential difficulties with institutional buy in
- Professionals seeing themselves as 'recovery oriented' even when they are not.

Keys to sustained long-term recovery

- Kinship and social networks
- Community support
- Admission that past problem-solving efforts have failed
- Visible expression of commitment to change
- Inventory of assets and vulnerabilities
- Development of a recovery action plan
- Management of continuing self-defeating patterns of thinking, feeling, actin and interacting
- **Character and identity reconstruction** (who we were, what happened, who we are becoming)-echoing Mate stating finding one's true-self)
- Reconciliation and reconstruction of key relationships
- Recovery maintenance rituals (e.g. centering rituals, sober fellowship, acts of self-care, acts of citizenship and service) (White, 2008)

Mutual Aid Support Groups Choice Philosophy (White and Kuntz, nd)

- Knowledgeable about the diversity and styles of recovery as well as the full spectrum of religious, spiritual and secular recovery support groups and the main ideas expressed by each.
- Knowledgeable about the patterns of co-attendance (attendance at one or more types of recovery mutual aid groups); as well as the transition process from one group to another.
- Become aware of and accept that some in recovery transition out of self help at some point in their recovery careers.
- Clients and families are educated about the variety of recovery experiences; that there are multiple pathways and styles of recovery.

Mutual Aid Support Groups Choice Philosophy

- Client choice is respected – no one is demeaned or disrespected for the recovery strategies they choose.
- Motivational Interviewing principles are used regarding recovery pathway and style choice as opposed to coercion or confrontation.
- Professionals and peer specialists are encouraged to bring to supervision any negative feelings about alternative styles and pathways to recovery.

Benefits of Mutual Aid groups

- Shared wounds among the members
- A place of sanctuary where the person can feel comfortable both physically and psychologically.
- One is accepted, not in spite of one's imperfection, but because of it.
- There is a shared sense of a "torn-to-pieces-hood" (William James)
- A fellowship of people that would not normally mix.
- One can discover oneself in others' stories.
- Shared pain and hope can be woven into stories that is more like communion as opposed to communication.

Benefits of Mutual Aid Groups

- Loss of treatment effect may occur if not reinforced by a social context supportive of abstinence.
- Factors outside of treatment seem to be even more important after 6 months, with social network that supports reducing substance use related to abstinence.

Recovery Stabilization – EBP's

- Cognitive Behavioral Therapy – Substance Use Disorders
- Acceptance and Commitment Therapy
- Motivational Interviewing, Motivational Enhancement Therapy
- Contingency Management
- Matrix Model
- Mindfulness Based Sobriety

Differences between Treatment plans and Recovery plans

Treatment plans

- Generally developed by the professional with client input
- At some agencies, this is done with the professional as the expert and author.
- Focused on symptoms/problems and needed interventions.
- Based upon the training and experience of the professional.

Recovery Plans

- Developed by the client with professional input.
- Based upon a partnership or consultant relationship
- Broad in scope addressing all aspects of recovery capital with a weekly action plan to mark progress towards goals.
- Based upon the strength and strategies of the collective experiences of others in recovery.

Long Term Recovery Management

- Begins at point of discharge from primary treatment
- Key point for the client to fully transfer what has been learned in treatment to their natural environment.
- Steps
  - Ongoing check ups and support
  - Stage appropriate recovery coaching
  - Ongoing or as needed assertive linkage to recovery support groups
  - Helping resolve environmental and personal obstacles to ongoing recovery
  - Early re-intervention or re-linkage to treatment if needed.

Post Recovery Check up benefits

- Can decrease the total number of treatment episodes needed to achieve stable and ongoing recovery
- Can speed admission to treatment if needed
- Enhance the dose of treatment and support services needed
- Hasten recovery stabilization and maintenance.

Strategies used in Recovery Management

Attraction

- Recovery focused anti-stigma campaigns
- Early Screening and brief intervention
- Assertive community outreach
- Non-stigmatized service sites (hospitals, health clinics, workplace, school, community centers, libraries)

Access and Retention

- Streamlined intake
- Addressing wait list issues
- Hope based motivational strategies
- Appointment prompts and phone follow up for missed appointments
- Institutional outreach for regular re-motivation
- Motivation not a precondition for entry into tx
- Motivation is a shared responsibility between tx providers, family, community and client.

Assessment and Recovery Planning

- Global rather than categorical
- Strengths based (assess recovery capital)
- Emphasis on self assessment versus professional diagnosis
- Scope of assessment including individual, family, and recovery environment.
- Ongoing assessment
- Transition from treatment plans to recovery plans

Treatment

- Emphasis on evidenced based, evidence informed and promising practices.
- High degree of individualization; **menu of options**
- Emphasis on mainstream services that are gender specific, culturally competent and trauma informed.
- "For healthy and long-term changes in the brain, one must be free of some of the stressors in life, biologically speaking, people who live with a great deal of stress in their everyday lives are prone to their body experiencing the physical manifestations of stress: high levels of cortisol, adrenaline, hypertension, etc.." Mate

Composition of Service providers

- Involvement of Primary Care
- Recovery Coaches
- Community Recovery Centers
- Emphasis on volunteer programs, consumer councils and alumni associations.
- Inclusion of ‘indigenous healers’; faith community.

Locus of Service Delivery

- Home, neighborhood and community based
- Question: 'How do we nest recovery in the natural environment of this individual or create an alternative recovery conducive environment?'
- "Healing Forest" metaphor; concept of treating the community.

Service dose and duration

- One of the best predictors of treatment outcome is service dose.
- Post -treatment monitoring and support
- Assertive linkages to communities of recovery
- Early re-intervention if and when needed.
- Focus is on managing the course of the disorder to achieve lasting recovery.
- Assertive continuing care to successful and unsuccessful completers.
- Responsibility for contact is on the program, not the client.

Relationship with Recovery Communities

- Staff knowledgeable of multiple pathways/styles of long term recovery, local recovery community resources and online support groups.
- Direct relationship with H & I committees
- Assertive linkages to support groups and larger communities of recovery.
- Clients need to shift from a culture of use to a culture of recovery.

Service Relationship

- Partnership model
- Relationships are natural, reciprocal, enduring and non-commercialized
- Continuity of contact
- Provider role is like that of a primary care physician.

Evaluation

- Focus on effect of interventions on addiction/treatment/recovery careers at multiple points in time
- Focuses on long term recovery processes and quality of life in recovery.
- Greater involvement of clients, families, and community elders in design, conduct and outcome studies.
- Search for potent service combinations and sequences.

Recovery Oriented Systems of Care

Recovery Oriented Systems of Care

- Networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by severe substance use disorders. The system in ROSC is not a treatment agency but a macro level organizations of a community, a state or a nation.

Examples of Recovery Oriented Systems of Care

Governor's Cabinet Opiate Action Team – Andrea Boxill

- Worked with the Bureau of Workman's Compensation to institute a rule for an additional 18 months of coverage for individuals who have become addicted to opiates while receiving medical services.
- Worked with the Ohio Child Welfare Training program to provide online Substance Abuse training for free (four monthly trainings) to staff of Job and Family Services
- Awaiting approval from the Governor's office for a marketing campaign to decrease the use of prescribing of opioids.
- Applied for funding from SAMSHA for $52 million for the expansion of MAT, Overdose Education/Naloxone Distribution and prevention.
- Many other ongoing projects and initiatives.

Attorney General Mike DeWine's Heroin task force – Ideas in Motion

- Prevention and Education in schools
- Coalition Building throughout Ohio
- Providing training to agencies in trauma informed care
- Criminal Justice, treatment providers, medical community and others working together towards addressing the issue of Substance Use Disorders
- Development of Continuum of Care plans for all counties in Ohio

Franklin County Opiate Crisis Task Force Community Action Plan

- Treatment – All persons in need of treatment will be able to gain access to the level of care they need, including a continuum of services to ensure a pathway to recovery.
- Prevention and Education – reduce opiate abuse through targeted education and harm reduction strategies.
- Law Enforcement – The crisis of opiate misuse and addiction will be addressed through public safety, including a reduction in the supply…
- Policy and Legislation – will ensure that legislation and policies support the work of preventing and reducing harm…provide treatment and recovery opportunities for those in need.
- Recovery – all persons in recovery from opiate addiction will find the supports they need to sustain their recovery journey.

Fort Hamilton – Golden Ticket

- Targeted program for addicts who present in their Emergency Department for treatment of an overdose.
- Within 72 hours, their team visits the house with the hope of engaging the person in a recovery program.
- Team consists of a social worker, law enforcement, hospital chaplain and an ED pharmacist if an opioid overdose kit was prescribed.

Pickaway County Jail - Opiate Crisis
Lt. Gabriel S. Carpenter, Jail Admin.

- Counselors come into the jail and help with Medicaid applications so the day they are released, they have active Medicaid.
- PO visits inmate in jail and works on a recovery plan
- PO goes in front of the judge and advocates for the inmate for txt.
- Judge approves; writes orders
- Inmates are released to a **Ross County counseling center** to get their first dose of Naltrexone.
- Transportation is paid from home to counseling center and back by Medicaid.
- Introduces inmates to church family.

Rapid Response Emergency Addiction and Crisis Team (RREACT)

- **Columbus Fire and Southeast Healthcare**
- Outreach teams consisting of mental health nurses and outreach coordinators respond with EMS on opiate overdoses/mental health crisis.
- Improved and immediate access to treatment throughout the community healthcare system.
- Systems based approach to continuity of care.
- Home follow ups to ensure success in accessing and receiving comprehensive services (medical, addiction, detox, recovery)
- Secondary involvement with on-scene involvement with EMS for mental health crisis interventions. **Funded by ADAMH Board**.

HOPE – Heroin Overdose Prevention and Education

- **Southeast Healthcare/Franklin County Sheriff's Office**
- Unique opportunity to reach those individuals with an opioid use disorder and provide access to a spectrum of healthcare services.
- Team of detectives responding to overdoses – the person is treated as a victim and linked to a Southeast Healthcare worker.
- Provides immediate intervention and support during the home follow ups.
- Offered and/or linked to a wide variety of services – prevention, medical and preventive care, women's health, mental health, detox and other recovery supports.
- Support of family and loved ones as well. – all funded by **ADAMH.**

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References:

- Clark Hammond, G. PhD. (2013). The Phoenix rising: describing women's stories of long-term recovery: a narrative analysis. Columbus: Scholar's Press.
- DuPont, R. MD., Compton, W. MD., & McLlan, A. PhD.. (2015). Five-year Recovery: a new standard for assessing effectiveness of substance use disorder treatment. Journal of Substance Abuse Treatment 58, 1-5.
- Granfield, R., & Cloud, W. (1999). Coming clean: overcoming addiction without treatment. New York: New York University Press.
- Mate, G. M.D. (2017) Freud meets Buddha. Public talk 3/9/2017.
- McCullough, M. E., Willoughby, B.. (2009). Religion, self-regulation, and self-control: associations, explanations and implications. Psychological Bulletin, 135, (1), 69-93.
- Millere, A., Puce, A., Zumate, Z. (2014). Treatment motivation factor analysis of patients with substance use disorders in Latvia. Procedia Social and Behavioral Sciences 159, 2980302.
- The Role of Recovery Support Services in Recovery-Oriented Systems of Care. https://store.samhsa.gov/shin/content/SMA08-4315/SMA08-4315.pdf Retrieved 3/18/2017
- White, W. (M.A). (2008). The mobilization of community resources to support long-term addiction recovery. Journal of Substance Abuse Treatment 39, 146-158.
- White, W. (M.A), Cloud, W. PhD. (2008) Recovery Capital: A primer for addictions professionals. Counselor, 9(5), 22-27
- White, W. (M.A.), Kuntz, E (nd) Linking Addiction treatment and Communities of Recovery: A Primer for Addiction Counselors and Coaches.