

2013 KENTUCKY SCHOOL OF ALCOHOL AND
OTHER DRUG STUDIES

40TH YEAR!

PRESENTS

PARTNERS IN RECOVERY: THE EFFECTIVE
USE OF PEERS AND ADDICTION COUNSELORS
IN HELPING CLIENTS RECOVER

PRESENTER

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RECOVERY MANAGEMENT

DEFINITION OF RECOVERY MANAGEMENT

Recovery management is an approach that shifts from treating addiction in short-term acute episodes toward how we traditionally treat other chronic and progressive illnesses (diabetes, cancer, etc.). Recovery management is a paradigm shift that involves the use of addictions professionals, peers, indigenous community healers to facilitate recovery.

The Crises that Preceded the Paradigm Shift

1. Crack crisis of the 1980s

- Cocaine replaced marijuana
- Baking soda replaced ether
- War on drugs
- Cocaine lost status
- Many inpatient programs became major profit centers.
- Greater distance between the treatment and 12-step communities
- Stigmatizing term “crack baby” was born

**“We were all on crack.”
Chris Rock**

2. Managed care

3. Methamphetamine crisis today

“Combine some hardware and a few common chemicals, with about as much skill as it takes to bake a cake, and you have a methamphetamine epidemic in rural America.”

Neal Conan

- Number one legal problem in some states
- Number one cause of rural fires
- Number one public health problem in some states
- A number of states report that, in spite of the crisis, only a small percentage of methamphetamine users make it to treatment.

4. Limitations of the acute care model

- Ineffective service dose
- Difficulty with attraction
- Long waiting lists and high dropout rates
- High administrative discharge rates
- Abandonment – aftercare as an afterthought

- Perception of treatment as ineffective – A potential backlash against the slogan "Treatment works"

Source: William White, Recovery Management Symposium
Great Lakes ATTC

- When clients experience the greatest difficulties, service providers are no longer working with them
- Those who need treatment the most are the most likely to drop out.

Source: *GLATTC Bulletin*, September 2005, <http://www.glattc.org>

Lessons from History

“Historically, when systems of treatment and support collapse; recovering people, their families and visionary professionals form grassroots movements to rebuild systems of care to support long term recovery.” - William White

- ❖ Grassroots advocacy groups
- ❖ The emergence of recovery homes
- ❖ Faith-based drug ministries

THE NATURE OF CHRONIC ILLNESSES

- ❖ Chronic illnesses are progressive.
- ❖ Chronic illnesses often get worse if left untreated.
- ❖ The symptoms of chronic illnesses ebb and flow over an extended period of time.
- ❖ Chronic illnesses often lead to other illnesses.
- ❖ Chronic illnesses often improve when the treatment regimen is followed and get worse when the treatment regimen is discontinued.
- ❖ Recovery from chronic illnesses can often be a long-term process frequently requiring multiple episodes of treatment.
- ❖ Adherence to recommended medical regimens is the most significant determinant of treatment outcomes for individuals with chronic illnesses.
- ❖ Individuals in the lowest socioeconomic status, who lack family and social support and who have a concurrent mental illness, have the poorest outcomes in terms of recovery from chronic illnesses.

Source: Thomas McClellan, Ph.D., Treatment Research Institute

Questions: How many of the above statements about chronic illnesses are true for substance use disorders? If the addiction field truly believed that addiction is a chronic disorder, how would treatment be different?

THE NEED FOR A PARTNERSHIP TO ADDRESS CHRONIC RELAPSE

3 VARIABLES THAT INFLUENCE CHRONIC RELAPSE

1. High problem severity

- A. Family problems/dysfunction
- B. Abuse
- C. Trauma
- D. Mental illness
- E. Medical complications

2. Low recovery capital

Recovery Capital – Assets an individual possesses that aid in their recovery efforts

- A. Success prior to addiction
- B. Vision for the future
- C. Education
- D. Employability
- E. Resources
- F. Wealth
- G. Communication skills
- H. Family support
- I. Community support
- J. Involvement in prosocial community groups
- K. Spirituality
- L. Religion
- M. Return to culture

3. Early age of first use

THE 3 CONTINUUMS OF RECOVERY MANAGEMENT

(A recovery coach can be utilized in all three continuums.)

- 1. Pre-recovery support services to enhance recovery readiness
 - A. Recovery coaching/peer mentoring
 - B. Community outreach
 - C. Increasing client motivation
 - D. Helping clients understand what to expect from treatment
 - E. Keeping in contact while clients wait
 - F. Linking clients with needed resources
 - G. Helping with other services while clients wait

2. In-treatment recovery support services to enhance the strength and stability of recovery initiation
 - A. Peer support
 - B. Check-ins
 - C. Linkage in communities of recovery prior to discharge
3. Post-treatment recovery support services to enhance the durability and quality of recovery maintenance
 - A. Recovery coaching in the natural environment
 - B. Help with the fragility of early recovery
 - C. Strong linkages in communities of recovery

Areas in which addictions counselors recovery coaches can provide support to clients:

In the short-run

1. Return to an anxious home (therapist and coach)
2. Dealing with pressure from bill collectors (therapist and coach)
3. Early efforts to disengage from a drug culture (therapist and coach)

Types of drugs

Socially celebrated
 Socially tolerated
 Socially prohibited

Types of addicts

Acultural
 Bi-cultural

Source: White, W. (1996). *Pathways from the Culture of Addiction to the Culture of Recovery*. Center City, Minnesota: Hazelden.

4. Feelings of uselessness in the community (therapist and coach)
5. Separation/Divorce (therapist and coach)
6. Disengagement from self-help groups and other sources of support (therapist and coach)

Areas in which recovery coaches can provide support:

In the long-run

1. Unresolved grief and trauma (therapist)
2. Development of recovery capital (therapist and coach)
3. Chronic pain (therapist)
4. Existential crises (therapist)

5. Generativity vs. despair – A stage in which you look back on your life, reflecting on the contributions you have made and the “mark you are leaving.”
6. Phase 2 recovery
 - A. Learning to have healthy relationships (therapist)
 - B. Dealing with negative core beliefs (therapist)
7. Other problems about which the client may be ambivalent. (therapist and coach)
8. Periods of celebrations, anniversaries, holidays, accomplishments, etc. (therapist and coach)

WHAT THE RECOVERY COACH DOES NOT DO

- 1.
- 2.
- 3.
- 4.

SIMILARITIES BETWEEN A RECOVERY COACH AND A SPONSOR

1. Both are credentialed by experience rather than education.
2. They both allow self-disclosure.
3. They both remove obstacles to recovery.
4. They both model recovery competence.
5. They both maintain contact in the community.

DIFFERENCES

1. The sponsor’s service is provided through a voluntary organization
2. The recovery coach is a paid representative of a social service organization
3. The sponsorship relationship can occur in isolation
4. The recovery coach is a part of a multidisciplinary team

5. The organization plays a part in determining when to terminate a case in the sponsor/sponsee relationship; there is rarely any organizational involvement.
6. The recovery coach usually has to respect multiple pathways and styles of recovery. The sponsor has to honor only one pathway to recovery.

Pathways

- A.
- B.
- C.
- D.

STYLES OF RECOVERY

- ❖ Total abstinence
 - ❖ Temporary drug substitution
 - ❖ Virtual recovery
 - ❖ Telephonic recovery
 - ❖ Treatment-assisted recovery
 - ❖ 12-step recovery
 - ❖ Secular recovery
 - ❖ Quantum change
 - ❖ Religious recovery
 - ❖ Shifting allegiance
 - ❖ Partial recovery
 - ❖ Occasional use
 - ❖ Medication assisted
 - ❖ Cultural pathways
 - ❖ Disengaged style
 - ❖ Harm reduction
7. The recovery coach may need to accept a wide range of languages connected to these multiple pathways.
 - ❖ redeemed
 - ❖ delivered
 - ❖ saved
 - ❖ recovered
 - ❖ no longer demon possessed
 - ❖ well
 - ❖ confession
 - ❖ free
 8. The recovery coach may work to expand the number of support networks

9. Ethics, guidelines, and supervision
10. Rules around anonymity
11. Advocacy

HOW THE ROLE OF THE RECOVERY COACH DIFFERS FROM THE ROLE OF THE THERAPIST

1. Self-disclosure. Generally, recovery coaches self-disclose more than therapists.
2. Different competencies needed.

The therapist needs knowledge of:

- Evidence-based practices in the treatment of addictions
- How to do an assessment
- Treatment planning
- How to make a diagnosis
- Co-occurring disorders
- The integration of addictions and trauma treatment
- Family therapy
- Crisis intervention
- How to address suicide
- Domestic violence
- How to make referrals to mutual aid groups
- How to partner with recovery coaches

The recovery coach needs knowledge of:

- Advocacy
- Resources available in the community to support recovery
- How to develop resources in the community to support recovery
- Knowledge of long-term recovery
- Awareness of roadblocks to recovery that exist in the client's natural environment
- How to engage individuals in their natural environments
- Indigenous healers present in the communities
- The limitations of their knowledge
- What to do if a client is in a crisis
- How to partner with the treatment community
- How to provide various types of recovery support

Types of recovery support

- Emotional support. Providing care and concern, encouraging the expression of feelings, helping individuals in early recovery problem solve.
 - Informational recovery support. Provide information to individuals and families in recovery about where they can receive services, such as job readiness training, vocational training, GED programs, etc.
 - Instrumental recovery support. Assistance in meeting basic needs, such as where to find free clothing, emergency food pantries, referrals for housing support, etc.
 - Affiliational recovery support. Provide information on where and how to meet other people in recovery, information on various mutual aid groups, information that promotes sober fun, such as dances, movies, sober celebrations, sober sports festivals, etc.
 - Transportational recovery support. Miracle Village, an Indiana-based RCSP program, utilizes individuals in recovery to help motivate and transport individuals in public housing to and from treatment. TASC in Chicago utilized a van to help escort individuals from Stroger Hospital medical unit into treatment facilities.
3. Duration of contact. By providing pre-treatment, in-treatment, and post-treatment recovery support, the recovery coach generally has a longer-term contact with the client than the therapist.
 4. Where the helping relationship takes place. Recovery coaches are more likely to meet with individuals in recovery in the community. Therapists are more likely to provide office-based services.
 5. Help with acute care vs. long-term recovery. Therapists traditionally provide help with acute care, and recovery coaches provide support for long-term recovery.

Source: *Sponsor, Recovery Coach Addiction Counselor: The Importance of Role Clarity and Role Integrity*, by William White

Group Discussion

1. Examining how the role of the recovery coach differs from the role of the therapist, what is your opinion as to how their roles differ most?
2. What are some ways in which recovery coaches and therapists can be confused by each other's roles?
3. What are your recommendations as to how recovery coaches and therapists can partner effectively?

Which of the following are important to you in selecting a recovery support group?
(Check all that apply)

People who:

- Have experience with my primary drug
- Are the same gender
- Are close to my age
- Share my ethnic, cultural background
- Share my view on religion, spirituality, secularity
- Share my sexual orientation
- Smoke tobacco
- Do not smoke tobacco
- Have tolerant attitudes toward medication prescribed for addiction or mental illness
- Have prior experience in the criminal justice system
- So not have prior experience in the criminal justice system
- Have approximately the same income level
- Have had severe alcohol/drug problems
- Have had mild to moderate alcohol/drug problems
- Share my goal of complete abstinence
- Share of my goal of moderate use

Source: Recovery, Northeast ATTC, 2006