# Addiction and Recovery: Examining Recovery-Oriented Systems of Care and Recovery Management

by

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**Abstract**

This capstone explores addiction and recovery. The first chapter explores the history of substance use within North America to provide context to modern perceptions of addiction. The moral and disease models of addiction are explored, which are contrasted against a modern perspective called dislocation theory. Briefly stated, this theory claims that addiction is a bi-product of free-market capitalism and is fueled by disconnection. Chapter two explores recovery from addiction, specifically looking at recovery-oriented systems of care (ROSC) and recovery capital. ROSC looks at recovery from a societal level, exploring how each level of the 'system' impacts a person in recovery. A significant focus of the chapter is on the system that immediately surrounds an individual recovering from substance abuse, exploring topics such as the role of community, peer-support, identity formation, and how people can be integrated and connected to their community via relationships. Recovery capital is then explored, which outlines a way of conceptualizing an individual's internal and external resources to sustain their recovery and how this conceptual framework is essential when understanding how an individual will experience recovery. Chapter three combines the concepts laid out in chapter one about the different perspectives on addiction and uses the research developed from chapter two on ROSC and recovery capital to outline a pragmatic model of working with individuals in recovery, called recovery management. Recovery management structures an addictions program with concentration on the long-term recovery of its clients. Within this chapter, specific suggestions are made to a recovery program operating within the Downtown Eastside of Vancouver, British Columbia.

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# Chapter 1 –Addiction and Recovery: An Exploration

## Chapter 1: Introduction

Vancouver, British Columbia, known to the world as one of the most beautiful, liveable cities because of its stunning location next to the ocean and mountains, its clean air, its accessible job market, and its plethora of outdoor activities. However, there is a darker side to the paradise that often is ignored and many of the locals pretend doesn't exist. Within Vancouver exists a social epidemic that has been occurring for a number of decades, homelessness and addiction. Since 2002 and every three years after, a broad study has been conducted to survey the homeless community. The study acknowledges the challenges of surveying this community and recognizes it is just a snapshot of the issue, not grasping its totality, the real numbers are much higher and impact much greater. That being said from 2002-2020 there has been an increase from 1181 to 2095 people counted (Mauboules, 2020; Greater Vancouver Regional District, 2002).

There is no simple solution to resolving the homelessness crisis in Vancouver and this paper makes no attempt at doing so. Instead, this paper will examine the most commonly stated issue amongst individuals experiencing homelessness, and that is addiction (Mauboules, 2020; Greater Vancouver Regional District, 2002). In Vancouver, addiction is rampant, often times very explicit. The writer, being located in Vancouver and working within the Downtown Eastside, the epicenter of the stated issues, has seen first-hand the devastating impact of addiction, unaddressed mental health, and the intersection of different systems of oppression. Through their experiences, the writer has seen many people suffer greatly and die in this environment. Thus, this topic is very personal to the writer and he wholeheartedly believes in the importance of holding hope for folks, not shying away from brokenness and pain, and persevering towards wholeness.

**Purpose of this Capstone**

This paper aims to explore issues surrounding addiction, specifically examining recovery in a holistic sense. The first chapter will focus on understanding addiction, its history and ways in which it has been conceptualized. It will also introduce recovery, its origins, and new frameworks for conceptualizing working with individuals healing from addiction. The second chapter will explore recovery-oriented systems of care, specifically examining recovery capital, assertive linkages, and community connections. The third chapter will explore a model of implementing a recovery-oriented system of care to treatment centers, called recovery management. Suggestions will then be offered to a treatment center operating on the Downtown Eastside.

**Focus of this Chapter**

This chapter will focus on an exploration of addiction. It will begin with a survey of historical use of psychoactive substances, exploring drug use within modern North America today, and the factors that have influenced the modern understanding of addiction. Addiction being a complex and nuanced phenomenon has not been understood the same throughout history. Therefore, this paper will explore the historical perspectives to give context to how it is understood today. Then, two different models of understanding addiction will be explored, the moral/ choice model, and the disease model. Although these models are by no means the only perspectives on addiction, they are arguably the most pervasive in today's society and therefore necessary to discuss. An alternative lesser known but convincing perspective will also be explored, dislocation theory. Lastly, the chapter will shift to exploring recovery from addiction and one perspective on conceptualizing recovery.

## Human Relationship to Drugs

Humans have been using substances to alter their mental state for as long as history has been recorded. Historically, psycho-active substances had three purposes; one, for medicinal uses; two, for religious ceremonies; three, for staple commodities used by the general population. Some of the earliest documented cases around humans using drugs are hallucinogens, (Greydanus, & Merrick, 2013). Cannabis is also thought to be one of the earliest drugs ever used as there is clothing that is made of hemp dating back 8000 BC (Greydanus & Merrick, 2013). Opium was found to be used in Ancient Egypt (Eddy, 1957) and wine can be traced back to 7000-5000 BC (Johnson, 1989).

People since antiquity have had a fascination with psychoactive substances. However, people's relationship to substances have changed over time as the values of society shift. For example, many substances were used for religious, ceremonial or spiritual purposes in ancient history, whereas in western society, they are more commonly used recreationally and rarely for spiritual purposes (Crocq, 2007). Certain substances have been socially acceptable in previous times but were not considered 'illicit', such as cocaine as it was used in Coke-a-Cola. This highlights that that substance use is closely tied to societal values and norms, which directly impacts the moral weight placed on the use of that substance (Frank & Nagel, 2017). Addiction and substance use cannot be examined outside of a sociological lens, as all drug use is contextualized within societal norms (Crocq, 2007).

Viewing substance use as contextual within a society, heroin gives a prime example. In efforts to create a painkiller, CR Alder Wright developed heroin in 1874, which was hailed as a wonder drug as it was considered a non-addictive form of morphine (Greydanus & Merrick, 2013). It received its name because of its 'heroic property of analgesia' (Greydanus & Merrick,

2013). It was then widely used and prescribed for a number of years until the negative effects on the population began to emerge. Another example, methamphetamine, developed in 1919 was first marketed as a wonder drug and used to treat narcolepsy, keep World War II bombers awake, manage obesity and attention-deficit hyperactivity disorder, as well as help treat heroin addiction in the 20th century (Greydanus, 2003). It wasn't until the 1970's when the dangerous and adverse effects were recognized, and it was put under legislation as a controlled substance.

## Examining North American Drug History

Recognizing that substances have been used throughout history and there has been varying relationships and understandings of them, it cannot be denied that the modern-day experience of substance use is wildly different than that of previous millennia. The following sections are based mainly on American history, as it is the largest and most well documented accounts of North American drug history. Although many other continents have their own drug histories, this section will focus on North American and Western Europe exclusively.

By the early 1900's in the United States, 0.33% of the population had an opioid addiction (1900 Census: Volume I. Population, Part 1; Greydanus & Merrick, 2013). These drugs were unregulated and widely available at pharmacies and supermarkets.

As drug abuse problems began to increase in the United States, laws began developing to regulate it – a period of history now known as the Temperance Movement (Alexander, 2008). The first law restricting the selling of drugs to only physicians was developed in 1914, alcohol was then prohibited in 1919 (later to be repealed in 1933), and cannabis regulation came later in 1937 (Crocq, 2007). These laws, however, did not stop the progression or development of drug abuse in the United States as rates of addiction continued to climb (Crocq, 2007; Alexander, 2008).

**War on Drugs**

As drugs became more widely available and rates of abuse were reaching all-time highs, the American government made steps to address this in the best way they knew how. Enacted by President Nixon in 1973 and re-dedicated by President Reagan in 1982, the War on Drugs was a way the American government tried to manage and subdue the vast effects drugs were having on the American population. This resulted in increasing anti-drug enforcement spending, creating a federal drug task force, and helping to foster a culture that demonized drug use and drug users (Benson, Rasmussen, & Sollars, 1995).

It is now widely understood that the War on Drug campaign has not had the intended effects; it did not decrease drug use or the drug trade, cost the American people billions of dollars and became a platform in which systemic racism was enacted (Fellner & Vinck, 2008; Pearl, 2018; Saadatmand, Toma, & Choquette, 2012; Wood, et al., 2009). It has been found that 53% of all people incarcerated for drug possession are African Americans and having black skin made one 10 times more likely to be imprisoned for drug offenses than if they had white skin (Fellner & Vinck, 2008). In terms of rates of incarceration, 20% of the incarcerated population is serving for drug related offenses (Pearl, 2018). According to the philosophy of the War on Drugs, if the individual is imprisoned, it will deter them from continuing to use drugs, sell them, or be involved in drug related activities. However, Saadatmand, Toma, & Choquette (2012) found that incarcerations had no impact on crime rates and reducing further rates of incarceration. Purely from an economic perspective, the toll of this war has cost the American economy, since 1971, $1 trillion (Pearl, 2018), with little to no positive outcomes (Wood, et al., 2009).

What was evident about the War on Drugs in America was that it did not seem to fully understand addiction and how to solve it. Bruce Alexander stated that although the War on Drugs has proven ineffective, in some degree it is still necessary as it is aiming to solve real social problems, but he argues that a paradigm shift is needed to appropriately address the issue of addiction (Alexander, 1990; Alexander, 2008; Alexander, 2012). As North American society has continually attempted to gain an understanding of addiction, how it impacts people, and how to overcome it, there have been mainly ideas, concepts, and solutions developed over the years. Some frameworks for understanding addiction have fallen out of popularity and scientific evidence, while others continue to gain support. This next section will explore the concept of addiction and examine a few frameworks for conceptualizing it.

## History and Definitions of Addiction

When examining the social and individual concerns of drug misuse, often the term 'addiction' is used. Although the understanding of the term 'addiction' has been used for millennia, it has changed meaning throughout the years. In the Middle Ages, the term *addictus* was 'a person who was made to become a slave to a master because of unpaid debts' (Crocq, 2007). Throughout the following centuries, many different scholars, theologians, and physicians have conceptualized human's abusive relationship with substances in a variety of manners, always being filtered through the cultural understandings of the era (Alexander & Schweighofer, 1988; Crocq, 2007).

However, in more recent history, the American physician Benjamin Rush of the 18th century, stated that compulsive drinking was characterized by a loss of self-control, and that the disease was primarily attributable to the drink itself and not the drinker (Crocq, 2007). It is only since the 20$^{th}$ century that term addiction has taken on its modern meaning, whereas in the 18$^{th}$

and 19th centuries terms like ‘inebriety’, ‘habit’ or ‘morphinomania’ were used and often only described in relation to dependence on opiates (Berridge & Mars, 2004). In the latter half of the 20th century, the concept of addiction began to move past just alcohol and narcotics, to other substances such as tobacco (Crocq, 2007)

As science has evolved and a greater awareness of the impacts of substances on people has developed, the belief that it is the substance itself that is addictive has fallen out of expert opinion. The dominant medical system now believes that addiction involves not only physiological effects of the substance, but psychological impacts as well.

**Definition of Addiction**

Although there have been many definitions of addiction over the years, each has been a result of the societal understandings, beliefs, expectations, and scientific beliefs of the time (Alexander, 2008; Greydanus & Merrick, 2013). The current definitions that exist are no different and are the attempts of society to understand this devastating and harmful experience and try to adapt it into their worldview and mental schemas.

Addiction, as described by the National Institute on Drug Abuse (National Institute on Drug Abuse, 2010) states addiction as “a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences.” This medical perspective of addiction equates addiction similar to other medical diseases, like hypertension, describing similar relapse rates, genetic predispositions, and environmental factors (National Center for Drug Abuse Statistics, 2021). Taking a slightly different approach, another researcher by the name of Bruce Alexander (2008) defines addiction as “Addiction is neither a disease nor a moral failure, but a narrowly focused lifestyle with an intensity that partially compensates for a lack of adequate psychosocial integration. The function of addiction to drugs is no different from the

function of addiction to any other habit or pursuit." The Alcoholics Anonymous society has no formal definition, however it has been described as "physical compulsion, coupled with a mental obsession that is beyond our capacity to control and are unable to stop" (This is AA, 2017).

## Different Theoretical Views of Addiction

Throughout different centuries and cultures, perspectives on alcohol and drug use have differed widely. The problems have been defined in religious terms (sin and redemption), spiritual terms (hunger for meaning and personal transformation), criminal terms (amorality/immorality and reformation), medical/disease terms (sickness and recovery), psychological terms (flawed thinking/coping and maturation), and socio-cultural terms (historical trauma/oppression and liberation/cultural renewal) (White & Kurtz, 2006). These highly divergent approaches and their historical roots have been a subject of considerable debate (Miller & Kurtz, 1994). Each perspective frames how addiction is perceived and how one interacts with those experiencing addiction. Therefore, it is critical for any work on addiction to identify the dominant perspective(s) that are influencing those views. For the sake of brevity and relevance, this chapter will focus on exploring three concepts of addiction, that is the moral/choice model, the disease model, and dislocation theory.

### Moral Model or Choice Model

The first that will be examined is the moral model. The moral model of conceptualizing addiction began in the early 1900s of the Temperance Movement (Levine, 1978). Up until this point, heavy drinking was not considered a sin, but a choice. Through this movement, there was shift in belief where heavy drinking changed from being an indulgence to something that is sick and evil (Levine, 1978). This rhetoric continued to develop over the decades, which is evident through the various prohibitions and laws that developed in its wake and peaked in the War on

Drugs in the 1970's (Alexander & Schweighofer, 1988) and is still very much prevalent in the 21st century (National Center for Drug Abuse, 2021).

Now understood as the moral model, this perspective described using drugs as a conscious choice and ultimately a moral failure on behalf of the user; it states that the person is responsible for their actions and because they continue to go back to drugs, it is due to a lack of self-control and impulse regulation (Brown & Clarey, 2012). A prime example of this model being adopted at a governance level was the War on Drugs, were the USA decided to restrain the drug trade through increased policing, stricter enforcements, longer sentences, and greater numbers of incarcerations as a way of combating increased drug use. The intention was to scare potential users (seen through "the thrill can kill" or "just say no" campaigns) and deter them by enforcement and stating moral failure. As quoted in an ad run by Clint Eastwood and Nancy Reagan "If you go ahead and try them, at least it won't be out of ignorance, just stupidity" (Oscars, 2015).

***Arguments Against Moral Model***

Central to the idea of the moral model of addiction, there is the concept of choice. However, there is evidence from cognitive neuroscience that the mechanisms involved in addiction are different from those engaged in ordinary choice (Levy, 2013). Neuroscience shows that in active addiction, the pre-frontal cortex is supressed, and the individual experiencing drug cravings has a highly activated limbic system (National Center for Drug Abuse, 2021). This results in a reduction in rational thinking and the 'hijacking' of the normal survival mechanism (Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General, 2016).

Using shame and fear as tactics to prevent drug use, which was an approached used in the War on Drugs, was examined by Brown and Clarey (2012). They found that fear and shame-based strategies surrounding drug education among young people in schools, when paired with zero tolerance policies, create cognitive dissonance, did not decrease drug use, and created hostility between the school and students. This resulted in students feeling like they were uncared for and rejected when they feel they instead should have received help.

Most often, moralization involves a shift in focus to the individual as the problem, not the phenomenon itself, nor the social context. Today's society places moral value on many things, such as smoking, vaccines, and carrying excess body fat. For example, to be fat is viewed negatively because there is societal moral value placed on the act of eating, self-control, and being thin (Frank & Negal, 2017). The challenge of a moral/choice model of understanding addiction is that it shifts the focus of the issue of addiction onto the individual and does not adequately acknowledge the impacts of society, economy, and culture on perpetuating addiction (Frank & Negal, 2017).

**Disease Model**

The disease model for conceptualizing addiction is widely held by many in society today, most notably the medical care system and the Alcoholic Anonymous community. National Center for Drug Abuse (2021) calls addition:

> A chronic relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain – they change its structure and how it works. These brain changes can be long lasting and lead to the harmful behaviours seen in people who abuse drugs.

Neuroscience and animal models of addiction have been particularly influential in the wide adoption of this paradigm (Frank & Nagel, 2017). Specifically, in regard to studies of the mesolimbic reward system and how the brains of addicted people look in an fMRI (Leshner, 1997). It has been shown in these studies that individuals who abuse drugs have radically altered limbic system structures, and depending on the substance abused, prefrontal cortex's as well.

Evidence also comes from animal research that shows rats and mice can become addicted to a variety of substances through repeated use and will engage in self-destructive behaviors to access the substance (Bozarth & Wise, 1985). This pattern is often paralleled in humans. It means the greater the exposure to a substance causes a greater addiction, which results in a worse disease.

Similarly to hypertension, there are common 'risk factors' that are believed to cause addiction, such as parents who use drugs or alcohol (Biederman et al., 2000), struggling in school and having poor social skills (Whitesell et al., 2013), early use (Squeglia et al., 2009), and mode of injection (Verebey & Gold, 1988). These risk factors are believed, much like any disease, to precipitate addiction. Additionally, many pharmaceutical companies have developed medications that can ease withdrawal symptoms and help prevent relapse (Erikson, 2007).

***Arguments Against Disease Model***

Much like the moral model of conceptualizing addiction, the disease model is critiqued as having to narrow a view on addiction and is in danger of oversimplifying the complexities of the issue (Alexander, 2008). If drug abuse is a disease and there is a lack of self-control due to a diseased brain, it does not explain the very complex and intricate ways in which people will go to get their drugs of choice. The planning and strategy required often does not imply a 'lack of impulse control' (Levy, 2013).

Additionally, there is a large percentage of people who decide to quit and over time are no longer addicted to their substance of choice (Lopez-Quintero et al. 2011). This is called spontaneous recovery. Although this is not the case for all individuals, the fact that some individuals 'recover' on their own without professional interventions implies it is not necessary solely a disease and requires further investigation. Often times individuals will have periods of not using. This also implies there is less of a disease because there is no control in a disease. For example, a diabetic cannot decide to just stop taking insulin and be okay, their bodies will not suddenly start producing insulin again. They rely on the injections. Addiction does not always act like this, implying it is not a full description of addiction.

One of the biggest critiques of disease theory is the development of the neuro-plasticity field and the recognition that the brain is not static, but it adapts, and changes based on the environment and circumstance the person is in. Therefore, as someone uses substances, overtime the brain will adapt and change to accommodate (Lewis, 2017). Lewis makes the argument that changes in the brain do not necessarily indicate a disease, it indicates adaptation.

Critics of the disease model also stated that a result of calling it a disease stigmatizes addicted persons, prevents them from developing self-control, and damages self-esteem (Frank & Nagel, 2017). Although it is clear that the medical and social work field had shifted from viewing addiction as a moral issue to a disease issue, elements of moralization still remain within the disease model paradigm (Frank & Nagel, 2017). This is evident in the continue stigmatization, marginalization and limits to accessing housing and services of those who use substances.

**Dislocation Theory – Looking Towards an Alternative**

Bruce Alexander, a researcher based out of Vancouver, British Columbia, has spent decades studying addiction. He recognized that there were extensive resources being poured into addiction treatments, recovery, and addiction management, but the problem of addiction in western society only seemed to be growing. He interpreted it that the current ways of understanding addiction were not complete and requires a change (Alexander, 2008).

Instead of viewing addiction through the current field of addiction research, he decided to explore multi-disciplinary perspectives in pursuit of insight, including research from sociology and history. Alexander contributes the current state of affairs surrounding addiction to be attributed to the birth of free market society back in the 1500s in England (2008). There was a shift where the market moved from being subordinate to social and religious concerns to it dominating them (Polanyi, 1944).

Free market society is primarily defined by a society that financial markets are the governing element. With the birth of capitalism, competition in markets and society is not only encouraged but is integral to the functioning and survival of the society. Alexander (2012) states that free market societies fragments culture in many ways, 'breaking the social and economic links that have traditionally given people a sense of belonging, meaning, purpose, and identity.'

He gives the example of colonization of Indigenous land in Canada and how the aboriginal people were separated, prohibited from practicing their culture, and forced into a foreign culture. This caused widespread and almost universal 'dislocation,' which was first used by Polanyi (1944) and is described as a lack of psycho-social integration. Alexander states it is less that the First Peoples of Canada are especially susceptive to alcohol and drugs, but rather the psychological and social climate in which they were forced to adopt was oppressive and resulted

in entire generations being displaced from their way of life; addiction then being a response to the pain of dislocation (Alexander, 2008). Alexander (2008) uses this term and applies it to addiction calling it "dislocation theory." In short, this theory states that "addiction is neither a moral failure nor a disease, but it is a narrowly focused lifestyle that functions as a meagre substitute for people who desperately lack psycho-social integration" (Alexander, 2008).

Alexander uses historical evidence to connect dislocation with the spread of free-market society (2008, chapter 5) and that addiction closely follows dislocation (2008, chapter 6). Alexander (2012) describes three principles for understanding dislocation in the context of addiction. The first principle is that free-market society is a social system that demands unregulated competition in virtually every aspect of human existence. It is built on the premise that competition on all levels of society will spur growth and wealth - thusly improve the well-being of all. This ideology and social system have been globalized and adopted (often times by military and political force) worldwide (Alexander, 2012).

Although this social system has improved the wealth of nations, the wealth gap is growing at exponential rates, the social and financial distance between the rich and the poor grows at unparalleled rates (Alexander, 2008). Although there is less material poverty world-wide than any other point in history (United Nations Development Programme Human Development Report Office, & Oxford Poverty and Human Development Initiative, 2019), the world is experiencing dislocation on a global scale (Alexander, 2008). This ideology has transcended the values and loyalties to religion, family, traditional cultural obligations, friends and customs (Alexander, 2008; Alexander, 2012; Polanyi, 1944).

The second principle Alexander describes is that sustained dislocation is unbearable. Alexander (2012) uses historical evidence to support his claim. He states that prior to

implementation and globalization of free-market societies, individuals in every culture and nation would concentrate their energies in finding and maintaining a place within their society. He states that when people know they have a place and a role within their family, their community, their country, it creates a sense of belonging, identity, and connection to a place. Having stable social relationships comes with expectations about one's role and helps to establish who one is, but also who they are not. This connection to people, place, and purpose Alexander describes as 'psycho-social integration.' Alexander (2008, 2012) states that a lack of psycho-social integration is dislocation. Dislocation is unbearable for people. Often the symptoms of dislocation are depression, anxiety, shame, rage, anguish, boredom and sometimes suicide (Alexander, 2008, 2010, 2012)

Part of psycho-social integration is the connection to one's soul. Alexander, a professed atheist (Alexander, 2008), describes the inherent importance of spirituality, discovery of an individual's place amongst the world, and connection to the divine as essential to experiencing psycho-social integration. He quotes Polanyi (1935) who states "The discovery of the individual soul is the discovery of community… Each is implied by the other." Alexander states that spirituality and soul play an essential role in establishing people in their communities, their nation, and internationally.

The third principle he describes is that addiction is a way of adapting to sustained dislocation. Alexander (2010) states that when individuals experienced dislocation over a prolonged period of time, that they will attempt to restore a sense of normalcy to cope with the emotional and psychological pain. However, this often results in individuals turning towards substances to meet their needs (Alexander, 2008).

Alexander however does not state that substance addiction is the only response to dislocation. He states that addiction has had many definitions over the course of time and different paradigms, as was seen above. Alexander describes addiction in a broad sense, where it is a 'narrowly focused lifestyle' and can be to any habit or pursuit, not just drugs or alcohol (Alexander, 2008, chapter 8). He states that addiction is an adaptive response to dislocation, but it does not mean it is desirable for the individual or society. However, it does buffer people against the anguish of being dislocated socially, emotionally, spiritually, and physically.

The paradigm shift in understanding addiction in terms of dislocation is that addiction no longer becomes a maladaptive response, a poor choice, a disease or deficiency in the reward pathway, genetics, or psychopathology, but an understandable response to being disconnected to a purpose, a place, and people (Alexander, 2008).

***Critiques Against Dislocation theory***

Alexander recognizes that dislocation theory is not intended to explain all drug use problems in history, but only in regard to the modern world (1500-present). He also recognizes that more research is required to fully establish this paradigm as valid (Alexander, 2012). He also states that dislocation theory is not intended to refute or deny the fact that certain factors play a role in an individual becoming more susceptible to addiction, such as genes, brain damage, and childhood trauma. However, he does state that this theory does aim to remove the individual as the sole cause of addiction and focus more on the sociological factors that are driving global and societal rates of addiction.

Through this writer's examination of the literature, there was virtually no critics of this theory in the databases that were searched. This is not to say this theory is without flaw, but it more highlights the fact this is a relatively new theory requiring more extensive empirical

evidence. As this theory attracts more attention, it will hopefully receive a greater level of academic scrutiny that will further refine it.

In summary, there are many ways of conceptualizing addiction, of which only a few were explored here. However, separating and differentiating these concepts are often an intellectual pursuit and generally do not have meaningful impacts for individuals seeking healing from addiction. What is important is how these frameworks catalyze someone and mobilize them to overcome their addiction (White, & Kurtz, 2006). They often can provide a cognitive cornerstone for someone to understand their experience and move towards re-writing their story (White, 1996). In essence, people are diverse, with diverse experiences, epistemologies, identities, and ideas and there is a variety of concepts and pathways to recovery to suit.

## Recovery

So far, this paper has examined addiction, its historical elements, how it is defined and how it is conceptualized. The discussion in this chapter will briefly touch on the topic of recovery, that is 'how do we heal from addiction?'

Much like the definition of addiction, there are differing opinions on the term recovery. Two of the more common definitions are as follows: Center for Substance Abuse Treatment states it as "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" (Center for Substance Abuse Treatment, 2007); and Betty Ford Institute defined it as "Recovery is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship" (Betty Ford Institute Consensus Panel, 2007). As seen here, both of these definitions emphasize different elements. It is important to recognize that there is not one 'right' way to recover, and each individual is intitled to discover this for themselves (White, 2000). This highlights the

current belief that there is not one road to recovery from addiction that works unilaterally, but many (McQuaid et al., 2017).

**History of Recovery**

Within American society, groups of people who gather with the explicit purpose of recovering from addiction has been around since colonization. Some of the more notable recovery groups that have immerged are abstinence-based Native American religious and cultural revitalization movements (from the early 1730s), recovery circles of the Delaware Prophets, Handsome Lake Movements, Shawnee and Kickapoo Prophet movements, Indian Shaker Church, Native American Church and today's Wellbriety Movement, the Washingtonians (1840s), the Fraternal Temperance Societies (1850-1900), the Ribbon Reform Clubs (1870s), institutional support groups such as the Keeley Leagues and the Godwin Association (1870s-1890s), and such faith-based groups as the Drunkard's Club, the United Order of Ex-Boozers and the Jacoby Club (early 20th century) (White, 2001). The most famous and prolific of these recovery support groups is Alcoholics Anonymous which started in 1935 and since has expanded worldwide and into a plethora of other similar 12-step support groups (White, 2001).

However, recovery support groups have not been the only way individuals wanting to get control of their substance use have sought help. Residential treatment programs are another popular option, especially when the individual feels more vulnerable to their use. Many of these recovery treatment centers started as community agencies, trying to serve the needs of the people (White & Kurtz, 2006). Conversely, starting around the 1980s, most treatment programs moved from being community-based agencies to businesses (White & Kurtz, 2006). This occurred partly due to the processes of professionalization, industrialization and commercialization occurring throughout the Western world (White & Kurtz, 2006). In the process, they became less

reliant on local funding, less accountable to local communities, and less connected to local communities of recovery (White & Kurtz, 2006).

Many long-term service professionals have recognized this shift through North America and one addictions counsellor who was interviewed after leaving the field is quoted saying:

> Something got lost on our way to becoming professionals—maybe our heart. I feel like I'm working in a system today that cares more about a progress note signed by the right color of ink than whether my clients are really making progress toward recovery  The kids who come here do so well while they are in treatment, but so many of them relapse in the days and weeks following their discharge. We bring them back to treatment and they seem to do well again but often repeat the relapse pattern when they go back home. How can they do so well in treatment and so poorly in their natural environments? (White & Kurtz, 2006).

This is reflected in the statistics that although many people will succeed in a treatment setting, it has been found that the majority will return to their substance of choice in the year following (Wilbourne & Miller, 2003). Many recovery treatment centers have also been compared to a 'revolving door,' with 64% of people entering have had one or more prior treatments and between 25-35% will be re-admitted within one year and 50% being re-admitted within two to five years (Office of Applied Studies, 2005).

These statistics show that treatment programs are not having the intended effect. This phenomenon has prompted a move in the recovery community to evaluate the status quo and conceptualize a new recovery paradigm (White & Kurtz, 2006). This has formalized as a refocus on the long-term process of recovery, meaning greater emphasis is needed to connect people to local communities and to local recovery specific communities, celebrating and recognizing the

many different pathways to recovery, and changing recovery support services into a *recovery-oriented system of care* (White, 2000; White, 2002; White & Kurtz, 2006).

**Recovery-Oriented System of Care**

The next chapter of this paper will explore the literature surrounding a new conceptual framework for working with addictions in a recovery setting – recovery-oriented systems of care (ROSC). The move from traditional treatment to a recovery-oriented system of care is an attempt to counter the seemingly revolving door of addictions treatment, with the explicit goal of long-term healing from addictions. Through the next chapter, the ethos behind this approach will be discussed, along with recovery capital and how it aims to conceptualize ROSC. Lastly, the final chapter will discuss a practical implementation of ROSC in a treatment setting in Vancouver's Downtown Eastside and make some practical suggestions based on the literature.

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# Chapter 2 – A Literature Review on Recovery-Oriented Systems of Care

## Chapter 2: Introduction

This chapter explores recovery-oriented systems of care (ROSC) concerning alcohol and drug recovery. This term will be defined and explored, focusing on the following areas: recovery capital as a way of conceptualizing an individual, the importance of community in recovery, the benefits of mutual aid groups, the role of identity, and the importance of assertive linkages. However, before discussing ROSC, the current predominant model of addiction treatment will be discussed along with its limitations and why a shift must occur.

### Acute-Care Model

During the first part of the 20th century, the primary recovery care providers were hospitals, inebriate penal colonies, and psychiatric asylums (White, 2013). As these institutions' ineffectiveness became more understood, there was a development of lay therapists who were 'ex-addicts,' often from Alcoholics Anonymous (AA) groups who began assisting those seeking recovery (White, 2013). These paraprofessionals provided counselling and were highly integrated with their communities. At this time in addiction recovery, there was a greater emphasis on lived experience versus scientific knowledge (White, 2013).

However, in the 1960s and '70s, addiction management experienced a rapid shift to privatized institutions as federal funding was funnelled into 'fighting the war on drugs' (White, 2008). During this time of transitioning to privatized institutions, the medical model was applied to addiction treatment as it was believed to be the gold standard of care. The medical-model, or more accurately understood in the context of recovery as the acute-care model, is mainly focused on symptom elevation (Sheedy & Whitter, 2013). This meaning that clients are treated explicitly for their substance use, much like one would be treated for a broken bone at the hospital. This

professional care resulted in the need for licenced addiction experts, which by its nature often discredited the lay counsellors, and there was a shift to many treatment professions having no lived experience of recovery at all (White, 2008; 2013). The professionals through the acute-care model had a significant influence on the direction of treatment, being responsible for the assessment, treatment planning, and service delivery decision-making for the client (White, 2008). During the decades following the 60s and 70s, there was a greater expanse of treatments that were made available, many falling into either in-patient detoxification, outpatient detoxification, short-term in-patient or residential treatment, long-term residential treatment, methadone maintenance treatment and other medication-assisted opiate treatments, and outpatient drug-free treatment. These approaches have been profoundly influenced by the broader acute-care model of addiction treatment (White, 2008).

Throughout the following decades, the effectiveness of treatment centers have been thoroughly studied, and it has been found that most people who complete a treatment program experience a decrease in overall substance use by more than 80% in the months following discharge and substance-related problems (such as incarceration, eviction, criminal activity) decrease by 60% in the months following treatment (Miller et al., 2001). However, there is also conflicting statistics that state that most people completing addiction treatment resume alcohol or drug use in the year following treatment (Wilbourne & Miller, 2003), with over half of all post-treatment lapses and relapses occurring within 30 days of discharge (80% within 90 days of discharge) (Hubbard, et al., 2001). Additionally, 64% of individuals in the United States entering a treatment center have had one or more prior treatments, and that 25-35% of people will be re-admitted within a year, and 50% will be re-admitted within two to five years (Substance Abuse

and Mental Health Services Administration & Center for Behavioral Health Statistics and Quality [SAMHSA & CBHSQ], 2017).

**Issues with the Acute-Care Model**

What do these statistics mean concerning in-patient treatment? When the individual graduates or completes the program, the impression is often given to the individual, family, workplace, and community that treatment is 'complete' and recovery is self-sustaining (White, 2008). Consequently, when the individual experiences a relapse, it is stated as an individual failure rather than placing any onus on the treatment center. However, it is well known through the research that recovery is not considered self-sustaining until 4-5 years of sobriety (Best, 2019), and during that time, there is a considerable reliance on external resources to support sustained recovery (Dennis et al., 2014). The challenge with acute treatment of addiction is that little is done regarding follow-up treatment for those exiting treatment centers (White & Kurtz, 2006). Therefore, on their own, acute treatment of substance abuse does not adequately prepare the individual to continue their recovery outside of the institution (Best, 2019; White and Kurtz, 2006). As centers have become more professionally focused, there has been a disconnection from the local communities of recovery, such as reduced number of staff in recovery, abandonment of the expectation that all staff would participate in local recovery support meetings (e.g., open meetings of AA), a reduction or complete discontinuance of meetings between the treatment center and the service committees of local recovery support fellowships, and the weakening or collapse of volunteer programs (White, 2008; 2013). This disconnection and failure to plan for the individual's long-term recovery are partly responsible for the "revolving door" that Sheedy and Whitter (2009) describe.

## Paradigm shift

Acknowledging these concerns, a shift has occurred in the addictions and mental health fields over the last two decades in response (Kourgiantakis et al., 2020). There has been a recognition that acute treatment has not been having the desired effect of long-term recovery, so there has been a shift away from the acute biomedical model of "assess, diagnose, treat, discharge, terminate the service relationship" (White & Kurtz, 2006) approach to working with individuals to a re-evaluation of the more extensive 'system' recovery takes place in and a refocus to more long-term recovery. Many recovery advocates state that this does not require a few small adjustments or corrections but demands a fundamental shift in how recovery from alcohol and drugs is made system-wide (White, 2008; White & Kurtz, 2006).

As with any disorder, episodes of acute biopsychosocial stabilization are essential to save lives, and such episodes often play a critical role in the movement toward long-term recovery. The issue is not whether we have professionally directed addiction treatment or peer-based recovery support services, but how these and other supports can be best combined and cooperate to enhance long-term recovery outcomes (White, 2008). Additionally, there are shifts that treatment centers can make that move from simply offering acute-care to helping be apart of the larger recovery-system for the individual.

### *Defining a Recovery-Oriented System of Care*

Recognizing that the entire system of addictions recovery needs to be re-addressed, extensive resources were poured into determining what that would be, and a "recovery-oriented system of care" (ROSC) was developed (SAMHSA, 2010; Sheedy & Whitter, 2009; White 2008; Pennsylvania Drug and Alcohol Coalition [PDAC], 2010). ROSC is defined as:

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 this phrase is not a federal, state, or local agency, but a macro-level organization of the larger cultural and community environment in which long-term recovery is nested. (White, 2008)

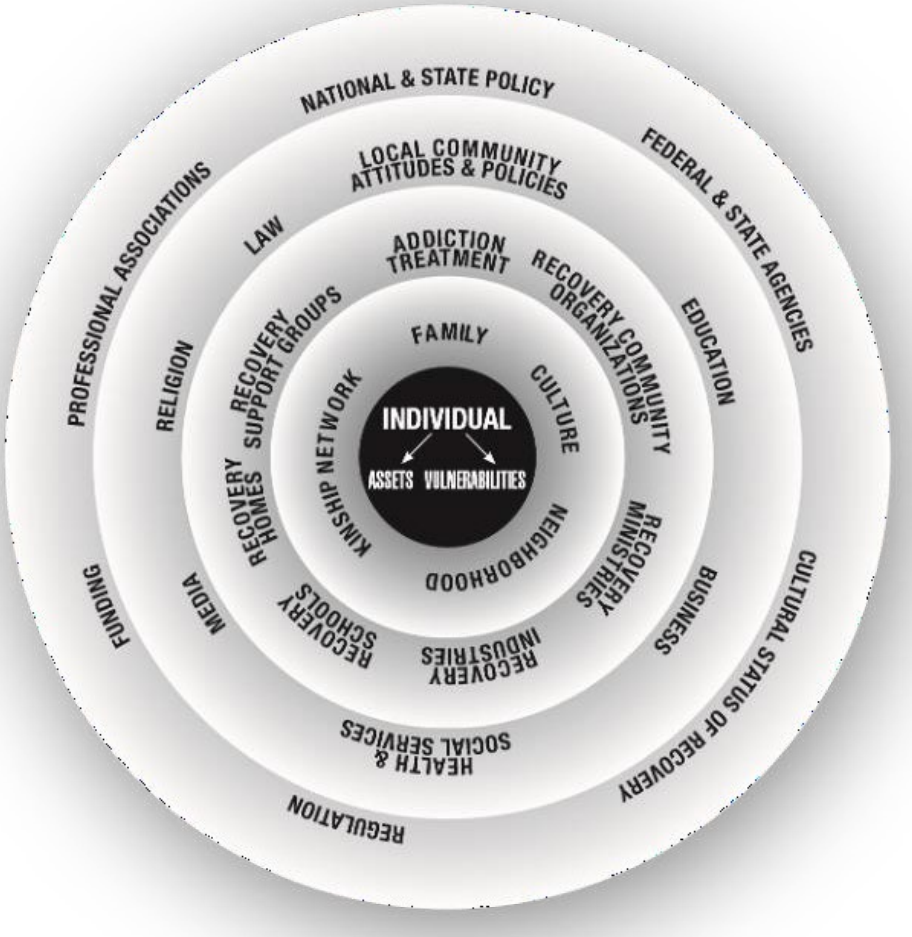


**Figure 1: The Ecology of Recovery**

Understanding the individual seeking treatment functions within a ‘system,’ that system can be understood through William White’s (2008) adaptation of Urie Bronfenbrenner's ecological systems theory (1989), as seen in Figure 1.

This chart's center describes the individual and the internal vulnerabilities and assets that the individual brings to recovery. Surrounding the individual is the micro-ecosystem, which is the immediate physical, family, social, and cultural environments that directly influence the individual on a day-to-day basis and can either inhibit or support recovery. The second layer of the environment is the mesosystem, which is the professional services and local community recovery supports available to the individual aiding in long-term recovery. The third layer of the ecosystem is the exosystem, the larger community environment which includes community attitudes about addiction/recovery, resources accessible from the broader network of health and human services, and how key community institutions interact with those with substance abuse issues (such as law, religion, medicine, financial institutions, media, business, and industry). The broadest layer of the recovery environment is the macrosystem. The macrosystem encompasses broad provincial, national, and international trends that impact the recovery efforts of individuals, families, and local communities. The macrosystem includes policies and programs on the provincial and federal levels that support institutions in the addictions field (e.g., advocacy, research, education, and training) (White, 2008).

Therefore, a ROSC is the whole system that supports individuals in recovery (Sheedy & Whitter, 2013). This fundamental shift towards long-term recovery is needed at all levels of the ecosystem to provide the recovering individual with the best possible environment to succeed. Seeing this system through the lens of psychosocial integration, as described by Alexander

(2010), reduces the possibility of dislocation as the individual is accepted by society and exists in a system designed to support them on every level.

SAMHSA's National Summit on Recovery (Center for Substance Abuse Treatment, 2007) outlined 12 guiding principles on the implementation of ROSC based on current research. They are:

1. There are many pathways to recovery, and it is the right of each person to select a pathway and style of recovery that represents their personal and aspirational values.
2. Recovery is self-directed and empowering.
3. Recovery involves a personal recognition of the need for change and transformation.
4. Recovery is holistic.
5. Recovery has cultural dimensions.
6. Recovery exists on a continuum of improved health and wellness.
7. Recovery emerges from hope and gratitude.
8. Recovery involves a process of healing and self-redefinition.
9. Recovery involves addressing discrimination and transcending shame and stigma.
10. Recovery is supported by peers and allies.
11. Recovery involves (re)joining and (re)building a life in the community.
12. Recovery is a reality.

The same summit also identified 17 essential elements of a recovery-oriented system, which are:

1. Person-centred care on all levels.
2. Family and other ally involvement in recovery is essential.
3. Providing Individualized and comprehensive services across the lifespan.
4. Systems are anchored in the community, not disconnected.

5. Continuity of care exists in the system (pre-treatment, treatment, continuing care, and recovery support).
6. Partnership/consultant relationship, focusing more on collaboration and less on hierarchy.
7. A strengths-based approach to working with the individual (emphasis on individual strengths, assets, and resilience).
8. Culturally responsive, recognizing that culture greatly impacts service delivery.
9. Responsive to personal belief systems.
10. Commitment to peer recovery support services and integrating it into the care.
11. Inclusion of the voices of individuals in recovery and their families in each layer of the system.
12. Integrated services: recognizing the need for a continuum of care, including pre-treatment, treatment, continuing care, and recovery support, meaning that individuals should have a full range of stage-appropriate services from which to access at any point in the recovery process.
13. System-wide education and training on ROSC, recovery, and addiction for each layer of the system.
14. Ongoing monitoring and outreach, even after the individual leaves an agency.
15. Outcomes-driven.
16. Based on research.
17. Adequately and flexibly financed.

Building and expanding on these ideas, Sheedy and Whitter (2013) stated that recovery is best understood as being on a continuum rather than being a binary state, with there being times of greater involvement in their recovery and relapses being a natural part of that process. They

state that a ROSC sees people in recovery as active agents of change in their lives and not passive recipients of services. Additionally, that a ROSC does not underestimate the essential importance of family and peer support in recovery and place a high value on incorporating community as part of treatment, even in a residential setting.

## Recovery-Orientation in the Mesosystem

This paper's scope and limitations are not wide enough to allow for a thorough and explicit discussion of each system's level and how it can be designed to support recovery. Therefore, this paper's direction will now explore specific elements of ROSC in the mesosystem and how the philosophy of long-term recovery can be cultivated. Specifically, this paper will examine the current dominant framework for conceptualizing individuals within a recovery-oriented system known as recovery capital, the community's role, including peer-support groups, the role of identity in recovery, the importance of assertive linkage, and asset-based community development. It is worth noting that a significant part of recovery in the mesosystem is treatment centers, which will not be covered in this chapter. Please refer to chapter three for a thorough description of how treatment centers can be involved in a ROSC.

### Recovery Capital

This next section will explore recovery capital, which has developed in tandem with recovery-oriented systems of care. It gives a framework for identifying and forming a holistic view of the person and the different areas that contribute to their recovery. The different areas are expressed using the language of 'capital' as they are 'resources' that can be gained or lost depending on a variety of intersecting factors and that an individual can draw upon their 'capital' to help in times of need (Granfield & Cloud, 2008).

### *Defining Recovery Capital*

Recovery Capital', defined by Granfield and Cloud (2008) as "The breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from alcohol and other drug problems." Meaning there is an acknowledgement that inside each person, internal resources can be used and cultivated to live in recovery well. Also, recognizing that no one is self-sufficient and external resources are needed to sustain recovery. Recovery capital diminishes during active addiction and increases during sustained recovery (Granfield & Cloud 1999).

Recovery capital was adapted from earlier work of individuals like Lyda Hannifan (1916). She described a 'social capital,' which was understood as goodwill, fellowship, and mutual sympathy that makes life worth living. Recovery capital, which built off this concept, was birthed out of a qualitative study of 46 formerly dependent individuals who had avoided formal treatment but were considered "natural recoverers" (Granfield & Cloud 1999). This study examined why these individuals were able to recover independently of professional help. It was found that each person had a high degree of recovery capital (that is, strong social networks, greater economic resources, supportive families) in which they could access to initiate and sustain recovery. Since then, it has been found that individuals with low recovery capital often have multiple treatment episodes and are more likely to experience a relapse (White, 2008; 2013)

### *Different Elements of Recovery Capital*

In the last two decades, numerous models of conceptualizing recovery capital have immerged, causing differing perspectives on how to view it. However, one of the most comprehensive explorations of the diversity of recovery capital comes from a meta-analysis by Hennessy (2017). She found eight recovery capital components which can be grouped into three

categories: individual, meso, and micro. In totality, the different areas of capital are physical, human, health, growth, social, family/social recovery, cultural, and community. Although there are overlaps between the different areas, they help capture the greater picture of the individual and their resources to initiate and sustain recovery. They will be discussed below.

**Physical** capital is understood as tangible capital, such as material resources including money, property, cars, availability of a public treatment facility, having insurance, and having essential needs met such as food and clean and safe housing (Cloud & Granfield, 2008; Best, 2019).

**Human** capital is personal characteristics that help to achieve goals, such as knowledge, marketable employment skills, interpersonal skills, emotional stability, mental health stability, problem-solving capacities, physical health, genetic inheritance, self-esteem, self-awareness, self-efficacy, sense of meaning, informal knowledge, life skills, hopes, and aspirations (Cloud & Granfield, 2008). The essential resources are self-esteem, self-efficacy, communication skills, coping skills, and resilience (Best, 2019).

**Health** capital is physical and mental health. The original definition of human capital encompassed health, but Neale and Stevenson (2015) suggested that health should be a unique domain because they found it a complex issue with high importance according to their sample of individuals recovering from heroin dependence.

**Growth** capital is the available internal and external resources that help move the recoveree in a positive direction, to overcome obstacles, and to actively support further personal growth (Hewitt 2007 p. 231). Growth capital also includes the individual's innate desire for positive growth, which gradually increases through the recovery process.

**Social** capital is understood as the resources available to someone through their social network. This can be understood as favours owed, access to social groups, emotional support provided by those close to them, and positive expectations of the recoveree. It can also include one's ability and capacity to create, maintain, and develop meaningful social relationships with friends, colleagues, and peers (De Silva et al., 2005). Social capital grows as the recoveree moves away from using-communities to more recovery-communities (Best, 2019).

**Family** capital is like social capital but refers explicitly to family and spouses. It describes their willingness to assist and support treatment, to provide a sober living environment, and to positively engage with them in their recovery (White & Cloud, 2008).

**Cultural** capital is personal qualities such as values, beliefs, dispositions, preferences, or behavioural patterns arising from membership within a particular cultural group (Cloud & Granfield, 2004). This capital identifies the importance of being familiar with cultural norms and acting in line with these norms. Specifically, this applies to the alignment of pro-social norms and values around substance use (ex. binge drinking is socially frowned upon).

**Community** capital refers to community attitudes, policies, and resources related to recovery, such as efforts to reduce addiction-related stigma, the existence of recovery role models, and an available continuum of formal and informal treatment/recovery resources. One cultural capital element is the positive norms and expectations for behaviours supported by a recovery community and indicates access to culturally appropriate recovery supports (White & Cloud 2008).

**Negative** capital refers to a range of barriers that inhibit recovery, such as mental health illnesses, involvement in the criminal justice system, belonging to greater stigmatized populations (Cloud & Granfield, 2008).

### *Ways to Measure Recovery Capital*

Included in Hennessy's (2017) study of recovery capital, there was an evaluation of how it is measured. Sterling et al. (2008) developed a 23-item RC measure; Groshkova et al. (2013) developed a 50-item measure called Assessment of Recovery Capital (ARC); Burns and Marks (2013) developed a 67-item measure called the Recovery Capital Questionnaire (RCQ). Through Hennessy's (2017) analysis, they found the 23-item recovery capital measure scale did not have good predictive validity, meaning there were no significant relationships with days abstinent, substance use problems, and Addiction Severity Index and Drug Taking Confidence Questionnaire scores. The 50-item ARC was found to possibly be a good predictor of recovery outcomes based on personal and social recovery capital with a test-retest reliability rating of 0.50 to 0.73 and scores correlated with four of six World Health Organization Quality of Life Assessment Instrument domains (Hennessy, 2017). The RCQ measured physical, social, human, and community capital domains but was found to only have predictive validity concerning physical capital and addiction severity; the other areas were less predictive (Hennessy, 2017).

Throughout the meta-analysis, Hennessy (2017) found a large variance in assessing, evaluating, and even conceptualizing Recovery Capital. However, a common theme from the analysis was; one, recovery is an ongoing process, where recovery capital is gained and lost over time depending on many intersecting factors; two, that recovery capital is understood best from an individual, micro, and meso levels - essentially a holistic understanding of a person's life; three, that the greater the recovery capital an individual has, the more likely they are to sustain recovery. It was noted that there are limitations on all the current methods of measuring recovery capital, and further development is needed to legitimize their use empirically.

#### **REC-CAP.**

Recognizing the current limitations on assessing recovery capital, Dr. Best developed an evidence-based assessment & recovery planning instrument called REC-CAP (standing for recovery-capital). This measure assesses the quality of life and satisfaction using a "ruler" to measure five areas of well-being: psychological health, physical health, quality of life, accommodation, and social support. Barriers to recovery are also assessed in five areas: accommodation, substance use, risk-taking, offending, and employment. The measurement links the strengths to barriers in an easy-to-read and user-friendly way to assist recovery care planning. The instrument's goal is not solely to collect data but is very client-centred, aiming to help the individual draw upon their strengths to address their barriers (Best et al., 2016).

Regarding validity, efficacy, and reliability, a study by Cano et al. (2017) found that the REC-CAP has strong psychometric properties and suggests it would be beneficial for use in recovery treatment settings and a broader range of recovery services.

Central to the REC-CAP model is the understanding that recovery is a gradual process that eventually will require the active engagement of assets in the local community, and both internal and external resources will be needed to support this (Best, 2019). Therefore, the REC-CAP tool is designed not to be used exclusively in a treatment setting but rather to be administered and managed by a 'navigator' (Best, 2019). This navigator is not necessarily an addiction professional, but someone who has a strong, trusting relationship with the recoveree and is willing to accompany this person over a lengthy period. The REC-CAP is appropriate for use in clinical and peer settings, facilitating a connection between a client's exiting addiction treatment and their capacity for self-directed recovery (Best et al., 2016).

The REC-CAP tool uses three cyclical stages to provide insight and direction for the recoveree: Measure, Plan and Engage (Cano et al. 2017). The tool would be used every three

months in what is called a recovery care planning session. This length of time is chosen to allow enough time to elapse between sessions for meaningful change to occur. It is recommended that the planning sessions occur for multiple years; however, if progress is good, the frequency can decrease (Best, 2019). This tool helps to provide a degree of continuity for the recoveree as they move through different life stages and aligns with the ROSC approach.

### *Critique of Recovery Capital*

As discussed above, there are numerous conceptions and little agreeance on what areas of recovery capital are most relevant. Although the many ways of conceptualizing it overlap, this disagreement undermines the model's reliability and robustness. However, it is also important to recognize that recovery capital is a relatively new model, existing for about 13 years, and requires more thorough empirical validation.

Based on Bruce Alexander's (2010) interpretation that modern-day addiction is based on the development of free-market capitalism, the use of the language 'capital' is relatively insensitive of this. By using the language of capital, it roots the problem of addiction back into capitalism, which conceivably avoids the systemic global and societal reasons behind addiction. Although it is uncertain whether this nuance impacts the effectiveness or reliability of recovery capital's goal to capture the holistic view of a person, it is worth noting. This writer believes for a paradigm shift to occur in the addictions field, the systemic concerns need to be thoughtfully addressed, including the language of 'capital.'

Language is a profoundly influencing force. Relational frame theory (RFT) is helpful when examining the impact of language. RFT describes how people interpret language in the context of their lives; it states the only way people interpret their world is through language, and because of that, it is the root of all psychological pain (Hayes, 2014). Although it is a strong and

bold statement, it highlights that language is understood differently by each person due to the context and experience of their life, having the potential to influence other 'related frames' through association (Lee, 2018). Therefore, examining the term 'capital' can have many-layered meanings. For example, in a setting like Canada, an individual who has grown up in First Nation residential schools, experienced extensive racism and dislocation from culture, society, and the workforce, 'capitalism' may share similar relational frames with Western oppression or poverty. Therefore, this writer believes that if recovery capital is to continue being a part of a ROSC and the paradigm shift in the recovery field, especially in Canada, it is necessary to rebrand it with a more neutral term that does not include colonizing overtones.

Recovery capital is also not the only framework for conceptualizing an individual that exists. Although this paper's scope is not set to explore the other frameworks, it is important to note the essentials of recovery capital are not new. The most apparent parallel is the biopsychosocial model, which conceptualizes the individual within a biological environment, a psychological environment, and a social environment (Yates, 2015). This model also gives a framework for understanding addiction and a method of assessment and treatment planning, with many empirically validated measures for assessment (such as the Addiction Severity Index and Maudsley Addiction Profile) (Yates, 2015). The difference separating recovery capital and biopsychosocial is that recovery capital is addiction-specific and focuses on long-term recovery. In contrast, the biopsychosocial model operates much more within an acute medical model (Yates, 2015).

**The Role of Community in ROSC**

Best (2019) describes that in a ROSC, recovery is not executed, directed, and maintained by professionals, although professionals can help with counselling, detox, medications etc., but

ultimately happens in and is supported by the community. Although recovery may begin in the service of professionals, it will eventually be carried out in communities, wherever the individual ends up. Therefore, Best (2019) argues for the essential involvement of the recoveree in the community, especially a recovery-oriented community. He also argues that recovery is not just an internal state but is a social phenomenon that extends past the individual; that is, there is a larger social and community collectivism and solidarity. The role of community is supported by a study by Litt et al. (2007), who found that for those who introduced one non-using peer to their social network, they were 27% more likely to be not using 90% of the time 12 months later. Additionally, those whose social group had a greater opposition to a person's drinking and who engaged in less frequent drinking were found to have fewer days of drinking and fewer binge days (Longabaugh et al., 2010).

When examining the definition of recovery capital, that it is the internal and external resources that help an individual initiate and sustain recovery, it is no surprise that marital, family, and other relationships were among the top reasons participants from the Life in Recovery survey (McQuaid, 2017) began their journey of recovery (reported by 64.9% of participants) and that 96% of respondents reported them as essential parts of their recovery supports.

Additionally, Best et al. (2008) reported that, although initial discontinuance of use was initiated by psychological change and significant life events, maintaining long-term recovery was more strongly predicted by transitions in peer groups from using to recovery focused. However, the quality and size of peer groups matters; Best and Lubman (2016) found that those who moved away from their using peer groups but did not replace those networks with anyone else had significant deteriorations in social functioning, mental health, and well-being, although they

were more likely to maintain abstinence than those who returned to their using peer-group. Only those who maintained the size of their social network and replaced their using peers with peers in recovery or those who were non-using maintained or improved their mental and social health.

**Peer-Support and Mutual-Aid Groups as Essential for Long-term Recovery**

Peer support is characterized as a mutual helping relationship without hierarchy in which respect, pursuit of a common goal, and self-disclosure are defining features (Barrenger et al., 2019) and include support on instrumental, informational, emotional, and affiliation levels (PDAC, 2010). Originating from 12-step groups, peer-support groups have grown to encompass a wide range of supports such as SMART meetings, Celebrate-Recovery meetings, and a plethora of 12-step specific meetings (such as AA, NA, CA, MA, ASA) (White, 2008). Peer-based recovery support services (P-BRSS) are non-clinical services provided by peers in the recovery community or in-treatment centers that help individuals and families recover from substance use problems. These services do not replace but rather augment and complement the focus of treatment, outreach, engagement and other strategies and interventions to assist people in recovery to gain the skills and resources needed to initiate, maintain, and sustain long-term recovery (PDAC, 2010).

Regarding the impact of P-BRSS, the Life in Recovery survey found that 92% of the respondents have participated in some form of peer-support service during their recovery, and 80% declared these supports as 'very important' to their recovery (McQuaid, 2017). This contrasts with 60% of people participating in in-patient treatment settings, and of those, 82% found them helpful (McQuaid, 2017). In a study by Collins et al. (2018), it was found that when studying those in long-term recovery (defined as five or more years), those who maintained involvement in a mutual support group versus those who did not, had greater self-esteem, a

broader social network, greater perspective, and a more defined sense of spirituality. Peer services have been shown to improve relationships with providers, facilitate engagement, decrease self-stigma, and increase activation, empowerment, hopefulness, and quality of life (Barrenger et al., 2019; Beth et al., 2016).

The benefit of peer support has been acknowledged for almost a century, where Hanifan (1916) stated, "It was not what they [professionals] did for the people that counts in what was achieved; it was what they led the people to do for themselves that was really important." Hanifan was convinced the strength of an individual was in their social network and self-help and peer support groups being essential to that. P-BRSS aims to do just that and fosters engagement in the recovery community. They strive to increase participants' recovery capital by addressing their basic needs, gaining employment, going back to school, forming healthy social relationships, and encouraging leadership development. These services are anchored in the community and offered in many different settings: recovery centers, halfway houses, recovery houses, transitional living programs, missions, ministries, shelters, and informal settings (PDAC, 2010). Their effectiveness has been extensively studied and found that engagement with peer support groups decreased substance use, convictions, hospital visits, crisis events, and improved mental health (Davidson et al., 2010).

Regarding a relatively new development, peer support specialists have emerged, specifically in the USA (Pantridge et al., 2016). It comes from recognizing the impact and importance of peer support in recovery. There is a move to professionalize peer support workers by paying them while also providing valuable training and certifications to assist them in their work (Caroline et al., 2016). These peer support specialists can be found in a wide range of settings such as peer-run programs, mental health settings, crisis services, residential services,

employment settings and criminal justice settings (Barrenger et al., 2019). Their goal is to act as social connectors, assertively link their peers to the community, and help their peers engage in various support groups (Pantridge et al., 2016).

White (2008) warned against the professionalization of recovery supports as it disconnected the recoveree from the community; however, peer-support specialists seem to straddle that line, as they are hired explicitly based on their lived experience and to facilitate connection to the community. Recognizing the principles of ROSC and that there are multiple ways of recovery, the role of peer-support specialists have been widely adopted (now present in the healthcare system in over 40 states) (Barrenger et al., 2019).

**Role of Identity in ROSC**

One of the most influential aspects of the social network is that it changes an individual's perception of themselves. The issue of identity has long been considered central to recovery. Biernacki (1986) stated that for long-term sustained recovery to be possible, addicts must create a new sense of identity that is not tied exclusively or mainly to the addict's identity.

Best, Beckwith et al. (2016) produced a Social Identity Model of Recovery (SIMOR) that suggests that the identity change linked to recovery is as much social as personal and is primarily accomplished through group connections. SIMOR suggests that the greater involvement a recoveree has to a recovery group, the more likely they are to adopt the group's values, and there is a greater likelihood that these values will be recalled at times of risk. Likewise, reducing the ties to non-abstinent, prodrug-using groups diminishes the commitment to the values and beliefs of those groups and their capacity to draw the individuals back into addiction and risky behaviours (Best et al., 2017)

Beckwith et al. (2015) describe the importance of transitioning from an "addict" to a "recovery" identity in sustaining abstinence and well-being. They state that the growth of a recovery identity is linked to the adoption of pro-social behaviours, connected in solidarity to a recovery community, and moving away from previous behaviours linked with addiction (such as criminal activity and lying). Alexander (2010) states it slightly differently, that the more disconnected people are to their community, themselves, and spirituality, the greater the dislocation or lack of psychosocial integration.

However, both Beckwith et al. (2015) and Alexander (2010) root the formation, cultivation, and development of identity as central to the community and social network in which one is surrounded. This is important when examining a ROSC because the way the individual understands themselves will directly impact how they engage with their environment and how they view themselves in it. The healthier and more robust the environment around a person, the healthier sense of self they will have in their recovery. However, this identity transformation process is not a linear nor simple process (Best, 2019). It is recognized that this change takes time, and when looking at the benefits of long-term attendance of mutual aid groups, it is found that there were significant improvements in internalized stigma, self-esteem–self-efficacy, and community activism–autonomy (Vayshenker et al., 2016), all necessary components of identity formation.

**Asset-Based Community Development**

Asset-based community development (ABCD) is a strengths-based approach that aims to mobilize resources that exist in the community to help that community develop and meet its own needs. It operates on the belief that communities should not be built on their insufficiencies but on their capacities and assets of the people (Collinson & Best, 2019). Kretzmann and McKnight

(1993) noticed a pattern that had developed that whenever a problem was identified in a community, professionals were brought in to solve it. However, this approach's challenge is that many of these professionals had a minimal stake in the community and would leave that community each night. They found that this reliance on professionals created a dependency as well as minimized the local resources. ABCD is an essential part of a ROSC philosophy and approach as it aims to empower and mobilize the local community and resources to benefit the community.

The attraction to ABCD strategies and techniques emanates from the understanding that communities already possess many of the necessary assets needed to develop further, that these assets are often unrecognized, and persons residing in the community often have the skills, resources, and talents needed to mobilize these assets for the greater good of the community (Best et al., 2017). In this model, the most critical resources in a local community are its people, informal groups, and formal organizations, all of which represent community (or cultural) capital.

McKnight and Block (2010) argued that building integrated and supportive communities rests on "more individual connections and more associational connections" (p. 132) (also known as assertive linking), which in turn relies on identifying those who can connect with others in our communities. McKnight and Block (2010) refer to such people as "community connectors." They argue that to make more accepting and integrated communities, "we want to make more visible people who have this connecting capacity. We also want to encourage each of us to discover the connecting possibility in our own selves" (p. 132). This approach develops leadership within a community and creates resilience within it as the community learns that it possesses many of the necessary skills and resources to meet its own needs.

Asset-mapping, the key to ABCD, identifies where the wealth of people, things, services, and resources are. It maps them together to highlight the interconnectedness and how they can work together to meet the community's needs (Collinson & Best, 2019). Although ABCD has gained widespread recognition, empirically validated support remains limited, and many critics claim it is overly optimistic and not pragmatic enough. Asset-mapping in ABCD was developed with little structure, often resulting in creating a simple directory of the community's resources with limited potentiality.

Collinson and Best (2019), in response to the lack of structure of asset mapping, created a variation to this called Asset-Based Community Engagement (ABCE). This model recognizes the impact of social contagion on communities, that as the community becomes more connected and engaged, it has impacts outside the individual's social network. ABCE attempts to support community engagement by identifying what assets are utilized by recovery communities and potential barriers to engagement. The ABCE process relies on the individual in recovery and a recovery navigator forming a dyadic relationship to manage and facilitate community engagement. Collinson and Best (2019) created a workbook that helps the recovery navigator and recoveree navigate community assets, which is done through six stages that aim to provide structure and guidance.

**Assertive Linkage**

Linkage is the process in which a person is connected with a resource, person, or place. Linkages are essential for connecting individuals to the community and can help them develop the recovery capital they need to sustain their recovery (Best, 2019; Best et al., 2017; White, 2016). It is essential to spend time focusing on linkages because, as Best et al. (2017) state, long-term recovery does not take place in the care of professionals but rather in the community. Based

on the literature of individuals in early recovery (less than five years), most rely heavily on external factors to maintain their recovery (Betty Ford Institute, 2007). Recognizing that most people seeking recovery are not aware of the resources available to them, and most do not have the confidence to seek them out independently, linking recoverees is an essential part of recovery management. Linkages can be divided into passive or active, where passive is merely telling the individual about the resource, whereas assertive linkage means the individual is accompanied to the resource (Manning et al., 2013).

Manning et al. (2013) conducted a study to assess the effectiveness of these two linking methods. Recognizing that most referrals in professional settings are passive linkages (Humphreys et al., 2004), the hypothesis was that assertive linkages would have a better outcome in attendance to a peer-support group (such as AA or NA). They tested this by allocating 151 participants to one of three conditions: one, new patients were given a leaflet about AA; two, a condition where a doctor recommended attendance to the group; three, where a peer came to explain the purpose of the meeting, to take participants to their first meeting, and to discuss it with them afterwards. The hypothesis was supported as they found that when clients had a peer come to take them to their first meeting and talk about what had happened afterwards, they had better attendance at peer-support meetings during their stay and following discharge had lower rates of substance use in a three-month follow-up.

Linkage to recovery support services bolsters or, in some cases, replaces formal residential treatment if the individual's recovery capital is high enough (McQuaid, 2017). Effective linking provides the individual with multiple avenues of connection, helps individuals initiate recovery, and helps them feel cared for and supported. As discussed earlier, being connected bolsters the individual's social, cultural, and personal capital, and is necessary to

sustain recovery long-term (Kaplan, 2008). Being connected to services is also critical for individuals and families as it provides instrumental support that directly impacts the recovery process (such as finding help securing housing, employment, medical care, and identification) (PDAC, 2010). Therefore, when examining a ROSC, assertive linkages are crucial to its implementation and should be a focus of any person or agency providing recovery support.

## Conclusion of Chapter Two

This chapter discussed the current paradigm shift that has over the last 20 years in the recovery field. The shift moved away from siloed addiction recovery support to recognize that for long-term recovery to flourish, there needs to be a greater connection; that is, the connection within services, connection to the community, and greater social connections. In chapter one, this paper explored some of the beliefs around why addiction is so prevalent, and Alexander (2010) proposed that disconnection exists on all levels of society and addiction is a response to disconnection. A ROSC aims to create a fundamental shift in how society addresses addiction, where connections are central. Assertive linking and Asset Based Community Development and engaging are both ways the field has tried to bridge connections in a very pragmatic sense. Although this chapter discussed only interventions on the mesosystem level, efforts are being made across the entire system, and considerable resources are being dedicated to making this shift a reality in many areas of North America; however, there is still a long way to go. The next chapter of this paper will examine how a ROSC can be implemented in an addiction's recovery treatment center, offering suggestions based on current research and practices.

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# Chapter 3 - Recovery-Oriented Systems of Care, Recovery Management, and Implications for Treatment

## Chapter 3 - Introduction

This third chapter aims to take the knowledge and exploration learned from the survey on addiction and recovery in chapter one and recovery-oriented systems of care (ROSC) in chapter two and apply it to a practical model of operation within a treatment center. Specifically, this chapter will explore a Recovery Management (RM) model of treatment, using available literature that is evidence-based and empirically validated.

This chapter will explore the recovery management model to make suggestions to adapt within an existing addictions treatment program at Union Gospel Mission (UGM) Vancouver located in the Downtown Eastside (DTES) of Vancouver, British Columbia. UGM's Men's Recovery program serves men in the DTES who often have severe substance use problems and low capacity or resources to manage them. Presently, I work as an addiction counsellor in this program, which is why I have selected this program as my subject of focus. Therefore, I recognize that I am not impartial in my suggestions but acknowledge that my embedded position is an asset for suggesting changes to improving the existing services.

Union Gospel Mission has engaged in recovery-oriented care, and recovery capital conversations for many years and implemented some of these approaches' principles and philosophies. There has also been significant investment in sending staff to conferences, inviting guest speakers, and numerous staff meetings dedicated to the topic, yet never has a comprehensive literature review been done on the available resources to compare UGM's existing policies, procedures, and practice, and offering suggestions on implementation. This paper aims to provide a brief and general list of suggestions after each section to highlight how

UGM can better align with best practices and improve their services based on the literature, informed by my personal understanding of the program.

## Recovery-Oriented System of Care

Thoroughly discussed in chapter two and briefly stated here, a recovery-oriented system of care is the entire system that supports a person through their recovery. It is not localized to a specific agency but is a community perspective. It adopts a person-centred, self-directed approach to services. A recovery-oriented system of care utilizes individuals, families, and communities' strengths and resilience to help them take charge for their sustained health, wellness, and recovery. A recovery-oriented system of care offers a comprehensive array of prevention, treatment, and support services that can be combined and readily adjusted to meet an individual's needs (Substance Abuse and Mental Health Services Association [SAMHSA], 2012)

The first section of this paper will discuss some essential elements of a recovery-oriented systems of care, specifically looking at how they can be integrated within an addiction's treatment program to integrate it as part of a 'system.' Essential elements discussed will be policies and procedures, anti-oppressive practice, developing networks of recovery-oriented services, research and outcome measurement, leadership, and a model called CHIME.

## Recovery Management

The second part of the chapter will focus on examining a Recovery Management (RM) model. In short, recovery management is a pragmatic model for addiction treatment centers focusing on long-term recovery using a holistic perspective of the individual. This model aims to reduce hierarchy within the helping relationship, focusing on connecting individuals and overcoming barriers to help the individual achieve their goals.

Within this section of the chapter, the recovery management model will be more thoroughly explained, with a significant focus on implementing the model within a treatment center setting. Discussed will be: treatment structure, philosophy of choice, the importance of assertive linkage, creating access to treatment, fostering client retention, drug replacement therapies, length of treatment, the pertinence of supervision, using peer-based support services, involvement in mutual aid groups, utilizing a recovery plan versus a treatment plan, promoting wellness, the importance of spirituality, promotion of and strengthening social relationships, the inclusion of families in treatment, use of recovery coaches, utilizing asset-based community development and engagement, utilizing sober living communities, engaging clients in aftercare, and lastly use of measurements and assessments.

**Suggestions on Implementing a Recovery-Oriented System of Care**

As previously discussed in chapter two, working with a recovery-oriented systems of care focus requires a fundamental shift in practice, not just minor changes to existing practice (Kelly & White, 2011). Every level of an organization needs to be re-evaluated systematically. It is insufficient to simply offer recovery-oriented services within a traditional service system. Instead, it is necessary to change the service system structure to implement a genuinely recovery-oriented service system (SAMHSA, 2012). In their attempt to operationalize recovery-oriented system of care, SAMHSA (2010) provided a few fundamental guiding principles on implementation. First, the organization should create a conceptual framework of what is a recovery-oriented system of care, which needs to be understood and accepted across the organization. Second, the organization needs to build capacity, which involves assessing its ability to change towards a recovery-oriented system of care. The third is developing a strategic plan throughout departments, which is visioning what the shift would look like and assessing all

the areas involved. The fourth principle is the implementation of the strategic plan by altering policies, procedures, and financing. The last guiding principle is evaluating the change, measuring outcomes and continually re-assessing if the change aligns with the vision, and then making alterations as necessary (SAMHSA, 2010).

When looking at how Union Gospel Mission may implement a recovery-oriented system of care, it helps examine how this has happened in other treatment settings. In Connecticut, a three-phase approach was used (SAMHSA, 2012). In the first phase, the recovery-oriented system of care model's vision and development were established by defining the principles and core values of the philosophy and comparing that to the treatment centers. They first gained consensus across the organization on implementing a recovery-oriented system of care and ensured that the fundamental principles of a recovery-oriented system of care were understood. Using SAMHSA's guidelines (2010), the second phase-initiated change by assessing the organizational capacity, who was present on staff and how that would impact them and assessing funding structures to evaluate the viability of change. The third phase focused on increasing the depth and complexity of recovery-oriented system of care through advanced training, establishing performance measures, and implementing policy and resource changes.

In another example, Philadelphia's recovery-oriented systems of care initiative began with a change in leadership and assessed the city's behavioural health system (White, 2008). A Recovery Advisory Committee was established in the city to assist in directional changes and involve family members, providers, advocates, and city staff. Philadelphia first conducted a 'community recovery assessment' to determine the city's assets and limitations. Simultaneously, the city held community forums to raise awareness about the recovery-oriented system of care initiative. Next, the city developed and enacted a system-wide recovery-oriented system of care

proposal informed by stakeholders and the community recovery assessment. The city also invested financially in the plan by offering small grants to bolster implementation.

### *Suggestions for Union Gospel Mission*

1. Provide comprehensive training to staff across departments about recovery-oriented system of care to develop an understanding of its key concepts.
2. Gain consensus on a recovery-oriented system of care's philosophy and decide if it is possible to implement within the agency.
3. Develop a comprehensive strategic plan through a task force with representatives from each department. Assess each department of the organization to evaluate how recovery-oriented system of care can be implemented and make suggestions on changes to policies and procedures.

## Develop Policies and Procedures That Support A Recovery-Orientation

Regarding the implementation of a recovery-oriented system of care, it is imperative to change policies and procedures. Many organizations regularly evaluate their programs to ensure they are consistent with the organizational values, goals, and philosophy. Adopting a recovery-oriented approach is no different. SAMHSA (2012), in their review, suggested some important implications to consider when developing policies to ensure they are recovery oriented. The Pennsylvania Drug and Alcohol Coalition (2010) also held these suggestions as essential for their implementation of a recovery-oriented system of care. They recommended consulting people who are actively engaged in recovery and have experience with the agency to evaluate the suggested policy changes. Current policies relevant to people in recovery should be reviewed to ensure that the language used reflects a long-term recovery orientation rather than a short-term,

acute treatment. They also recommend that changes are made across the entire organization to support a recovery-oriented system of care.

***Suggestions for Union Gospel Mission***

1. Collect all formal and informal policies and procedures from each department.
2. Assess how each policy and procedure is consistent with a recovery-oriented system of care, using SAMHSA's guiding principles and essential elements as guides for evaluation. Consult individuals actively engaged in recovery in the evaluation of policies.
3. After the assessment, make changes to align the policy and procedure with a recovery-oriented system of care philosophy.

**Develop Networks of Recovery-Oriented Services**

As discussed in chapter two, a recovery-oriented system of care is an entire ecosystem that recovery for an individual takes place. Therefore, the implementation of a recovery-oriented system of care necessitates collaboration with other agencies. These partnerships will provide a supportive network for individuals in recovery, assisting them to sustain their recovery (SAMHSA, 2012). To develop appropriate support networks, the organization first must map what needs the community has, how it is currently meeting those needs, who is currently offering those services, and how to create greater collaboration to improve service delivery and reduce non-collaboration between organizations (SAMHSA, 2012). Agencies are encouraged to develop policies and practices that encourage collaboration between organizations, such as community-action teams and committees. (White, 2009). SAMHSA (2012) also recommends creating an advisory panel to guide the agency's collaboration and monitor and evaluate agencies' collaboration process.

### *Suggestions for Union Gospel Mission*

1. UGM already contains two departments that focus on network development (Church Relations and Community Engagement). I suggest fostering consistent and more frequent collaboration between Church Relations and Community Engagement and the direct service departments such as Men's Recovery, Sanctuary, and Outreach to increase appropriate partnership and community development.
2. Through these conversations, Church Relations and Community Engagement will have a greater awareness of various programs' needs and how to support them. If one does not already exist, I suggest creating an easily accessible community recovery asset map of the Downtown Eastside (DTES) and across the Lower Mainland of all services relevant to the population served at UGM to expedite and improve service delivery to clients.
3. After identifying key agencies through an asset map, Church Relations and Community Engagement, in collaboration with Men's Recovery, Sanctuary and Outreach, should develop official partnerships with these outside agencies. Partnership development should look at how both organizations can provide mutually beneficial support to each other and to the communities they serve.
4. An often-cited criticism of UGM from employees within UGM is the disconnection between departments. UGM leadership should make concerted efforts to improve collaboration between departments through inter-departmental meetings focusing on improving service delivery to clients accessing services at all organization levels.

## Workforce Development

SAMHSA (2012) stated that establishing a recovery-oriented workforce is essential to facilitate recovery-oriented services and supports. Therefore, staff need to adopt the philosophies

and practice of recovery-oriented service, which can be fostered and maintained through ongoing training and supervision. SAMHSA (2012) identified specific steps to develop a competent and effective workforce with a recovery-oriented system of care focus. First, to clearly define staff roles and responsibilities and invest in team building. Second, to incorporate individuals in recovery at all levels of the organization. Third, create a culture that actively fights the stigma associated with recovery. Fourth, build resiliency and promote the health and wellness of staff to prevent burnout.

### *Suggestions for Union Gospel Mission*

1. UGM is highly inclusive of individuals in recovery being a part of the workforce. It will be essential to maintain that commitment, and UGM can be a leader in modelling inclusion to other service agencies.
2. For all managers and supervisors to revisit job descriptions, assessing how they can be modified and clarified to incorporate a recovery-oriented system of care philosophy. Then to explicitly communicate to staff the expectations of their role and how to support a recovery-oriented system of care.
3. Currently, UGM recognizes certain certifications and designations as reasons for increased wages. According to a ROSC perspective, lived experience through addiction should also be recognized financially through wage increases, as these individuals bring crucial skill, knowledge, and expertise to the agency.

## Research and Outcomes

Within a recovery-oriented system of care, the focus of a program is to facilitate long-term recovery. Key Performance Indicators and expected outcomes should shift to reflect this with less focus on solely measuring abstinence as an indicator of success (Kelly & White, 2011).

A recovery-oriented system of care understands that recovery is not linear, and relapse is often a part of the process of recovery, especially when the clients served are low in recovery capital and high in problem severity (White, 2008). Agencies are encouraged to critically examine what current KPIs, and other measures of success are measuring. Do they measure key factors that affect long-term recovery and wellness? What purpose do KPI's serve? Who are KPI's serving? What story are they telling of the client? If looking to measure long-term success in recovery, some examples the research suggests tracking are involvement in the community, attendance of 12-step meetings, presence of a sponsor, engagement in meaningful activity, the health of the social network, family in recovery, and amount of recovery capital (Kelly & White, 2011; White, 2008; SAMHSA, 2012).

Additionally, a vital aspect of a recovery-oriented system of care is elevating the voice of people in recovery. SAMHSA (2012) suggests involving people in recovery in the processes of defining outcomes for recovery. SAMHSA also recognizes the importance of training and educating researchers and administrators who are involved in outcome measurement around recovery-oriented system of care and its principles

***Suggestions for Union Gospel Mission***

1. Critically examine all key performance indicators and data collected on service delivery and clients, assessing if the information gathered is aligned with recovery-oriented system of care's values of strengths-based, anti-oppressive, trauma-informed, and long-term recovery-focused. It is essential to ask the following questions: Do our current assessments measure key factors that affect long-term recovery and wellness? What purpose do KPI's serve? Who are KPI's serving? What story are they telling of the client?

2. The research suggests tracking involvement in the community, attendance of 12-step meetings, presence of a sponsor, engagement in meaningful activity, the health of the social network, family in recovery, and amount of recovery capital for determinants of success.

**Anti-Oppressive Practice**

It is important to discuss anti-oppressive practise (AOP) when examining how a whole system impacts a person in recovery. Although this paper does not have the available scope or breadth to discuss AOP thoroughly, it will make a few critical notes. AOP is an umbrella term for various social justice-oriented approaches, including feminist, postmodernist, Indigenous, poststructuralist, critical constructionist, anti-colonial, and anti-racist (Baines, 2011). AOP recognizes the social difference of power existing between the dominant social class and the disadvantaged (Adams et al., 2002). It can be described as:

> A person-centred philosophy; and egalitarian value system concerned with reducing the deleterious effects of structural inequalities upon people's lives; a methodology focusing on both process and outcome; and a way of structuring relationships between individuals that aims to empower users by reducing the negative effects of social hierarchies on their interaction and the work they do together (Dominelli, 1994 in Adams et al., 2002).

AOP acknowledges the power differentials in personal, family, community, organizational, and structural levels. AOP asserts that different forms of power and oppression are interconnected, and their intersections have a formative effect on the social reality for all people that live within them. Therefore, AOP actively exposes and challenges inequalities. People are called to critically reflect on the cultural positions and locations they occupy, to examine the relative power and oppression they experience as a result, and how this affects

interpersonal exchanges, their concept of self, and what they consider to be normative. In a therapeutic context, staff are encouraged to evaluate their positions of relative power critically, how power is operating as a result of professional status in the therapeutic relationship, how the cultural locations of the client may afford them less privilege, and how both the locations of the practitioner and client may interact. These intersecting systems may include, but are not limited to, white normativity and supremacy, eurocentrism, colonialism, classism, heteronormativity/ homophobia, cisnormativity/transphobia, neurodivergence-related stigma, ageism, ableism, racism, xenophobia, educationalism, and sexism.

Within a treatment center context, it is important to recognize that many clients are experiencing the extreme impact of multiple intersecting systems of power and oppression and may also occupy various cultural positions that can afford or decrease their social privilege. For illustration, consider the following example: there is a person in a recovery program who identifies as Indigenous and grew up on a reserve. Their parents were survivors of residential schools and used substances to cope with their traumatic experiences. As a result, this person was removed from the family and placed in foster care in North Vancouver when they were 12 years old, and then moved between three homes before they aged out of care. In high school, they were one of three students who were not white and experienced racial teasing. As a result of early childhood trauma and the impacts of intergenerational violence, they did not graduate from high school and used substances to cope. As a result of substance use and not completing high school, they had limited job opportunities and became involved in organized crime, resulting in later incarceration and further barriers to acquiring work. The person identifies as a cis-man and has experienced homelessness for the last seven years. They are now sent to attend court-mandated treatment at a Christian recovery program in North Vancouver.

In this short case study, the person in the recovery program and their family experienced oppression as a result of colonization, which had implications on their parenting, coping, and health. They were also living in Canada, a settler nation, that is infused with all of the previously mentioned systems of power and oppression. Not only would this person experience the effects of racism and colonial oppression through the intergenerational trauma but would also in the majority of the institutions that he later would interface with (such as the foster care system, justice system, education system, social services, medical system). He would experience this oppression because none of these institutions are immune to these respective systems of power. While he might have relative power as a cis-man, he will also experience a lack of privilege vis-a-vis his race, class, education level, and interface with the criminal justice system.

Furthermore, court-mandated treatment in a Christian recovery centre may be reminiscent of residential schools, and further, is situated in a predominantly white community. While staff can be aware of these systems of power and oppression, they cannot eliminate them or remove them. They can, however, actively work to resist their impact and reduce harm. Conversely, if the staff are unaware, they are at risk of colluding with systems of power, may unintentionally adopt the respective biases (for example, racial stereotypes), and then these systems might influence their work with the client. It is equally, if not more important for the staff to be aware of their positions within the relationship; systems of power and oppression cannot be eliminated at an individual level, people can only become aware of them or collude with them.

Anti-oppressive practice acknowledges that these systems of oppression exist and are perpetuated at every level on a macro-scale and an individual level. Systems of power and oppression become internalized and are both intentionally and unintentionally re-enacted and reproduced until these types of oppression can be brought into conscious awareness (Adams, et

al., 2002; Baines, 2011). Anti-oppressive social service workers not only provide service to people seeking it but also help clients, communities, and themselves to understand that their problems are linked to social inequality and to understand why they are oppressed and how to fight for change. They work to change clients' narrative that they are not just victims but can be active in their own liberation and that of others.

Therefore, within an addictions treatment program, it is essential for all staff to be aware of these systems of oppression, their place within them, how their work interacts with them, how it impacts their clients, how to fight and resist these oppressive forces, to examine at every level of the agency and in all policies and procedures who is being served (in efforts not to reproduce the same oppression they are working to fight against), and to continuously engage in critical reflexivity (Baines, 2011).

***Suggestions for Union Gospel Mission***

1. All staff should be required to regularly locate themselves within these systems of power and reflecting how that shows up in their work, possibly within a supervision context. Once this is recognized and reflected upon, staff should take personal and professional action to resist colluding with these systems of oppression.
2. Invite anti-oppressive educators into the agency to have informed discussions and engage in critical reflexivity.
3. Evaluate all levels of programming to examine where these systems of oppression have been reproduced and make efforts to change practice/policy/procedure to resist them.

**Develop Peer Leadership**

The literature uses the term 'peer' to refer to those in recovery to reduce stigma and hierarchy, which will also be used throughout this paper. Therefore, central to a recovery-

oriented system of care is the employment of peers at all levels of the system of care/agency. Nurturing peer leadership will ensure that the peer voice remains strong throughout the system and within every aspect of service delivery and evaluation. SAMHSA (2012) makes some suggestions on how to cultivate peer leadership. One, to provide training and education to peers to foster leadership skills. Two, fund and develop peer-run programs to educate and train social service providers on implementing peers in their agency. Three, establish opportunities for peers to take meaningful leadership roles within the agency. Four, retrain and educate staff to understand and respect the role of peer providers. Five, establish pay scales that acknowledge the value of lived experience in the workforce. Six, create media campaigns to educate and reverse the stigma of those in recovery.

### *Suggestions for Union Gospel Mission*

UGM has already made many steps to integrate individuals in recovery into the workforce. Suggestions for improvement include creating a peer-led task force to identify and brainstorm areas of improvement within the organization; create more opportunities for individuals in recovery to build leadership skills outside of internship roles, and critically evaluate pay scales to put a greater monetary value on lived experience.

## CHIME in Action

Leamy et al. (2011) studied 97 papers in a meta-analysis of personal recovery from mental illness. Although different from recovery from substance abuse, there are many shared similarities between the recovery processes (Leamy et al., 2011). This review of individuals' experiences in recovery identified five commonly shared elements linked to successful recovery. They are connectedness, hope and optimism about the future, identity, meaning in life, and empowerment (giving the acronym CHIME). Leamy et al. (2011) state that if an agency is

looking to impact the lives of the individuals they serve significantly, every procedure and intervention should be compared to CHIME and if it will impact all or some of the stated areas. Best (2019), recognizing this model's significance, builds on it to adapt it to recovery from substance abuse and labels it *CHIME in Action.*

Best (2019) operationalizes CHIME in Action by using a 'navigator,' 'champion,' or 'peer.' The navigator helps guide the recoveree by assertively linking them to recovery groups and communities. By championing the individual into new social circles, the navigator provides the recoveree opportunity for developing a healthier self-identity and engagement in meaningful activities to improve a sense of empowerment and self-esteem.

As the recoveree is integrated into recovery circles, Best (2019) describes the power of social contagion, which he states as the hope instilled in a community as more people initiate and sustain recovery. By seeing the reality that other people can live well in recovery, it inspires others in the community to try, shifting the culture towards the values of CHIME. Within the concept of social contagion, recovery capital is not seen exclusively as an individual resource but as an evolving community resource. This collective community recovery capital is developed through constant striving for inclusion and active participation of its members (Best, 2019).

***Suggestions for Union Gospel Mission***

1. Introduce the concept of CHIME to staff. Discuss how programs could implement a focus towards these values.
2. Evaluate current policies, procedures and practice in how it helps develop connectedness, hope and optimism about the future, identity, meaning in life, and empowerment within the client

3. Develop a 'peer navigator' system, that is, an individual farther along in their recovery (possibly alumni) who becomes personally invested in the life of a new recoveree. The purpose of this would be to foster social contagion, improving social networks, and assertively link the new recoveree when necessary.

**Barriers to Implementing a Recovery-Oriented System of Care to an Agency**

Regarding implementing a recovery-oriented system of care, many barriers have been identified as capable of inhibiting or immobilizing the process (SAMHSA, 2012; SAMHSA, 2010; White & Kurtz, 2006; White, 2008). They will be discussed briefly below.

Although many people agree with the values and principles of a recovery-oriented system of care (SAMHSA, 2010), the most challenging obstacle is often ingrained and internalized beliefs about recovery that are rooted in acute-care delivery (SAMHSA, 2012; White & Kurtz, 2006; Conner and Anderson, 2020). Because adopting a recovery-oriented system of care is not merely accomplished by small shifts within an agency but requires a fundamental orientation shift resulting in system-wide alterations, this can pose a real practical challenge (White & Kurtz, 2006; SAMHSA 2010).

White and Kurtz (2006) identify the following barriers to implementing a recovery-oriented system of care within an agency. They note a *conceptual barrier*, which is the difficulty shifting from problem-focused to solution-focused thinking or difficulty thinking outside the acute-care intervention model. This becomes a greater barrier if upper management or board members are unwilling to listen or consider alternative methods. They identify *personal/professional barriers*, which are the perceived loss of professional pride/status/power by addiction professionals, hesitancy to acknowledge the experiential wisdom of the recovery community, reluctance to accept alternative recovery methods, and unwillingness to introduce

peers as part of service professionals. The *financial barrier* is understood as the precarious position most treatment centers exist in, often relying on donations and grant funding. It is recognized that the lack of adequate financing can interfere with service changes (such as adding aftercare programs). Additional financial barriers exist if the funding source is explicit in how they would like services to be delivered and they are unwilling to make changes. *Procedural Barriers* are present in some agencies, which are the lack of well-defined and explicit protocols, procedures, and policies that are upheld and enforced. If these are weak or missing, it can pose a barrier for introducing system-wide changes, including recovery-oriented system of care. *Ethical barriers*, similar to procedural barriers, are the absence of ethical codes or enforcement to guide service delivery. This could be a barrier especially in implementing peer-based recovery support services where a strictly adhered to code of ethics is essential to protect all parties involved. Lastly, White and Kurtz (2006) describe *institutional and structural barriers* which are the challenges to implement changes when there is a high turnover rate of staff, insufficient staff, or limited physical space to implement service changes or additions.

SAMHSA (2012) found variations and different interpretations of recovery-oriented system of care values' implementation through an expert panel discussion examining communities that had implemented a recovery-oriented system of care. For example, the principle that 'there are many pathways to recovery' is often in conflict with mental health service models that require medications as an essential part of treatment (SAMHSA, 2012). Although universal acceptance and implementation are unrealistic across all systems, it is important to recognize and acknowledge the biases that each agency and leaders within that agency hold and how that exists within their work.

**Systems of Oppression within a Recovery-Oriented System of Care**

Additional barriers to implementing system changes may be impacted by unchecked prejudices, often taking the form of racism, sexism, classism, colonialism, and eurocentrism. As discussed in the section on anti-oppressive practice, these forms of oppression exist within all systems and operate unchecked until they are brought into awareness. All individuals working within the recovery-oriented system must make an honest and thorough appraisal of their locations within these systems of oppression and work to bring into awareness their own prejudices and actively work to dismantle them (Baines, 2011). If not critically examined, these prejudices, biases, and unconscious barriers will influence how an agency functions, which will interfere with clients' healing and recovery.

**Administration and Leadership**

Administrative barriers can severely limit an agency's adoption of a recovery-oriented system of care. Strong leadership is an essential ingredient for transformation to a recovery-oriented system. Although change can be suggested from within the organization, to sustain and implement it, leaders must adopt and actively pursue this change, involving stakeholders, creating cultural change, and foster organizational learning (Crews, 2010). Leaders must also guide the development of policies and procedures to assist in the implementation of a recovery-oriented system of care. If leadership does not adopt the philosophy of a recovery-oriented system of care, it will render the change impossible system wide.

**Cross-System Collaboration**

Additional barriers to implementing recovery-oriented care agency-wide involve the community and larger systems that recovery takes place in (SAMHSA, 2012). If other agencies, services, and government and provincial policies are not focusing on the individual's long-term recovery or are suffering from some of the barriers discussed above, it will inhibit the whole

system's efficacy. Recognizing that the whole system is involved in assisting an individual to recover from substance use and that within the first 4-5 years of recovery, the individual will be relying on external supports for sustaining recovery (White, 2004), it is in the best interest of the recoveree if the system unifies. However, recognizing that each layer of the system/different agencies has different philosophies, use of language, practices, and procedures, it is naïve to think that all recovery-oriented system of care values will be universally adopted and implemented in the same manner. Therefore, collaboration and engagement between all agencies in a system are needed to maximize partnership and reduce isolated care.

## Recovery Management

Presently this chapter has focused on implementing the broader concept and idea of a recovery orientation into the systems in which the care will take place. This chapter will now discuss how a Recovery Management (RM) model is involved in this process. It will begin with a thorough explanation of what a recovery management model is and then discuss how this can be implemented within a treatment center, giving specific suggestions to UGM's Men's Recovery program.

A Recovery Management model is a philosophy and practical application of organizing addiction treatment and recovery support services to enhance early pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery (Kelly & White, 2011; White, 2008). In most treatment centers, the acute-care model of addiction treatment is the predominant approach, where the focus of care is on symptom elevation. Using the philosophies of recovery-oriented system of care, the recovery management model focuses on organizing care to foster long-term recovery in every layer of the agency (White et al., 2006).

A recovery management model shifts the focus of care from professionally driven and expert-directed to client-led, with the understanding there are multiple pathways of recovery and that within each client, there are inherent strengths and resources that can be fostered to sustain recovery (White, 2008; White et al., 2006). The recovery management model also recognizes the importance of developing highly individualized and nuanced recovery plans for each person, focusing on connecting the individual to recovery communities and their desired community upon completing treatment. Within these plans, there is a focus on reducing pathology and then later on building recovery capital and a meaningful life (White & Sanders, 2006).

In recovery management, there are three main focuses, each requiring equal effort and resources: one, on pre-recovery support services to enhance recovery readiness prior to formal treatment; two, in-treatment recovery support services to enhance the strength and stability of recovery initiation; and three, post-treatment recovery support services to enhance the durability and quality of recovery maintenance (White et al., 2006).

**Redefining Recovery**

Within the recovery management model, there is a specific understanding of what recovery means. For example, abstinence is not the goal and exclusionary requirement of being in recovery, but instead, the focus is on *global health*. Therefore, the goal is the resolution of substance use problems by any means possible. For example, for individuals with less severe substance use problems, moderation of use may be a legitimate form of recovery. Global health being the focus of recovery includes not only having a healthy individualized relationship with one's substance of choice, but also includes the quality and breadth of one's relationships, the pursuit of meaningful activities, integration into society, and the formation of a healthy self-

identity (White et al., 2006). Simply put, the shift in focus moves from what recovery eliminates to what recovery adds to the individual, their family, and community.

Therefore, with this definition of recovery, treatment center service providers will not view prior treatment as a predictor of poor prognosis (and grounds for denial of treatment admission), as there is a recognition that recovery is not linear and often multiple treatment episodes are required for sustained recovery (Kelly & White, 2011). There is also a shift away from assuming clients should achieve complete and lasting sobriety following a single treatment episode, and instead, there should be a focus on connecting and building upon multiple treatment episodes. In the same vein, clients would not be discharged for becoming symptomatic (i.e., relapsing), unless this violated the safety and integrity of the treatment center, other clients, and staff.

## Implementing a Recovery Management Model

The following section will specifically outline the literature and research surrounding recovery management's implementation within a treatment center. Discussed will be the choice philosophy, access to treatment, client retention, service scope, length of time in treatment, the structure of treatment, using peer-support, the role of mutual aid groups, using a Recovery Plan, how to promote wellness and a healthy lifestyle, developing coping skills, the role of spirituality, the role of social relationships, involving families, roles of staff, assertive linking, fighting stigma and using anti-oppressive practice, developing social identity maps, and lastly using Asset-Based Community Development and Engagement. Following each section, suggestions are offered on how UGM may include this information and practice into its agency.

## Structure of Treatment

When examining the program structure of addiction treatment center, the literature suggests that clear treatment policies, high expectations of clients, highly structured treatment activities, a large number of staff in recovery, and a comprehensive range of psychosocial services are beneficial for those early in recovery (White, 2008). There is a necessary period of stabilization for individuals just beginning their recovery journey (Kelly & White, 2011). However, depending on the individual's level of recovery capital and severity of problematic substance use, they may benefit better from less intensive treatment (Kelly & White, 2011; McKay, 2009). Sobell (1992) found that individuals with the highest problem severity of use desire clinician set goals, likely because they have lost confidence in their own decision making. However, once a client has stabilized and developed more self-confidence, they should be encouraged and empowered to develop their own goals and choices, and the structure of the treatment center must be able to facilitate this (Kelly & White, 2011).

### *Suggestions for Union Gospel Mission*

1. It is suggested that UGM structure the Men's Recovery program so that it has a highly structured stabilization period, that there are high expectations of the clients, and those expectations are clear and enforced.
2. Once a client is deemed stable, they should be offered time and space to explore their own goals in a structured and monitored way.
3. Clients should be engaged in meaningful activities in addition to educational and psychotherapeutic activities, as the literature points to the importance associated with engaging in meaningful activities (Kelly & White, 2011).

**Choice Philosophy**

Central to the recovery management model is a "philosophy of choice," which emerges out of the literature that found clients who are more active in their treatment rate their treatment experience (services, primary counsellor, and treatment organization) more positively, remain in treatment longer, and achieve better post-treatment recovery outcomes (Hser et al., 2004). Recognizing there are multiple pathways and styles of long-term, it is assumed that not all clients will respond the same to the identical treatment (Kelly & White, 2011). Therefore, it is important to provide a wide range of services to support individuals in their unique pursuits of recovery (ex. effectively using outreach, in-patient treatment, aftercare, and education as forms of recovery management) (White & Kurtz, 2006).

***Suggestions for Union Gospel Mission***

1. Recognizing that UGM offers many elective classes on select topics, albeit only occasionally, my suggestion is to develop consistency in the delivery of these classes and add classes that promote well-being, such as nutrition and sleep hygiene. Additionally, to clarify and enforce expectations on attendance as often only a handful of people attend.
2. The Men's Recovery program has embraced the choice philosophy. However, it is vital that choice not become 'do whatever you want' and that structure and expectations be clearly defined and enforced.

**Assertive Linkage**

An essential element of the recovery management model of addiction treatment is the emphasis placed on assertively linking to recovery communities (Kelly & White, 2011). Assertive linkage, described in greater depth in chapter two, is the active connection to a resource, i.e., going with the person to the resource and discussing their experience with them

afterwards. Connection to communities of recovery and other support services is essential to the recovery management model's perspective on helping clients achieve long-term recovery. Therefore, within a treatment center, it is inadequate for staff to merely passively suggest that a client access a resource, but instead assertively link them to that resource, either by accompanying them there personally or by enlisting the help of a peer or 'guide' to do so if they are unable.

***Suggestions for Union Gospel Mission***

1. Develop a process of how to connect clients in the Men's Recovery program to resources assertively.
2. Train staff in this process and ensure follow through via supervision
3. Utilize the asset map (more on this in a following section) to inform what resources to assertively link to or engage a 'recovery connector,' that is, someone who is aware of available resources.

**Attraction and Access to Treatment**

Although not all individuals with alcohol and drug problems require in-patient treatment (White, 2010), those with lower recovery capital and higher problem severity often benefit the most from treatment (White, 2004). The majority of drug-dependent persons who achieve sustained recovery do so after participating in treatment (the percentage varies by substance: cannabis (43%), cocaine (61%), alcohol (81%), and heroin (92%) (Cunningham et al., 2000) acknowledging that for people with severe substance use problems, it on average takes three to four episodes of residential treatment over eight years to achieve stable and enduring recovery (Dennis et al., 2007).

However, access to treatment can be difficult, with many treatment centers have extensive waitlists, and unfortunately, there is a 50–64% dropout rate between the first call for help and meeting with an addiction treatment center (Gottheil et al., 1997). In a study by Moos and Moos (2006), those seeking treatment and immediately receive it have much better recovery outcomes than those who receive delayed treatment.

Therefore, within a recovery management model, it is important to have interventions in place at all stages of substance use problem development (Kelly & White, 2011). A robust recovery management-oriented agency will be reaching out to people at the early and middle stages of substance use problem development. This outreach may be done through education directed at the public, assertive outreach programs, low barrier service programs (such as meal programs, drop-in centers, shelters), and access to case management before in-patient treatment (Kelly & White, 2011; White & Sanders, 2006).

The recovery management model also recognizes that recovery exists on a continuum, and if an individual is surrounded by a supportive, recovery-focused environment, it will develop their recovery capital and the likelihood of sustaining recovery (Best, 2019; Kelly & White, 2011). This natural growth of capacity for recovery that develops when in a supportive environment should inform how clients are permitted access to treatment. Often motivation for recovery is thoroughly assessed before admittance to a program. Although motivation is essential for long-term recovery, the literature has found it to be something that can emerge within the service relationship and should not be a precondition for service (White & Sanders, 2006). Therefore, if a client states they want treatment but do not appear 'ready' from an outside perspective, they should not be denied treatment.

### *Suggestions for Union Gospel Mission*

1. It is important to recognize that UGM excels in reducing barriers to provide access to services. In addition to the Men's Recovery program, UGM has a robust menu of supports from street outreach, a drop-in center, a shelter, case management, women specific resources, and transition beds. UGM's resources and current programs are considered an ideal scenario according to the literature.
2. Regarding intake interviews, according to the literature, it should be encouraged that if an individual wants recovery, and if there are no safety concerns, they should be granted an opportunity to try recovery. Simply speaking, it is essential to maintain low intake requirements.

**Client retention**

According to SAMHSA (2002), more than half of clients who start an addiction treatment program do not complete, with 50% leaving within the first month. Client retention is a crucial element to consider when working towards helping individuals achieve long-term sustained recovery.

White and Sanders (2006) state that when a client prematurely leaves a program, often the onus is placed on the client as a personal failure and very little responsibility is taken by the treatment program. However, they suggest that agencies should critically examine their retention statistics as it can provide beneficial information, implicating the program's efficacy. Although there will always be natural attrition in recovery, critically examining client outcomes as not solely the client's responsibility is vital.

When examining common factors for early dropout, Stevens et al. (2008) found that lengthy and repeated assessment processes, multiple appointments before treatment begins,

failure to give clients the treatment they requested, inadequate methadone doses, and mixing clients at differing stages of readiness for change all were aspects of premature exiting. However, the best single predictor of client retention and premature exiting is the quality of therapeutic alliance established between the service professional and the client (Barber et al. 2001). Even when client characteristics (e.g., problem severity) and service professional's backgrounds (e.g., education, recovery status, and years of experience) are controlled for, the relationship is still noted as having the most significant influence on in-patient treatment outcomes (Kleinman et al., 1990). When examining low-motivated clients, the therapeutic relationship is linked to more significant long-term recovery outcomes than highly motivated clients (Ilgen et al., 2006).

The therapeutic relationship has the greatest strength in assisting the client in their recovery only during active treatment (Meier et al., 2006). It was found that the therapeutic relationship helped clients stay in the program, maintain in-treatment abstinence, and experience in-treatment and post-treatment gains in emotional health, but after the treatment was finished, the relationship had little impact on these factors (Nagalaksmi et al. 2002). This suggests that the service professional relationship may play a critical role in recovery initiation but that extra-treatment factors are more influential in achieving long-term Recovery (White, 2008)

Regarding treatment goals and client retention, it was found that clients who are more active in their treatment rate more positively the service they receive, their relationship with their primary counsellor, the treatment agency, remain in treatment longer, and achieve better post-treatment recovery outcomes (Hser et al., 2004; Meier et al., 2006). This 'choice philosophy,' discussed above, emphasizes the importance of clients setting their own goals for treatment once they have stabilized (Sobell, 1992).

Additionally, studies consistently show that providing a greater number of additional services to addictions treatment, such as medical, psychiatric, family, and employment services, can increase client retention, well-being, and abstinence by as much as 25-40% (McLellan et al., 1994)

White (2008), in his monograph, compiled a list of suggestions on how to improve client retention in treatment. Some of them are listed below:

1. Express hope for clients about positive outcomes of treatment for them.
2. Involve family members in the treatment process.
3. Using motivational interviewing to improve client readiness before entering treatment.
4. Increase the percentage of direct service staff with personal recovery backgrounds.
5. Use the most experienced, charismatic staff to conduct introduction seminars for potential new clients.
6. Correct any client misperceptions about treatment and their role in it.
7. Use an orientation video for clients entering treatment.
8. Assess the quality of the therapeutic alliance throughout the treatment process.
9. Evaluate client perception of services, counsellor, and treatment organization at multiple points in the service process so interventions or alterations to services can be made if necessary.
10. Provide financial incentives for retention of counsellors and staff.
11. Provide substance use self-management education to increase self-efficacy, problem-solving skills, and self-regulation.
12. Increase client choice of treatment goals, treatment methods, and recovery maintenance strategies.

13. Provide decisional support at times of crisis.
14. Work with a client when they relapse instead of immediate dismissal.
15. Provide case management services to eliminate obstacles to continued treatment participation
16. Provide external incentives for treatment participation, such as vouchers or coupons.
17. Hold informational seminars to staff and clients on Opioid Antagonist Treatment (OAT) to dispel negative attitudes towards it and common myths.

***Suggestions for Union Gospel Mission***

1. Recognizing that the therapeutic relationship is one of the most significant factors for client retention, ensuring coaches/counsellors are fostering relationships with their clients. Using supervision to ensure consistent, positive, and ethical contact.
2. Develop clear and explicit relapse policies that allow staff to continue working with clients when they relapse.
3. Develop clear guidelines and expectations of clients at the onset of treatment, potentially using an informational video to ensure consistent messaging, and providing an up-to-date booklet on rules and expectations.
4. As clients stabilize, allow them to develop personalized goals.
5. Recognizing that factors outside of treatment are often a cause for leaving prematurely, pre-emptively use case management, family counselling, and client-directed goals to help mitigate outside concerns.

**Drug Replacement Therapies**

Opioid Antagonist Treatment (OAT) is a method of treating opioid addictions by prescribing drugs like methadone and suboxone. The recovery management model endorses this

treatment (White, 2008) as empirically it improves client outcomes, reduces premature dismissal, and significantly decreases the likelihood of overdose and death (Davison et al. 2003). Within the early stages of recovery, the individual is precariously balanced between using and not using and using OAT can help mitigate some of the risks of relapse (White & Sanders, 2008). It has been found that OAT enhances metabolic stability, reduces post-detoxification cravings, reduces relapses, and death (Dunlap & Cifu, 2016; Wakeman & Rich, 2017).

***Suggestions for Union Gospel Mission***

1. UGM has been an abstinence-based program throughout its history. However, due to the ravaging opioid crisis, it is suggested they consider OATs from an evidence-based, neutral perspective in the spirit of preserving the lives of the clients served. I suggest inviting an expert in opioid management treatment to discuss commonly held myths, provide information, and offer possible ways of implementing OAT while upholding UGM's values.

**Length of time in treatment**

In many standard treatment centers, the length of stay ranges from 10 to 60 days. However, for many individuals, it is not possible to achieve recovery sustainability within such a short period (Kelly & White, 2011). The challenge within most of these programs is that upon completion, most clients are given the illusion that continued recovery is self-sustainable without further professional support, and many do not seek it (White & Kurtz, 2006). The research, however, does not support this, stating at least four to five years of sustained remission is needed on average for recovery to be self-sustaining (Ritsher et al., 2002), and within those years, there is often a greater reliance on external supports to effectively maintain recovery (White, 2008).

The Recovery Management model argues that 10-60 days is an insufficient amount of time for someone to develop the proper foundation for long-term recovery (White, 2008; Kelly & White, 2011; White & Sanders, 2006). The recovery management model also emphasizes pre-treatment and post-treatment recovery support as crucial elements necessitating attention (Kelly & White, 2011). The recovery management model does not offer a specific length of time for treatment but recognizes that most individuals benefit the longer they are in treatment (Kelly & White, 2011). recovery management recognizes that addiction is a chronic disorder that increases in complexity and severity over time and that individuals with lower recovery capital and higher problem severity will need longer in treatment than those with higher recovery capital and less severe addictions – emphasizing the importance of individualized recovery plans (White & Sanders, 2006; Simpson et al., 1997).

Simpson et al. (1997) state that the most notable predictor of long-term sobriety is the length of time in treatment. White and Sanders (2006) also state that the earlier one can access recovery support during active addiction, the greater the long-term outcomes. However, length of time itself is not the healing factor, but rather what happens during that time. Highlighting this, Zhang et al. (2003) found that 'unusually long' stays within a program had detrimental impacts on a person's recovery. They stated longer stays in segregated treatment programs, which limit the resident's engagement in employment and access to outside resources, results in greater barriers to sustaining recovery, causing the severing of economic, educational, and social connections, ultimately resulting in the development of an unhealthy dependency to the agency (SAMHSA, 2012). SAMHSA (2012) suggests that instead of segregating individuals in recovery in isolated communities, fostering social, educational, and employment connections will have a

greater impact on long-term recovery by developing the individual's sense of self-efficacy and decrease codependency upon the agency.

How individuals spend their time in treatment and what they do when they leave has a more significant impact than treatment length (Cano et al., 2017). Cano et al. (2017) state that it is vital for the time in treatment to be spent on meaningful activities and addressing acute barriers to recovery (as identified through a recovery capital assessment). These findings parallel the work done with Oxford Houses (Jason & Ferrari, 2010), which suggests that length of stay is related to better outcomes if it is long enough to provide an ample opportunity to develop recovery capital. Therefore, they suggest that time in treatment should be spent building recovery capital by developing meaningful activities (such as focusing on preferred employment, accessing education, engaging with volunteering and community engagement). Focusing on meaningful activities helps foster internal recovery capital, specifically empowering individuals through self-esteem development and regaining a sense of purpose in life. These internal characteristics require time to develop, which often cannot occur in a standard addiction treatment timeframe (Cano et al., 2017).

***Suggestions for Union Gospel Mission***

1. UGM excels in this area as it is not financially restricted and can offer up to two years of treatment and second-stage housing, which the research suggests is more than enough time.
2. Based on the literature, I suggest that there be pressure and an expectation for residents to engage in meaningful activities during their time in treatment. For example, if a resident has a skill set they are willing to offer, they should be encouraged to use it to benefit the community (such as teaching guitar lessons to other clients if they know how to play).

3. Recognizing longer than necessary stays may be detrimental, UGM should use measures to assess individuals' recovery capital and addiction severity. If a client is found to have sufficient recovery capital and low severity, it may be beneficial to encourage re-integration into the community rather than staying at UGM for an extended period.

**Supervision**

As policies and procedures shift, and the agency moves towards adopting a new way of conceptualizing its work, it is crucial to follow it up with adequate supervision to ensure staff are operating within the new paradigm. This supervision should occur at all levels of the organization to ensure adherence and compliance with a new philosophy shift and a culture shift. Regarding frontline work, counsellors and coaches need to be audited regularly in their practice and documentation for feedback and correction when necessary (Kelly & White, 2011). If staff are working behind closed doors with clients, these sessions must occasionally be audiotaped to ensure client safety, and that staff are adhering to policies, procedures, and ethics (Kelly & White, 2011).

Kelly and White (2011) recognize that most counsellors receive minimal structured supervision, with the majority happening as 'hallway supervision' (i.e., random communications based on crisis rather than proactive training) or weekly meetings that focused on process issues (i.e., who is taking what tasks in the agency, or reviewing case notes) rather than supervision focused on improving the skills of the clinicians.

***Suggestions for Union Gospel Mission***

1. Audit case notes of counsellors and supervisors regularly to ensure adherence to policies, procedures, and ethics.

2. Require auditing of 1-1 sessions through audiotape of counsellors/coaches to ensure adherence to policies, procedures, and ethics.
3. Supervisors to facilitate weekly 1-1 meetings with all frontline staff, following up on casework, asking questions in line with a recovery-oriented system of care, such as "what are your client's goals while at UGM?" and "How can we empower them to achieve those goals?"

**Peer-Based Support**

Within a treatment setting with a recovery management model, the literature is quite clear on the importance of peer-based group and support services and the impact on long-term recovery. (Bernstein et al., 2005; Kelly & White, 2011; White, 2008; White et al., 2006). Although general social support effectively assists individuals in their recovery, peer-based support is even more effective (White, 2008). Part of the benefit of peer-based recovery support relationships is that they are natural, reciprocal, and enduring (White et al., 2006). Peer-based support offers a level of care that professional relationships will never achieve due to the inherently hierarchical, commercialized, and transient nature of the roles (White et al., 2006). Moos (2003) even states that for many recoverees, there is little difference between an AA sponsor, a peer, partner, and a relative or friend versus that of a counsellor or psychotherapist, highlighting the most significant factor associated with healing is the relationship.

Separate from mutual aid groups (like AA), formalized peer-based recovery support services (P-BRSS) are non-clinical services offered on a paid or volunteer basis that guide individuals and families into a recovery-based lifestyle (White et al., 2006). P-BRSS offer guidance through the recovery experience, offering stage-appropriate recovery education, linking to communities of recovery, assist in navigated problems encountered in early recovery, assist in

holding the individual accountable in their recovery, and assistance with lifestyle reconstruction and identity transformation (White et al., 2006). P-BRSS have been called 'guides,' 'sponsor,' 'navigators,' or 'peers' (Best, 2019). Not only does the peer relationship help those new to recovery, but it also has a beneficial impact upon the helper (Best, 2019)

Although many peer relationships form naturally and organically when looking to include peer workers within a treatment setting formally, it is important to discern who should occupy that role:

> It is not the experience of having been wounded or having transcended such wounds that constitutes a credential. It is the extraction of lessons from that experience that can aid others and a new ethic that transforms that learning into service to others. Experiential knowledge requires wisdom gained about a problem from close-up-first-hand versus second-hand knowledge. Experiential expertise requires the ability to use this knowledge to affect sustainable change in self or others. It requires the ability to separate the experience of the helper from that of the person being helped (White & Sanders, 2008).

There are challenges associated with implementing a P-BRSS in a treatment program. SAMHSA (2012), recognizing this, developed some guidelines, stating: one, that the process should be done with purpose and intention, methodically determining how the individual would fit into the organization, what roles they would occupy, and what are appropriate expectations of behaviour; two, it is important more than one peer be hired in a program, to not engage in tokenism; three, peers should report to a high-level manager to allow any problems that arise to be addressed quickly and to improve the incorporation of the peer into the agency; four, peers should make a living wage; five, it is important to train these peers to equip them to do their work safely and effectively. When the Pennsylvania Drug and Alcohol Coalition (2010) met,

they also highlighted the importance of resisting professionalization of peer roles and maintaining their 'peerness' while still preserving the quality of services provided.

***Suggestions for Union Gospel Mission***

1. UGM should consider the implementation of peer-based recovery support service in the Men's Recovery program. The peer could occupy a paid or volunteer position and be another support for the men in the program but function solely on a peer level.
2. When implementing a peer into the Men's Recovery program, the SAMHSA guidelines should be followed.
3. Use peers to help bring men to meetings, facilitate activities, follow up on graduates of the program, or engage in meaningful ways in the community (ex. cleaning up the street).

**Mutual-Aid Groups**

Mutual-aid groups are people in recovery who gather with the explicit purpose of supporting one another in their recovery. Although they can take many forms (SMART, Wellbriety), the most common is the Twelve Step groups, specifically Alcoholics Anonymous. Regarding the statistical impact of mutual aid groups (most often studied is AA due to how prolific the meetings are), it has been found that rapidly involving an individual beginning residential treatment into a recovery support group produces better long-term recovery outcomes than delayed connection (Moos & Moos, 2005). It has also been found that individuals who maintain involvement in mutual-aid groups in treatment have greater outcomes than those who do not (Moos & Moos, 2004; 2005), with benefits extending past their time in treatment, assisting in long-term remission of use (Moos & Moos, 2005).

However, there are high early dropout rates of individuals engaging in mutual-aid groups, ranging from 40-70% (Kelly & Moos, 2003; Moos & Moos, 2005). Recognizing that for some,

mutual aid groups are not how they chose to engage in recovery, it is still necessary to recognize post-treatment engagement in recovery supports is essential for sustained recovery (White & Kurtz, 2006). Frequently, mutual-aid groups are the main form of support people receive post-treatment as they are often free of charge and geographically convenient (Kelly et al. 2006). Therefore, if clients can be connected, engaged and committed to a mutual-aid group, then it will significantly improve their chances of long-term sustained recovery (Moos & Moos, 2005).

When contemplating how to implement engagement in mutual-aid groups in a residential treatment program, Kelly & White (2011) have gathered a list of empirically validated suggestions:

1. Encourage the client to access a variety of recovery support groups and meeting formats.
2. At the treatment center, maintain a list of local peers engaged with various mutual aid groups who would be willing to transport and guide a client into their first meeting.
3. Assertively link clients entering treatment to mutual-aid groups as soon as possible, rather than delaying.
4. Matching clients to groups based on gender, age, attitude toward spirituality, smoking status, and drug choice.
5. Problem solving and resolving any obstacles that would inhibit participation, such as transportation or childcare.
6. Host on-site recovery support meetings at treatment facilities.
7. Facilitate engagement beyond meeting attendance, such as reading literature, getting a sponsor, initiating sober friendships, participating in social events such as dances and parties, and engaging in service work.

***Suggestions for Union Gospel Mission***

1. Currently, the Men's Recovery has one scheduled Twelve Step meeting a week. The literature suggests greater meeting attendance is beneficial for maintaining recovery, therefore increasing this requirement may be beneficial for the clients.
2. Create an expectation for clients to be engaging with outside meetings in communities they would eventually like to be a part of upon graduation. The literature suggests the meetings are most beneficial when there is a strong personal connection to the group.
3. Utilize a peer/alumnus to assertively link clients to various meetings in the area if they are unsure which meetings to attend.

**Recovery Plan**

Common within virtually all treatment centers is a treatment plan in which the client is assessed by a treatment professional, and specific goals are determined to assist the individual in their recovery. In a traditional treatment setting, often the relationships are psychotherapeutic, hierarchical, with an expectation that the care of the client falls on the professional and with the relationship being short-term and transactional (Kelly & White, 2011). However, within a recovery management model, the treatment plan looks slightly different and is called a *recovery plan* (White & Sanders, 2006).

The recovery plan is developed on the philosophy and principles of recovery coaches, described in another section, and is developed, implemented, evaluated, and refined by the client, not the professional (Borkman, 1997; Kelly & White, 2011). The plan is collaborative, where the client is empowered to assume responsibility for their recovery and long-term management. Instead of directing, the professional's goal is to provide support and guidance through the development of this plan, asking questions, challenging, and being curious, but not dictating it.

The plan should have a global perspective of the client's life, such as physical health, education, employment, finances, legal, family, social life, intimate relationships, and spirituality, with the explicit goals of reducing substance use problems (Borkman, 1997; Kelly & White, 2011). Pragmatically, the plan involves long-term goals of the client and short-term weekly goals that are revisited weekly. Often the plan will change as the client moves through their recovery, gaining recovery capital (Kelly & White, 2011). The recovery coach's goal with following up on these plans is to hold the individual accountable and to help the client overcome barriers when they encounter them (Loveland & Boyle, 2005).

***Suggestions for Union Gospel Mission***

1. All recovery coaches and counsellors should be trained in the philosophy behind the recovery plan, how to use them, and ways to empower clients to develop a realistic plan effectively.
2. UGM should develop a standard 'Recovery Plan' template for ease of use with clients. It should be structured enough to encourage the client to contemplate all the following areas: their physical health, education, employment, finances, legal, family, social life, intimate relationships, and spirituality; and provide guidelines on weekly goals and long-term goals. It should also be flexible enough to allow for the client's unique recovery experience to be addressed.

**Promote the Benefits of Wellness and a Healthy Lifestyle**

The recovery management model suggests included programming for individuals seeking recovery on a wide range of wellness and lifestyle choices, providing ample opportunity to practice them (Kelly & White, 2011). Programing should include some of the following: education on diet and recovery, psychoeducation around exercise in addition to physical exercise

expectations, sleep hygiene, caring for mental health and how to address mental health concerns, involvement in social activities (such as picnics, barbeques, dances, workshops, etc.), and participating in sporting events (running a baseball team for example) (McQuaid, 2017).

It is also encouraged to offer supplemental classes that help clients develop healthy hobbies or engage in meaningful activities such as poetry, music, painting, cooking, carving, and dance. An essential part of helping individuals recover from substance abuse is developing a new identity not associated with using. Impacting a client's sense of identity is their involvement with meaningful activities (Best, 2019). However, many clients may need support and encouragement to pursue hobbies or meaningful activities due to low self-confidence or not have engaged with them for many years.

Additionally, reducing barriers for clients is crucial in early recovery to develop capital. Therefore, reaching out to professionals such as physiotherapists, massage therapists, dentists, hairdressers, opticians, financial advisors, or podiatrists who are willing to offer pro-bono work can assist in barrier reduction. Another suggestion is connecting with therapy animals that allow individuals access to pets for therapeutic purposes (McQuaid, 2017).

***Suggestions for Union Gospel Mission***

1. Introduce classes to the educational curriculum (especially within the program's stabilization component) that focus on sleep hygiene, nutrition and recovery, exercise and recovery, and mental health and recovery.
2. Build time outside of the classroom that focuses on fostering health and well-being, such as cooking healthy meals as a program together, introducing mandatory exercise (such as walking, yoga, gym, or running), the use of sleep logs (examining behaviours before bed and how they impact sleep), and mindfulness exercises.

3. Connect with Community Engagement department to build relationships with professionals willing to offer pro-bono services (ex. physiotherapists, massage therapists, dentists, hairdressers, opticians, financial advisors, or podiatrists) to help meet the needs of the men to remove barriers.

**Spirituality**

Spirituality, an essential component of human health, has moved to the wayside within North American culture. However, research has shown that spiritual health is an important aspect of recovery. Specifically, findings show that clients get value from services with a spiritual orientation regardless of their attitudes toward spirituality before seeking treatment (Arnold et al., 2002) and that spiritual experiences improve treatment outcomes (Sterling et al., 2006). In the Life in Recovery survey (McQuaid, 2017), 47% of responders said spirituality was an important part of their continued recovery, and 87% stated spirituality was a very important recovery support.

Therefore, when looking to assist individuals with long-term recovery within a recovery management model, it is important to encourage clients to foster a sense of spirituality and connect them with spiritual supports (McQuaid, 2017). This can be done by modelling healthy spirituality by staff and providing ample opportunities to engage their spirituality through workshops, studies, lectures, weekend retreats, and guided meditations. If working with an indigenous population, it is also crucial to offer culturally specific indigenous supports and resources, providing ample opportunity for individuals to connect with their native culture, assertively connecting when necessary.

***Suggestions for Union Gospel Mission***

1. UGM, being a Christian faith-based organization, holds spirituality and faith very central to the work it does. My suggestion to improve services would be to ensure faith remains at the center of the care provided by:
    a. Leadership fostering staff's personal faith and spirituality through structured and scheduled prayer and meditation times, in addition to group spiritual activities.
    b. Provide culturally sensitive spirituality. For example, creating opportunities for Indigenous clients to smudge or attend sweat lodges.

**Promote and Strengthen Social Relationships**

Crucial to long-term recovery are the people that surround an individual. That is why in a recovery management model, developing healthy and secure social relationships is considered an essential part of recovery. Research shows that when an individual completes treatment and returns to social groups who use drugs/alcohol, they are much more likely to return to abusing substances (Best & Lubman, 2017). Therefore, if long-term recovery is the goal, a change within the social network is required. However, Best and Lubman (2017) found that if an individual solely removes people from their social network and does not replace them with new, healthy relationships, it leads to higher rates of psychological distress and poorer self-ratings of social functioning. Therefore, they found it necessary for individuals in recovery to maintain the size of their social network but to transition from using friends to abstainers.

To help a recoveree critically evaluate their social network, Best et al. (2016) adapted the social identity mapping (SIM) model to the addiction recovery field. This model maps the individual's social network in a visual, allowing the recoveree to examine the people in their life, determining if they are safe for their recovery, risky for their recovery or somewhere in between.

Using it within a treatment context helps a client identify how connected or isolated they are and how sustainable their social networks are to support long-term recovery. Although changing social networks can be a very challenging task, it has been shown that those who have stable, consistent, and healthy social support (i.e., strong social capital) have a significant resource to draw upon to enhance and support their long-term recovery (Best et al., 2017).

McQuaid (2017) in their report states that increasing the frequency and opportunities for social engagement will result in greater social network transition. They encourage treatment centers to engage their residents within the community, intentionally connecting with non-users and those not involved with addiction or mental health. Strongly encouraged is volunteering (Sheedy & Whitter, 2006), and it is encouraged that treatment centers develop a volunteer program to help the recoveree healthily engage with society, develop essential skills, be an example of 'living proof' that people can be in recovery (i.e., fighting stigma), and provide a meaningful opportunity for the recoveree while also benefiting the community.

***Suggestions for Union Gospel Mission***

1. The Men's Recovery Program utilizes 'service assignments,' which currently are mandatory kitchen work. My suggestion would be to create a broader range of service opportunities, allowing more opportunities for the residents to engage in work they find meaningful. By broadening service assignment possibilities, it would expand the available social network the residents could engage with, for example, volunteering with different churches within the community, if they have specific skills finding ways to let them offer those skills to support UGM or volunteering in a social enterprise where they are developing new social connections while also learning business skills.

2. Developing a secure recovery-focused social circle is strongly encouraged through the literature and at UGM. However, according to the above literature, residents should also be encouraged and provided opportunities to engage with healthy people outside of the addictions and mental health field. Some examples could be joining a soccer team in the local league, a church small group, or a First Nations social group. Introducing social engagement as part of expected programming in later stages of the program may be beneficial.

**Inclusion of Individuals and Families**

Concerning social relationships, family is one of the most important and influential social relationships. Often not as simple as changing social networks, family ties are enduring, and if the family is unhealthy, it will make the transition to stable recovery challenging, if not impossible. Therefore, including family in the recovery of an individual should be a priority for treatment centers with a long-term recovery focus (Kelly & White, 2011; White, 2008).

The Native American Wellbriety Movement has a useful metaphor to describe treatment that does not include the healing of family/community alongside the recoveree. To not treat the whole family, they say, is analogous to digging up a sick tree, transplanting and nurturing it back to health, and then returning it to the same soil in which it became sick, assuming it will get better. There is the acknowledgement that a person is not separate from their family or community, and to treat one and not the other is counter-intuitive. Therefore, the Native American Wellbriety Movement calls for creating a "healing forest," through which a renewed community provides health for everyone in it (Coyhis & White, 2006).

Families exert significant influence on an individual's long-term recovery and, if not addressed, may inhibit the individual's likelihood of remaining in recovery. Research shows that

families high in criticism, hostility, codependency, and enmeshment are more likely to precipitate a relapse (O'Farrell et al. 1998). Additionally, frequent substance use within a living environment can negatively affect recovery efforts (Godley et al., 2005). Furthermore, the trauma of addiction can have lasting impacts on a family, and healing will most likely involve addressing the maladaptive relational dynamics that formed due to substance abuse (White & Savage, 2005).

Therefore, when looking to assist an individual in long-term recovery, a recovery management model strongly supports families' involvement in the recovery process. It is encouraged that the treatment center provides family counselling, relapse prevention training for couples, and psychoeducation for families on the realities of addiction (White, 2008; Kelly & White, 2011).

***Suggestions for Union Gospel Mission***

1. Currently, UGM Men's Recovery does not engage the client's family within treatment. Therefore, based on the above literature, I suggest developing programming that encompasses the family as part of the treatment and developing specific programming for the client targeting issues surrounding family matters.
2. Develop a standard set of questions to determine the individual's family situation and whom they are connected with, asking these questions at intake or within the first counselling conversation.
3. To provide family counselling to all willing clients within the Men’s Recovery Program.

**Recovery Coach**

A recovery management model strongly suggests using recovery coaches within a treatment setting to support clients (Kelly & White, 2011; White, 2008). Recovery coaching

(RC) is an intensive community-based case-management program designed to be a component of an addiction treatment program (Loveland & Boyle, 2005). A RC's goal is to help the recoveree find and access resources, empower and support them to determine their recovery plan, and assist in creating connections via assertive linking (Loveland & Boyle, 2005). Key aspects of a RC are: it is a voluntary service, where the recoveree's participation is self-motivated; time-unlimited, where the recoveree can continue accessing the RC even after dismissal from a formal treatment program and that the RC is actively involved in supporting the recoveree in the community; harm reduction approach, where the RC will continue working with someone in active addiction if that is the client's choice and not to sever the relationship upon relapse; and assertive linking, where it is the RC's responsibility to be personally connected within the community, aware of various resources and supports for recoverees and to make active connections with their clients when appropriate (Kelly & White, 2011; Loveland & Boyle, 2005).

Within a recovery management model, the benefits of staffing recovery coaches are recognized alongside the comprehensive services of an addiction's treatment facility (Loveland & Boyle, 2005). It is not suggested to replace addiction counsellors or other treatment providers with recovery coaches, but rather to create a system for them to work in tandem (Kelly & White, 2011; Loveland & Boyle, 2005; Sheedy & Whitter, 2006).

***Suggestions for Union Gospel Mission***

1. Recognizing that the Men's Recovery program staff both individuals trained in recovery coaching, counselling, and case management, it is suggested to create clear roles and expectations for both professions, identifying who is responsible for what.
2. I recommended that coaches be responsible for:
    a. Co-developing a recovery plan with the client.

b. Assisting the client with follow through on the plan, including assertive linking and resource navigation.

c. Providing specific recovery-focused case management for the client.

3. I recommended the counsellors be responsible for:

a. Providing counselling services, including trauma and family counselling.

b. Running and facilitating group counselling.

c. Providing specific workshops on mental health management.

**Asset-Based Community Development and Engagement**

As discussed in Chapter 2, asset-based community development (ABCD) is a strengths-based approach that aims to mobilize community resources to enable the community to meet its own needs. Asset-mapping helps identify and mobilize the community's various resources (that is, the people, the informal, and formal organizations) to create greater interconnectedness. Identifying and mapping the community's available resources can help a treatment center avoid duplicating services and foster better connections between clients and the community.

However, a criticism of ABCD is the practical challenge of engaging and connecting individuals to these resources and connecting the various resources together. For example, Vancouver's Downtown Eastside has a plethora of services tailored to help those experiencing homelessness and addiction. In this neighbourhood, there are many duplicate services, with many people in the community who access these services unaware of the range of services available. Although many 'asset maps' circulate within the neighbourhood, many service providers are unaware/unfamiliar with them and therefore cannot connect their clients to them.

Recognizing this reality exists in many other communities, Collinson and Best (2019) developed an asset-based community engagement (ABCE) model, building off ABCD, in an

attempt to change clients' experience of navigating these resources. They developed a workbook that provides a framework for assisting recovery support workers to work with individuals in recovery. The model has six stages, which are briefly mentioned below.

The first stage is to help the recoveree identify their current level of community engagement, focusing on four distinct areas: peers and mutual aid; sports, recreation, and arts; professional services and education; and employment and training. Once the individuals' personal map of engagement is understood, the second stage focuses on exploring these assets. Each asset's strengths and limitations are discussed using a traffic light system (red, yellow, green) in four categories: affordability, accessibility, connectedness, and social network. See the figure below for an example:

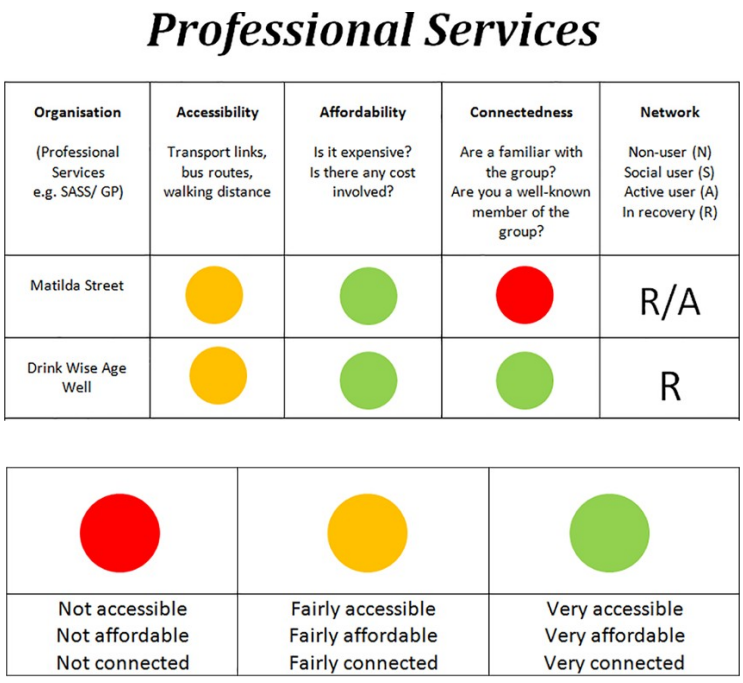


**Figure 2: Taken from Collinson and Best (2019)**

The third stage of ABCE would be to explore the individual's interests, supporting them to engage with people and places they would like to become engaged with and what they find meaningful. This process can empower an individual in early recovery as it can help them

recognize their potential to connect with these assets and remind them of their passions, skills and desires, which their commitment to may have been damaged by their substance abuse history.

The fourth step is identifying barriers that may hinder willingness to engage with these assets. Although the individual may have identified interests and passions, they believe are important to their recovery, they will likely not engage with these interests until barriers that have previously stopped them from engaging are addressed. Some common barriers include illness or disability, loss of contact to social connections, an absence of a supportive community, unavailability of transportation, fear of social rejection, and feelings of stigma. It is essential to address these barriers first before attempting to connect and access the community resources. Barriers may be addressed through counselling, providing access to resources (such as transportation or childcare), or going with the recoveree to the community resource to support them through the fears and insecurities that may exist.

The fifth and sixth step would be to use assertive linking by the individual supporting the recoveree. Collinson and Best (2019) describe these people as recovery navigators and community connectors who know where to find information regarding the community's assets and have a healthy relationship with the recoveree. They are to be active in engaging the recoveree in employing their ABCE plan, assertively connecting them when necessary, and seeking additional support when unaware or uncertain of a specific community resource.

***Suggestions for Union Gospel Mission***

1. After the client has had an adequate amount of time to stabilize within their recovery, I would suggest introducing asset-mapping as a mandatory component of the treatment

program. In partnership with their recovery coach, the individual would develop an asset-map, using the process and steps developed by Collinson and Best (2019).

**Aftercare**

One element that is a fundamental defining feature of a recovery management model within a recovery-oriented system of care is the focus on aftercare, which is the care that follows in the weeks, months, and years after in-patient treatment. There is such a strong emphasis on aftercare because recovery begins within a treatment context in an artificial environment where many factors are controlled, but recovery maintenance is only achieved in one's natural environment (White, 2008). The research supports this in recognizing that aftercare has a more significant influence on long-term recovery outcomes than social supports or treatment length (Ritsher et al., 2002), yet only one in five clients receive aftercare (McKay, 2001).

Additionally, a study found that the beneficial effects of in-patient addiction treatment diminish over time and that there is a high rate of relapse upon completion (McKay & Wiess, 2001) and that most people in recovery are precariously balanced between recovery and relapse during the first four to five years of recovery (Sheedy & Whitter, 2006; Kelly & White, 2011). It is also understood that post-treatment mental health problems increase in the first one to three years of recovery (Dennis et al., 2007). Therefore, the period following treatment is a vital phase for any recoveree, and there should be a strong focus for providing continued support. Unfortunately, this is often not the case, and most individuals are inadequately prepared in their transition from supported in-patient addictions treatment to complete independence with little to no support.

Therefore, the recovery management model dictates that post-treatment support should be incorporated into every treatment program to create the best possible environment for long-term

recovery. Within the recovery management model, aftercare is provided to all clients, not those successfully completing the program (White, 2008). The responsibility to connect is placed on the staff, not the client, as is not often the case for treatment centers (Kelly & White, 2011). Additionally, support is tapered, meaning that regular and consistent contact is established, maintained and followed through with within the first 90 days following discharge, and as time goes on, the frequency decreases but remains consistent for the years following (White, 2008; Kelly & White, 2011). Not all clients will require the same level of support, as those low in recovery capital and high in problem severity will require more intensive aftercare support than those who have higher recovery capital and less severe substance abuse problems (Sheedy & Whitter, 2006).

The aftercare offered can be varied, from in-person meetings in the client's community or treatment center, through telephone or video call, or by text or email (Kelly & White, 2011). A study by Horng and Chueh (2004) found that regular brief 15-minute telephone calls positively impacted abstinence rates, reduced heavy drinking, postponed and shortened relapses, and reduced the need for further in-patient treatment.

One successful model for implementing this aftercare telephone delivery service was through using trained volunteers. These volunteers were sometimes peers in recovery who would call graduates of an in-patient treatment program for 90 days following their discharge. In this particular study, the individuals received an average of four calls over the 90 days, but 29% of graduates received ten or more calls. They found that after 90 days, 78% of graduates maintained sobriety, and many reported looking forward to their call and had built up relationships with the volunteers (McKay et al. 2005). This intervention's effectiveness is just one example of how a successful aftercare system can be developed without extensive resources.

Development and fostering of alumni associations is another intervention to provide aftercare and foster community inclusion (Sheedy & Whitter, 2006). When implementing these associations, individuals upon graduating can access alumni services and may include group activities (ex. hiking), alumni AA meetings, organizing volunteer or charitable events, running groups/meetings for individuals currently in treatment, and offering themselves as twelve-step sponsors.

When looking to implement an aftercare program into a treatment center or further develop an already existing one, Kelly and White (2011) have collected a list of suggestions briefly mentioned below:

- Engage all clients/families in the aftercare, not just those who successfully "graduate."
- The responsibility for post-treatment contact lies with the treatment center, not the client.
- Involve both scheduled and unscheduled contact
- Recognize the first 90 days following treatment are the most vulnerable, as well as the days and weeks following significant life events (such as the death of loved ones, new job, or moving) and to increase check-ups during these times.
- Titrate the duration and frequency of check-ups based on a client's problem severity and amount of recovery capital
- When connecting, utilize assertive linkage rather than passive referral to community resources.
- Employ a wide range of mediums of connection: face-to-face contact, telephone, video call, text, and email

- Encourage connection with supports in their natural environment
- May be delivered by counsellors, recovery coaches, or trained volunteer recovery support specialists.
- Have each client assess their own post-treatment relapse risk level (which is more predictive of actual risk than counsellor predictions).
- Give each client choices related to continuing care options and arrange continuing care in congruence with these choices.
- Involve family members in the continuing care planning process.
- Extend post-treatment monitoring and support (to include at a minimum an annual recovery check-up) to at least five years following discharge from primary treatment.
- Target those who experience the highest level of craving during treatment for the most extended and intense levels of continuing care services.
- Utilize financial incentives to enhance linkage from in-patient to outpatient treatment.
- Conduct relapse prevention training in a group-based continuing care format.
- Use behavioural contracts and calendar prompts to increase participation in continuing care groups
- Actively resolve barriers to participation, including the need for transportation, the need for child care, and scheduling conflicts.6
- Increase the use of recovery homes and other sober transitional living environments
- Conduct quarterly post-treatment recovery management check-ups.6
- Provide case management as an alternative to traditional aftercare
- Provide structured substance-free leisure activities for alumni

- Provide couples relapse prevention sessions over the year following discharge from primary treatment

***Suggestions for Union Gospel Mission***

1. Out of all the proposed suggestions within this paper, I believe developing an effective aftercare program at UGM is the most important and will have the most significant impact. Currently, very little structure is in place to support individuals who leave or graduate from the program other than an alumni association.
2. My recommendations would be to follow the suggestions made by Kelly and White (2011). Specifically, I suggest creating structure around follow-up conversations within the first 90 days upon leaving the program. Recognizing that staff time is limited to attending to the program's residents, I would suggest training and employing peer volunteers to have follow-up conversations, similar to McKay et al.'s study (2003). I would also encourage leadership to modify all program staff's roles to encompass engaging in aftercare and ensure adherence through supervision.

**Sober-Living Communities and Social Enterprise**

In the pursuit of helping individuals achieve long-term recovery, there is evidence that enmeshing clients with high problem severity and low recovery capital within sober living communities can dramatically enhance long-term recovery outcomes (Jason, et al., 2001; Sheedy & Whitter, 2006). The Oxford Houses provide a great example. These houses are peer-led and abstinence-based and offer a recovery-focused living environment. As of 2016, there are over 2,100 Oxford homes in the U.S. and others in England, Australia and Canada (Oxford House, 2016).

Each Oxford House operates independently and is financially supported by its residents without any professional staff or external oversight (Jason, Davis, Ferrari & Bishop, 2001). Each Oxford House is run democratically and has an elected role such as a president, treasurer, accountant, coordinator, and secretary. Each position may only be held for six months and then rotated so that all residents have a chance to take on different leadership roles. The houses' rules are simple, stay abstinent, participate in house governance, pay rent, and complete all assigned chores. Research shows that living in Oxford Houses is associated with benefits for residents, such as lower substance use, higher monthly income, and lower incarceration rates (Jason and Farrari, 2010; McQuaid, 2017).

David Best (2019) also references a unique social enterprise named Jobs, Friends, and Houses (JFH). The aim of this was to create a successful business that supported individuals in recovery to pursue secure, supportive jobs in the construction industry. The JFH's business would build and renovate homes, sell some for-profit and funnel the money back into the business, and rent others out as recovery homes. The social enterprise was led by a group of trained professionals (electricians, carpenters, plumbers etc.), and the individuals in recovery would work underneath them. If the recoveree showed aptitude and a desire to learn more, they would be encouraged and supported to pursue further education in the trade. As JFH grew, it developed an extensive network of recovery homes, providing a positive atmosphere of connection, support, and respect for the recoverees. Best (2019) found that the social networks of recoverees in the program grew, that they developed a strong/healthier self-identity, it gave them a sense of purpose and meaning, involvement in the program developed hope, and participants were more likely to stay abstinent and not involved in the criminal justice system.

### *Suggestions for Union Gospel Mission*

1. Although not the only example, Jobs, Friends, and Houses is a successful blend of social enterprise and sober-living communities. UGM and the Men's Recovery Program's effectiveness certainly benefit if it developed a social enterprise, a sober-living community, or a program similar to Jobs, Friends, and Houses.
2. One of the main concerns for many residents within the Men's Recovery program is the treatment center location, located amid the DTES, a very tempting and challenging location for individuals in recovery. If sober-living communities were developed outside of the DTES, it would provide a stable and healthy living environment with the possibility of effective aftercare, which according to the research, would significantly improve outcomes of long-term recovery.

## Measurements and Assessments

Within a recovery management program, the focus on long-term recovery, empowering the client, and utilizing a strengths-based approach, should influence all program elements, including measurements and assessments. In traditional treatment, clinical assessments often look only at the client in the light of their substance abuse and are often pathology-focused. In recovery management models, assessments are holistic (focused on the whole life of the recovering person), asset-based (focused on what resources they already have – i.e., recovery capital), and is continual throughout the service relationship (White et al., 2006).

However, a recovery management model does not dissuade the use of assessments and measures to assess clients in their recovery but instead believes assessments should be done on an ongoing basis throughout the treatment process to highlight the client's change and growth. Some examples of measures that a recovery management model endorses include global

assessments such as the Addiction Severity Index (ASI) or the Global Appraisal of Individual Needs (GAIN), strengths-based assessment process such as the ETP Strengths Assessment (Kelly & White, 2011).

Additionally, the Recovery Capital Assessment (REC-CAP), discussed in depth in chapter two, has been empirically validated as a valuable tool for measuring a client's recovery capital (Cano et al., 2017). This measure assesses the quality of life and satisfaction in five well-being areas: psychological health, physical health, quality of life, accommodation, and social support. Barriers to recovery are also assessed in five areas: accommodation, substance use, risk-taking, offending, and employment. REC-CAP is intended to be a tool to engage clients in a strengths-based pursuit of overcoming barriers and capitalizing on their strengths, in addition to assessing their capacity to sustain recovery.

***Suggestions for Union Gospel Mission***

1. UGM Men's Recovery program at this time does not have any formal assessment tools that it uses to assess clients at any stage through the program. My suggestion is to implement empirically validated assessment tools for use throughout an individual's time in the program. Although many tools exist for this purpose, the one that appears to fit UGM’s needs best and uphold the values of Recovery Management is the REC-CAP. It was developed to assess the client, provide direction, and is done over time so they may see their growth and recognize their barriers. I recommend using this tool at the beginning of treatment, halfway through, upon completion of the program, and every six months afterwards for a period of up to four years, as recommended by Best et al. (2016) and Best (2019).

## Conclusion

This chapter explored the literature on how to implement recovery-oriented systems of care and recovery management model within an addictions treatment setting. Specific suggestions were made to Union Gospel Mission's Men's Recovery program to introduce some of the concepts to improve service delivery and outcomes. The suggestions made are not intended to be thorough and comprehensive but rather are intended to stimulate discussion and vision. Throughout the literature, no program implements a recovery management model or a recovery-oriented system of care the same way, as each agency holds different values, philosophies, and engages with different clientele. By adopting a recovery management model and working to operate within a recovery-oriented system of care, the intention is not strict universal adherence but instead to critically examine what currently exists, examine alternatives, and make changes to better support clients' long-term recovery within the agency and greater community.

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