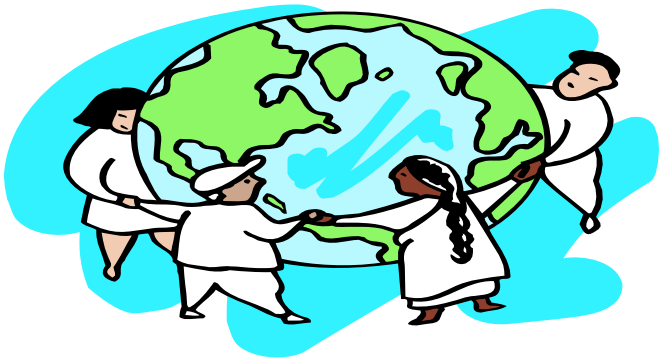
The Philadelphia Department of Behavioral Health and Mental Retardation Services (DBHMRS)

Tools for Transformation Series: Extended Recovery Support



Recovery is the process of pursuing a contributing and fulfilling life regardless of the difficulties one has faced. It involves not only the restoration, but also continued enhancement of a positive identity as well as personally meaningful connections and roles in one's community. It is facilitated by relationships and environments that promote hope, empowerment, choices and opportunities that promote people in reaching their full potential as individuals and community members.

Philadelphia Department of Behavioral Health/Mental Retardation Services (DBHMRS, 2006)

The Philadelphia Department of Behavioral Health and Mental Retardation Services (DBHMRS)
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Tools for Transformation Series: Extended Recovery Support-*Authorship page*

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Introduction

Creating a recovery-oriented system of care is a top priority of the Philadelphia Department of Behavioral Health and Mental Retardation Services (DBH/MRS). A recovery-oriented system is committed to supporting people in moving beyond their problems and challenges to develop a full and meaningful life in the community. This process involves discovering the hopes and dreams of people, who have experienced mental health and/or substance use issues, and using the assets of these individuals, their families and the community to achieve these hopes and dreams. It is grounded in the evidence that people impacted by such behavioral health issues can successfully achieve long-term recovery. In a recovery-oriented system of care, the thoughts and ideas of individuals and family members in recovery are taken seriously; service providers assertively include people in recovery and their families (as defined by the person) in making decisions. Each individual is treated as a whole person (body, mind and spirit) and in the context of his/her culture.

This document is one of a series of resource packets produced by the DBH/MRS to provide tools and a greater understanding of key recovery concepts for persons in recovery, family members, service providers and DBH/MRS staff as part of the Philadelphia DBH/MRS Recovery Transformation.

Each packet in the Tools for Transformation series focuses on a system transformation priority area that has been identified as important by numerous stakeholders in the system. During the next 12 months, these priority areas will be the focus of our recovery transformation. Other resource packet topics include:

- recovery planning/person directed planning,
- family inclusion and leadership,
- holistic care,
- partnership,
- quality of care.

Each packet has:

- Information for persons in recovery, providers, and DBHMRS staff about the priority area;
- A self assessment checklist for providers that lets them evaluate their own practice in the topic area;
- A similar checklist for people in recovery to think about ways their provider is supporting them in this area and to develop ideas about other ways that support could be given;
- A checklist for people in recovery to explore how they are doing in the area and to get some new ideas for ways they could take more steps in their own recovery;
- A checklist for DBH/MRS staff that lets them evaluate their practices in a priority area; and
- A resource list with information that can be obtained through websites, books and articles.

Extended Recovery Support
Concept to Practice Paper

Interest in extended recovery support services is growing. Such interest is being sparked by the growing accumulation of stories of people in recovery from all behavioral health challenges and by recent scientific research into the recovery process. Both sources are illuminating the stages and styles of long-term recovery and the kind of support systems that can first stabilize and then strengthen the recovery process as well as enhance the quality of personal and family life in long-term recovery.(Raiff, 1984, Laudet et al., 2000, Magura et al., 2003).

Why do people experiencing severe mental or substance use issues need specialized and extended support to sustain recovery? The answer to this question is two-fold. First, without such support services, the severity, duration, and consequences of these problems worsen over time for many people. This results in repeated outbreaks of symptoms and innumerable episodes of crisis interventions without the achievement of long-term recovery-sustained symptom reduction/remission, a movement toward global health, and enhanced quality of life. Second, with extended support, many people with severe behavioral health problems completely eliminate or drastically reduce episodes of active illness and achieve personally fulfilling and socially contributing lives in the community.

The interest in recovery support and sustained professional- and peer-based support services has grown out of several developmental models of recovery based on long-term studies of mental illness and addiction. These models share a number of key propositions:

- Recovery is often characterized by predictable stages and milestones.
- The movement through the stages of recovery is a time-dependent process; some aspects of recovery cannot be hurried; some aspects of the recovery process are enduring—requiring vigilance and active management throughout one's life.
- Each stage of recovery is marked by developmental tasks that must be completed before movement to the next stage can occur.
- These stages and tasks may vary from individual/family to individual/family.
- These developmental tasks are shaped by the interaction of problem severity/complexity and personal, family, social, and community recovery capital (assets).
- Treatment and support interventions appropriate to one stage of recovery may be ineffective or even harmful when misapplied to another stage of recovery.

Such interest has also grown out of research confirming the positive role of sustained support in the recovery process. The following factors can play crucial roles in strengthening and extending long-term recovery:

- Recovery support from family and friends,
- Participation in peer-based recovery support groups,
- Access to recovery-focused professional treatment,
- Participation in professionally-directed continuing care services,
- Participation in treatment Alumni Association activities,
- Access to peer-based recovery support services,
- A recovery-conducive living environment,
- Recovery conducive education/employment, and
- A local culture that celebrates recovery and eliminates barriers to full community participation.

One of the primary lessons we are learning from listening to the stories of recovered and recovering people is that recovery initiation and recovery maintenance are different processes. The former is a process of *recovering from*—escape from painful and often debilitating conditions. The latter is a process of *recovering to*—the discovery of new aspects of self and family and the exploration of new opportunities.

Behavioral health professionals (such as psychiatrists, psychologists, social workers, addictions counselors, etc) can enhance the development of extended recovery support for each people through six broad categories of activity:

- Assessing the recovery capital of each person to determine the level of family, social, and community resources that will need to be mobilized to sustain long-term recovery, A discussion of Recovery capital can also build resiliency in managing future challenges.
- Increasing personal knowledge of recovery support alternatives both locally and nationally (e.g., Internet-based recovery support meetings),
- Educating each person/family on the importance of post-treatment and on-going recovery support and recovery support alternatives,
- Assertively linking each person to local communities including communities of recovery and, when indicated, to indigenous recovery support institutions (e.g., peer recovery support centers, recovery homes, recovery schools, recovery industries, and recovery ministries/churches). Discussing with the Person in Recovery which community or communities they identify with and then facilitating linking with these communities.
- Delivering or advocating the development of post-treatment recovery support services that include sustained monitoring, stage appropriate recovery education, active recovery coaching, and, when needed, early re-intervention, and
- Working to sustain and expand recovery support alternatives within the local community.

In the following pages, we will explore additional ways of making this notion of extended recovery support come alive for persons in recovery, for persons delivering professional treatment and peer-based recovery support services, and for persons working on behalf of DBH/MRS.

Below are 2 Philadelphia programs that are utilizing extended Recovery Supports in innovative ways:

1) **Wedge Medical Center-Alumni Involvement Policy.**
2) **NET developed an Alumni group as part of their Consumer Council.**

Wedge Medical Center-

The Peer Government Board at the Wedge Medical Center recommended to the executive group that an alumni member join as an active member of the Board. The consumer council alumni member is the point person responsible for planning all alumni related events. The alumni point person, along with the other Peer Government board members, makes recommendations about the alumni involvement policy at the Wedge Medical Center. Alumni retain some of the program privileges and maintain a level of involvement in the program after graduation. Staff may be available to alumni for consultation on an as needed basis. However, the use of natural supports including family, mutual

aid groups and faith-based groups is encouraged. Alumni day is held 2 times per month in which alumni are invited to spend an entire day at the program. Alumni program participants engage in recovery story-telling and peer support groups so that they may share their experiences with current members. Their stories provide hope that recovery is real and that it happens every day. Alumni members also share resources with the current program participants that help them to maintain their recovery in the community. In addition, during alumni day, alumni members are able to participate in their own mutual aid groups. During this time they exchange resources and provide each other with support.

Northeast Treatment Centers (NET)-

The Consumer Council at the Northeast Treatment Center (NET) evolved out of a nation-wide Recovery Transformation and a transition to a consumer driven model of treatment. It first emerged in 1994, following a series of focus groups conducted by the NET division director. These focus groups were composed of people receiving services at NET and they suggested several profound service delivery improvements. The major change was the inclusion of people in recovery in the provision and direction of services at NET. These focus groups had a significant impact on the entire NET system and catalyzed the transformation to a Recovery Management Model.

These original focus groups evolved into a self supporting Consumer Council which has been a critical leader in the recovery transformation at NET. The council is now composed of multiple sub-committees:

- The Recovery Support Committee focuses on the re-integration of people in recovery into their community. Committee members coordinate programming and events, outreach efforts, and the establishment of collaborative partnerships with community organizations.
- The Treatment Committee focuses on assisting people in recovery with completing therapeutic goals. This Committee also coordinates a monthly recovery recognition celebration, participation in the consumer retention and re-engagement program, the management of the consumer emergency fund and fund-raising as well as a NET's community service program.

Extended Recovery Supports

Four checklists follow this definition of Extended Recovery Supports. If the checklists are provided separately, you may decide to include this definition.

What is Extended Recovery Support?

The concept of Extended Recovery Support was developed in the addiction community and refers to the availability of resources and relationships to bolster the ongoing recovery process following the stabilization of a behavioral health challenge. Such initial periods of stabilization may be self- or family-initiated and/or professionally-directed. For people with a primary mental health challenge extended recovery support refers to the availability of resources and relationships to support their long-term recovery and the achievement of their hopes and dreams.

The term *extended* means that these resources and relationships are available and present over a period of months or years rather than days or weeks. Where traditional models of treatment for behavioral health disorders often involve relationships that are hierarchical and short-term, recovery support relationships tend to be more reciprocal and more enduring. In the professional context, they are more analogous to a long-term relationship with one's primary care physician or a cancer survivors' support group than a visit to an emergency room or a course of short-term counseling.

Long-term recovery from behavioral health issues is enhanced by two kinds of support. The first is general support—resources and relationships that enhance one's quality of life in the community. The second is recovery specific support—resources and relationships that are critical to the long-term resolution of behavioral health problems. Recovery specific support can range from specialized treatment by service professionals knowledgeable about the long-term recovery process to peer-support offered through recovery support groups whose members share their experience, strength, and hope through the extended process of recovery. Together, these general and specific supports can be thought of as a form of *recovery capital*.

Recovery capital is the total quantity of internal and external resources that can be mobilized to initiate and sustain recovery from a behavioral health disorder **(**Granfield & Cloud, 1999**)**. This recovery capital can exist in individuals, families, neighborhoods, and whole communities. One of the primary goals of behavioral health systems transformation in Philadelphia is to increase recovery capital at all of these levels.

The meaning of *support* in the phrase "extended recovery supports" spans very different types of assistance. For example, peer-based recovery support services have often encompassed five types of support (Solomon, 2004):

1) Emotional Support: expressions of empathy, care, concern, reassurance, and encouragement; sharing "experience, strength, and hope" in the context of exchanging personal life stories.
2) Informational Support: enhancement of knowledge about the recovery process and recovery support resources; advice and other problem solving assistance; linkage to resources for recovery skills development.
3) Instrumental Support: assistance in the logistics of constructing a recovery lifestyle, e.g.,

safe and/or sober housing, transportation to recovery support group meetings, child care, development of social and leisure activities or recovery-conducive employment and education.

4) Companionship: helping people get connected to local communities of recovery as well as to the larger community.
5) Validation: Helping people normalize the recovery experience through comparison and feedback with others in recovery. Sharing that *"I have been there and gotten through it, you can too."*

Provider Checklist- Please think about your own practices and see how many of these activities support extended recovery support.

Statement	Yes	No	Notes
I/We educate each person/family on the role of post-treatment recovery support in achieving successful long-term recovery.			
I/We provide each person/family information garnered from national and program-specific studies on post-treatment recovery and relapse rates and factors associated with long-term recovery.			
I/We assess each person's level of recovery capital and the likely scope and depth of post-treatment resources needed for successful long-term recovery maintenance.			
I/We attend local open recovery support meetings.			
Representatives of my program regularly meet with service committees of local recovery support fellowships or support groups.			
I have visited websites of online recovery support groups for both addictions and mental health issues.			
I/We utilize a philosophy of choice in discussing long-term recovery support options with each person/family.			

Provider Checklist continued on the next page

Statement	Yes	No	Notes
I/We link (during rather than after treatment) each person/family to a particular person or recovery support meeting or community based recovery supports that we feel will achieve the best level of mutual identification and affiliation.			
I/We actively resolve obstacles to participation in post-treatment recovery support activities for people in recovery.			
I/We work to resolve problems when mismatches occur in this linkage process.			
I/We link each person/family to other post-treatment recovery support institutions as appropriate, e.g., recovery homes, recovery schools, outpatient medication and therapy appointments, faith-based recovery ministries, support groups, NAMI, MHA etc.			
I/We clarify with each person the role differences between psychiatrists, psychologists, therapists, recovery coaches, certified peer specialists and sponsors (or their equivalent in non-12 Step support groups).			
I/We monitor the progress of all people in recovery regardless of their discharge status.			
I/We view it as my/our primary responsibility to initiate and maintain post-treatment contact with each person rather than see this as the person's sole responsibility.			
I/We saturate post-treatment support services in the first 90 days following discharge.			

Provider Checklist continued on the next page

Statement	Yes	No	Notes
I/We are actively involved in advocating the development of local recovery support resources beyond those that directly affect my/our professional/financial interests.			
I/We use multiple media to provide post-treatment recovery support services, e.g., face-to-face meetings, phone calls, mailed and emailed communication, volunteers, and alumni association contacts.			
I/We try to emphasize recovery support contacts with each person in his/her natural environment.			
I/We are actively involved in advocating the development of local recovery support resources beyond those that directly affect my/our professional/financial interests.			
I/We individualize the process of maintaining an assertive connection based on those time periods or events in the coming year the person in recovery feels he or she will be most vulnerable.			
The agency facilitate a "culture of collaboration" in which the person receiving services, their psychiatrist, psychologist, therapist, identified support people/family and others meet regularly to discuss hopes, dreams and the recovery process.			
We encourage each individual to develop their own extended recovery support plan which may also include ongoing medication and therapy appointments.			

Provider Checklist continued on the next page

Statement	Yes	No	Notes
I/We increase or decrease the frequency and setting of post-treatment contact based on the needs of each person/family.			
I/We invite people/agencies identified as extended recovery supports by the individual receiving services so that connections can be made even while the individual is receiving inpatient, residential, intensive outpatient and outpatient services.			
All levels of the agency embrace the philosophy of extended recovery supports and create an environment where extended recovery activities of staff and people receiving services are encouraged, acknowledged and rewarded.			
I/We are able to model the concepts of extended recovery supports by providing peer support to other staff members through peer to peer consultation, peer to peer group supervision.			
Alumni groups are established for staff. For example, recently promoted staff is available for consultation to other staff members to discuss what aspects led to their success at the agency.			

End of Provider Checklist

Person in Recovery Working with Provider Checklist I- Persons in Recovery can assess whether the provider is promoting extended recovery support by determining whether they are engaged in the following activities (this is a non-exhaustive list):

Statement	Yes	No	Notes
My provider has encouraged me to participate in local and/or online recovery support groups.			
My provider has discussed the concept and benefits of extended recovery supports with me.			
My provider has discussed with me who I would choose to be in my extended recovery support network.			
My provider has made it easy for those I choose to be in the network to participate (as I choose) in planning meetings and activities at my agency.			
My provider provided me with the lots of choices for recovery support following treatment.			
The staff members who work for my provider know a lot about local recovery support resources.			
My provider has given me things to read about different types of recovery support (including ongoing medication management, faith based services, etc).			

Person in Recovery Checklist I continued on the next page

Statement	Yes	No	Notes
My provider helped me find a buddy to go with me to my first recovery support meeting.			
My provider helped me find recovery supports that I can get to easily such as local recovery support centers and recovery homes.			
I am working on a recovery plan now and will keep working on it after discharge.			
My provider has an active alumni association and has helped me know how it can help me now and when I leave services.			
My provider has explained to me that people will call me after I finish the program to see how I am doing with my recovery.			
I have been told how I can get help again if I need it in the future.			
My family members were told about local recovery support services that they can use.			

End of Person in Recovery Checklist I

Person in Recovery-Assessing One's Own Daily Activities Checklist II- Persons in recovery can do some of the following things to promote extended recovery support in their life.

Statement	Yes	No	Notes
I consider myself a member of a recovery support group [Schizophrenia Anonymous (SA), Narcotics Anonymous (NA), Recovery Inc.].			
I attend two or more recovery support group meetings per week.			
I have a support group (meeting that I attend regularly).			
If I did not make a meeting at my support group for two weeks, there are people who would call to see if I was okay.			
I speak at meetings.			
I perform service work at meetings (e.g., helping set up the room, reading, chairing a meeting, making coffee, cleaning up).			
I am in regular contact (face-to-face, telephone, email) with my key supports.			
I am supporting others with less recovery experience.			
I consider my providers (psychiatrist, psychologist, therapist, case manager, etc) as part of my support network.			

Person in Recovery checklist II continued on the next page

Statement	Yes	No	Notes
I socialize before and/or after meetings.			
I attend recovery social events.			
I regularly visit a recovery clubhouse or a recovery support center.			
I regularly read recovery-supportive literature.			
I carry an object (e.g., wristband, chip, keychain, etc.) that reminds me of my success and my commitment to recovery.			
I have phone numbers of people who support my recovery and who would help me in a crisis.			
I use recovery concepts to help me resolve problems I encounter in my daily life.			
I have detached myself from prior alcohol and other drug-focused relationships and places.			
I am aware of what my triggers are and how to manage them.			
I have daily rituals that strengthen my recovery (e.g., meditation, prayer, self-evaluation).			
I do volunteer service work in my community.			
I acknowledge my recovery status to others who are not in recovery.			
I encourage my family members to participate in family recovery support meetings.			
I have a living environment that is conducive to my recovery			
I educate my provider about the extended recovery supports that are available in my community.			

End of Person in Recovery Checklist II

DBH/MRS Staff Checklist-Use this checklist to increase extended recovery support in your own work and daily activities.

Statement	Yes	No	Notes
I am familiar with the broad spectrum of religious, spiritual, and secular recovery support groups.			
I have attended one or more open meetings of local recovery support groups in the past year.			
I have visited websites of online recovery support groups.			
People in recovery who are employed as staff and consultants at DBH/MRS represent a broad spectrum of recovery pathways.			
I have talked with my supervisor about how I can use my role to encourage the development of extended recovery support resources in Philadelphia.			
I have discussed the components which contribute to a long term recovery process including health promoting behaviors such as taking medications, a healthy diet and sleep schedule, attending to one's physical/spiritual health, etc.			
Through my role, I am encouraging providers to shift from a focus on crisis stabilization to the long-term recovery process.			
We work with each agency to facilitate a "culture of collaboration" in which the person receiving services, their psychiatrist, psychologist, therapist, identified support people/family and others meet regularly to discuss hopes, dreams and the recovery process.			

DBHMRS checklist continued on the next page

Statement	Yes	No	Notes
We are encouraging the development of non-clinical recovery support institutions, e.g., support groups, alumni groups, recovery support centers, recovery homes, recovery schools.			
We are continuing to revise funding and regulatory guidelines that might pose obstacles to the delivery of post-treatment recovery support services.			
I have visited the newly opened recovery support center.			
I have attended training that increased my understanding of the role of recovery support services in the long-term recovery process.			
We are making progress in extending recovery support services following discharge from primary treatment.			
DBH/MRS staff is encouraged to provide extended recovery support services for each other. Alumni groups are established for staff. For example, recently promoted staff is available for consultation to other staff members to discuss what aspects led to their success at the agency so that other staff can begin to do more of this.			
I/We are able to model the concepts of extended recovery supports by providing peer support to other staff members through peer to peer consultation, peer to peer group supervision.			
I actively seek out and listen to the stories of people in recovery in order to increase my knowledge of the long term recovery process and supports that facilitate that process.			

End of DBHMRS Checklist

Resource List

On Line Resources

A. Recovery Mutual Aid Groups

- http://www.facesandvoicesofrecovery.org/resources/support_home.php

B. Recovery Advocacy Groups

- http://www.facesandvoicesofrecovery.org/

C. American Self Help Clearinghouse

- http://www.selfhelpgroups.org/

D. National Self Help Group Clearinghouse

- http://www.selfhelpweb.org/

D. Recovery Organizations

- http://www.mhasp.org/

E. Depression and Bipolar Support Alliance

- www.**dbsa**lliance.org

F. Recovery Homes

- http://www.oxfordhouse.org/UserFiles/File/

F. Recovery Schools

- http://www.recoveryschools.org/

Relevant Articles

Monographs

White, W. & Kurtz, E. (2006b). *Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches*. Pittsburgh, PA: Institute for Research, Education and Training in Addictions.

Books

Humphreys, K. (2004). *Circles of Recovery: Self-Help Organizations for Addictions*. Cambridge: Cambridge University Press.

Kurtz, L. (1997). *Self-Help and Support Groups*. London: Sage Publications.

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

Articles

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D. & Tebes, J. K. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science & Practice*, 6 (2), 165-187; In: Davidson, L., Harding, C. & Spaniol, L.Eds; 2005). *Recovery from severe mental illness: Research evidence and implications for practice.* Boston: Boston University, p. 412-450.

Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol*, *58*(3), 231-238.

Kelly J.F. (2003). Self-help for substance-use disorders: history, effectiveness, knowledge gaps, and research opportunities. *Clinical Psychology Review*, *23*(5), 639-63.

Kyrouz, E.M., Humphreys, K., & Loomis, C (1998). A Review of Research on the Effectiveness of Self –Help Mutual Aid Groups in White, B. J. & Madara, E. J. , Eds , 2002 *American Self-Help Clearinghouse Self Help Sourcebook (7th edition).*

Laudet, A.B., Magura, S., Vogel, H. S., & Knight, E. (2000). Support, Mutual Aid and Recovery from Dual Diagnosis. *Community Mental Health Journal, 36 (5),* 457-476.

Magura, S., Laudet, A.B., Mahmood, D., Rosenblum, A., Vogel, H.S. & Knight, E. L. (2003). Role of Self-Help in Achieving Abstinence among Dually Diagnosed Persons. *Addictive Behaviors*, 28 (3) 399-413.

Raiff, N. R. (1984). "Some Health Related Outcomes of Self-Help Participation" Chapter 14 in Self Help Revolution edited by Alan Gartner and Frank Riessman. New York: Human Services Press.

Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, 27(4), 392-401.

White, W. (2008a). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices.* Pittsburgh, PA: Northeast Addiction Technology Transfer, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services.