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The Role of Clinical Supervision in Recovery-oriented Systems of Behavioral Healthcare
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[1] The Philadelphia Clinical Supervision Workgroup was appointed by the Philadelphia Department of Behavioral Health and Mental Retardation Services staff to collaborate in creating a vision of clinical supervision within the behavioral health systems transformation process that is underway in Philadelphia. This first paper focuses specifically on clinical supervision in addiction treatment settings and the Workgroup includes clinical supervisors representing different modalities and levels of care of addiction treatment.

Introduction

Converging paradigmatic shifts are underway in the field of addiction treatment and the broader arena of behavioral health care. First, there is a shift in emphasis from pathology to the pathways and processes of long-term recovery (White, 2004b, 2005). Second, there is the complimentary call for the redesign of addiction treatment from a model of acute care (biopsychosocial stabilization) to a model of sustained recovery management (recovery consolidation, monitoring and maintenance). This latter shift is evident in calls for models of chronic disease management (O'Brien & McLellan, 1996; McLellan, et al, 2000; Watkins, et al, 2003), extending case monitoring (Stout, et al, 1999), recovery management (White, Boyle & Loveland 1998, 2002; Dennis, Scott & Funk, 2003; White, Kurtz & Sanders, 2006), concurrent recovery monitoring (McLellan, et al, 2005), assertive continuing care (Godley, Godley & Dennis, 2001), adaptive treatment protocols (McKay, 2005), and a resiliency, wellness and recovery model (Flaherty, 2006). Viewed collectively, these reflect efforts to transform addiction treatment into a "recovery-oriented system of care."

The paradigm shifts being advocated involve dramatic changes in addiction treatment services philosophies, service technologies, service roles and relationships, and the relationship between service organizations and other community recovery support resources. There is little within the existing system of addiction treatment that will not be challenged in the coming decades as new service roles (recovery coaches, recovery support specialist, personal recovery assistants) and recovery support organizations (community recovery support centers) emerge and stand-alone levels of care become obsolete within the transformed world of addiction treatment (White, 2005, 2006; Compton, Glantz & Delaney, 2003).

These changes will exert a profound influence on the importance and design of clinical supervision in addiction treatment organizations. The goals of this article are to:

1. define recovery-focused supervision
2. identify the core principles upon which this style of supervision is grounded
3. describe changes in the structure and process of clinical supervision that occur within recovery-oriented systems of care, and
4. explore how recovery-focused supervision changes staff relationships with their clients and the community.

This paper integrates national and local perspectives. The lead author (White) has, in his role as recovery historian, advocate and researcher, aggressively promoted the shift toward more recovery-oriented systems of care, and has consulted with federal, state and local agencies to facilitate technical aspects of this transformation. The second author (Schwartz) has, in his role as the Clinical Director of Dawn Farm, been at the forefront of implementing this paradigmatic shift within a long-standing, community-based treatment organization in Ann Arbor, Michigan. The members of the Philadelphia Clinical Supervision Workgroup (PCSW) are clinical directors and supervisors from addiction treatment programs located in the Philadelphia metropolitan area appointed by the Department of Behavioral Health and Mental Retardation Services to explore the role of clinical supervision in creating a more recovery-focused behavioral health care system in the City of Philadelphia. Workgroup members represent multiple levels of care including therapeutic communities and methadone maintenance programs and adult and adolescent treatment programs. The experiences of Dawn Farm, selected Philadelphia-area treatment programs and other recovery management pilot sites will be used as learning laboratories from which we will illustrate key points in this paper. Toward that end, we will briefly profile Dawn Farm, and the behavioral health "system transformation" that is underway in Philadelphia.

Dawn Farm is a therapeutic community in Ann Arbor, Michigan founded by two recovering addicts in 1973. Although the founders had strong ties to the recovering community and the larger community, Dawn Farm became progressively isolated and developed increasingly hierarchical relationships with its clients. Over a span of two decades, Dawn Farm became:

- pathology-focused (delving deeply into an ever-ending list of client problems)
- preoccupied with power and control (via preoccupation with rule enforcement and power struggles that resulted in high rates of premature self-discharge and disciplinary discharge),
- family aversive (assuming based on years of experience with very toxic families that all clients needed to be protected from their families), and
- arrogant, condescending and aloof (e.g., shaming returning clients for relapsing, conveying to the recovery community that treatment was more important than peer-based recovery support, undermining the service roles within the recovering community by absorbing sponsorship functions).

One of the earliest turning points in this history involved Dawn Farm's experiment with transitional housing in the late 1990s. Sober housing was provided without any treatment, but with the expectation that residents would work full-time, pay rent, live within basic house rules and attend recovery mutual aid meetings on a daily basis. It became evident over time that many transitional housing clients were achieving a more solid and sustainable recovery than people who were receiving long-term residential treatment at Dawn Farm. This led to Dawn Farm undertaking a "fearless and searching" inventory of its philosophies and clinical practices. The result was a refocused mission, a new treatment philosophy and significant changes to clinical practices and clinical supervision, and a radical reconstruction of Dawn Farm's relationships with its service consumers, with the recovery community and with other helping organizations.

In 2004, Dr. Arthur Evans was appointed the first director of the newly created Philadelphia Department of Behavioral Health and Mental Retardation Services (DBH/MRS). Following extensive dialogue with community stakeholders, a decision was made to embark on a sustained process of "systems transformation" that would reshape DBH/MRS into a system that was recovery-oriented, client/family-driven, holistic, culturally competent, trauma-informed and evidence-based. DBH/MRS created a Recovery Advisory Committee and entered into partnership with its treatment providers, local recovery advocacy organizations and the faith community to reshape behavioral health services. Those partnerships are fundamentally redefining the conceptual premises, management practices and service technologies for DBH/MRS and local behavioral health care providers in Philadelphia. This system transformation process has been detailed in two recently published documents: *Recovery-Focused Transformation of Behavioral Health Services in Philadelphia: A Declaration of Principles and a Blueprint for Change* (2006) and *An Integrated Model of Recovery-Oriented Behavioral Health Care* (2006). In the spring of 2006, DBH/MRS established a clinical supervision work group to explore changes in clinical supervision that will need to occur as part of the systems transformation processes in Philadelphia. The highlights of workgroup discussions are reflected throughout this paper.

Defining Recovery-focused Clinical Supervision

Clinical supervision as we once knew it is now almost non-existent.
--Long-tenured Clinical Director

The supervision of frontline addiction service professionals (counselors and other direct service staff) has historically involved two quite different functions: clinical supervision and

administrative supervision. Lindbloom, Eyck and Gallon (2003) distinguish these functions as follows:

> *Clinical supervision emphasizes improving the counseling skills and effectiveness of the supervisee. Administrative supervision emphasizes conformity with administrative and procedural aspects of the agency's work.* (p. 22).

Considerable tension exists between the demands emanating from these two spheres of supervisory activity. A single person usually performs both of these functions, and demands in both of these areas have increased exponentially in recent decades (Dixon, 2004). As a result, front line clinicians and supervisors alike report that clinical supervision has been hijacked by financial (e.g., negotiating with managed care gatekeepers), regulatory (e.g., keeping up with documentation), and administrative (e.g., attending meetings) demands (Durham, 2003). These escalating demands on treatment programs are a product of redundant accountabilities to federal, state, county, city and private regulatory bodies that produce an exponential growth in standards and monitoring site visits. Clinical directors and supervisors report that pockets of high quality clinical supervision continue to flourish, but that they now represent the exception. There is no consistent structure of clinical supervision within the field or even across programs within the same treatment organization. Other factors that have compromised the quality of clinical supervision include concurrent demands for supervisors to carry clinical caseloads and the demands to perform clinical duties when counselors are absent for vacation, illness, medical leave, training, or resignation. Retaining and developing staff is particularly challenging in such historically stigmatized treatment modalities as methadone maintenance clinics.

In the wake of such demands, supervisors and clinicians report feeling like they have become people and paper processors and that it is getting harder to feel good about what they are doing in their professional lives. They express fears that even the collective memory of client-focused care and quality supervision will be lost as this generation of long-tenured supervisors and clinicians ages out of the field. What we will describe here as recovery-focused clinical supervision is not possible without providing clinical supervisors relief from these administrative demands and renewing the focus on service relationships and service outcomes in addiction treatment.

As a field, we are calling for services that are developmentally appropriate, gender specific, family centered, culturally competent, trauma-informed, strengths-based and evidence-based (to name just a few). The call for recovery-focused clinical supervision could be experienced as one more faddish demand placed upon already over-burdened service roles, or a framework for integrating many of these recent initiatives and a means of recapturing the importance and integrity of clinical supervision within addiction treatment. It is our hope that it will be the latter.

> ***Recovery-focused clinical supervision*** *(RFCS) is the process through which a clinical supervisor assures that services to AOD-impacted individuals, families and communities are directed toward their ultimate goals: the permanent resolution of AOD problems and the enhancement of global health and functioning. The mechanisms through which these goals are achieved include program development; staff recruitment, orientation and training (knowledge, skills and attitudes); modeling core recovery values; case consultation; fidelity monitoring; performance evaluation; liaison with community recovery support resources; and program evaluation and policy advocacy.*

Success in RFCS is measured by the degree to which the service activities of supervisees result in intermediate and long-term recovery outcomes for the individual, family and community. Short-term outcomes for the individual and family include such elements as early identification,

engagement, biopsychosocial stabilization, recovery initiation, and assertive linkage to communities of recovery. Long-term outcomes are focused on two non-negotiable goals: 1) the sustained reduction and resolution of AOD problems and 2) enhancement of each client and family's global health and functioning. Global (whole) health is measured along such dimensions as physical health, emotional health, the stability and quality of family and peer relationships, the safety and comfort of one's living environment, positive community participation, and life meaning and purpose. In short, global health embraces the whole person/family, including the causes and effects of illness. Short-term outcomes for the community include relationship building between the treatment institution and indigenous communities of recovery, identification of existing recovery support resources, and recovery resource needs assessment. Long-term outcomes include recovery community mobilization, expansion of local recovery support resources, reductions in social stigma attached to recovery and the expansion of the physical, psychological and social space where recovery can flourish.

The focus of RFCS is on building recovery capital[2] in the individual, family and community. Recovery capital constitutes the internal and external assets that one can draw upon to initiate and sustain recovery and achieve a meaningful life in the community (Granfield and Cloud, 1999). RFCS 1) directs attention beyond the achievement of professionally-guided acute biopyschological stabilization toward the processes of client-directed recovery consolidation and sustained recovery self-management, 2) extends the focus of services beyond the individual to the family and social network and larger cultural community, and 3) integrates clinical models of intervention with models of cultural renewal and community organization/development. RFCS is an attempt to respond to what we believe are justifiable criticisms, that addiction treatment has become disconnected from the larger and more enduring process of addiction recovery, and that addiction treatment institutions have become disconnected from the grassroots communities (and local communities of recovery) out of which they were born (White, 2001; White & Hagen, 2005).

Foundational Recovery Principles: Implications for Clinical Supervision

Recovery-focused clinical supervision (RFCS) is grounded in a number of core principles about the nature of recovery from severe AOD problems and the role of professionally-directed treatment in that resolution process.[3]

There are multiple pathways through which AOD problems can be resolved. These pathways span diverse:

- religious, spiritual and secular frameworks of recovery and their corresponding mutual support structures
- catalytic metaphors (key words and ideas that spark recovery initiation)
- degrees of recovery (partial, full, transcendent)
- methods of recovery initiation and maintenance (abstinence-based, moderation-based, medication-assisted; solo, peer-assisted, professional-assisted)
- differing relational styles of interacting with other people in recovery (acultural, bicultural, and enmeshed), and
- varying identity adaptations to the recovery experience (recovery positive identity, recovery neutral identity, recovery negative identity) (See White & Kurtz, in press for a review).

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[2] Recovery capital is the total internal and external assets that an individual can mobilize to initiate and sustain recovery (Granfield & Cloud, 1999).

[3] For an elaboration of the recovery-related research upon which these principles are based see White & Kurtz, 2006.

This principle calls for the extension of the counselor and clinical supervisor's expertise from a focus on addiction and treatment processes to an in-depth understanding of long-term recovery processes. One of the most significant implications of this understanding is the need for the clinical supervisor to enhance each counselor's understanding of recovery pathways and to utilize this knowledge within highly individualized service planning and delivery processes.

Pathways and styles of AOD problem resolution are greatly influenced by the interaction of problem severity and recovery capital. The need for professionally-directed treatment and sustained recovery supports rises in tandem with increasing problem severity/complexity/chronicity and decreasing recovery capital. Persons with lower problem severity and higher recovery capital may resolve AOD problems without formal peer/professional assistance or with brief models of such assistance, and are often utilize moderation-based approaches to problem resolution. Individuals with high personal vulnerability, high problem severity and complexity, and low recovery capital (the dominant profile of people entering addiction treatment in the United States) often require abstinence-based models of treatment and systems of sustained peer-professional recovery support. This principle calls for a thorough assessment of recovery capital, level of care placement decisions that factor the interaction of problem severity and recovery capital, and a potential shift in focus from decreasing pathology to increasing recovery capital. RFCS helps staff keep their eyes on the prize. The ultimate goal is not treatment: it is sustainable recovery.

Pathways and styles of recovery differ significantly across developmental experience, primary drug, developmental age of recovery initiation, gender, culture and degree of cultural affiliation and the presence and severity of co-occurring problems. Individuals often combine words, ideas and rituals from multiple sources to construct a personally and culturally congruent style of recovery. This principle provides the framework to integrate other initiatives within RFCS (e.g., cultural competence, gender-based treatment), while focusing these efforts specifically on those service adaptations that have significance for recovery outcomes.

Acute biopsychological stabilization in and of itself is not a predictor of recovery outcome; serial episodes of such stabilization are as likely to be milestones in one's addiction career as milestones of recovery initiation. RFCS helps service workers transcend the demands of detoxification and chaos management posed by each client to find windows of opportunity for entry into sustainable recovery. RFCS helps staff define their roles within recovery processes (and sometimes multiple treatment processes) that span years, as an alternative to a narrow focus on a prescribed set of activities that must be completed in a set number of days or sessions.

Short-term behavioral compliance with treatment protocol is enhanced by external coercion; long–term recovery outcome is enhanced by choice and commitment. Treatment can be coerced, but sustainable recovery is by definition a voluntary process. Supervisees inevitably drift toward a focus on pathology and preoccupations with coercion and control (particularly during periods they are experiencing high stress and diminished support or during periods of rapid turnover of clients). One of the key functions of the recovery-focused supervisor is to continually help supervisees re-shift their focus from pathology to strengths, control to support, frustration and anger to re-engagement and encouragement. Recovery involves a rehabilitation of the will; client choice and feelings of personal self-efficacy enhance the strength, durability and quality if life in recovery.

Long-term recovery outcomes can be enhanced by unique combinations and sequences of services that generate synergistic or cumulative effects on recovery initiation and maintenance Anglin, Hser, & Grella, 1997; Dennis, Scott, Funk & Foss, 2005). All approaches to addiction treatment and all recovery support frameworks have persons who fully respond, partially respond or do not respond to their respective approaches (Morgenstern, Kahler, Frey & Labouvie, 1996). This principle suggests the need for clinicians to look beyond their particular type of service or level of care toward constructing potent, personally matched service combinations and sequences. This requires seeing treatment episodes not as discrete events

that succeed or do not succeed, but as steps in the search for a match between person and recovery priming ingredients.

All recovery-focused services hinge on effective engagement: The service RELATIONSHIP is the foundation of recovery-oriented systems of care and all clinical and non-clinical recovery support services. Everything we are able to help each client achieve is contingent upon sustaining an empathic relationship. Recovery-focused treatment is about engagement, engagement, engagement. The process of engaging and motivating each client is a continual one, as the strength of our service relationships and each client's motivation for recovery ebbs and flows. At a practical level that means that every contact with a client is about re-engagement and re-motivation. Our degree of effectiveness with this task is measured at the most basic level by our ability to enhance service retention rates, lower rates client-initiated disengagement from services and lower rates of administrative discharge (see White, Scott, Dennis & Boyle, 2005).

Community is the ultimate healing agent, not treatment. Where communities have been so wounded that they lack such healing powers, efforts must be undertaken to find, awaken and help actualize the hidden resiliencies within those communities. Some think of this as treating the soil in which addiction flourishes (Coyhis, 1999). The primary role of treatment is to remove the personal and environmental obstacles that prevent this connection to a recovery-supportive community and to participate in building such communities where they do not yet exist.

The greater the physical, psychological and cultural distance between the treatment center and each client's community, the greater the problem of transferring learning from the institutional to the natural environment. Recovery is not viable until it has been anchored within the life of the community. At its most practical level, this requires knowledge (on the part of the counselor and the supervisor) of each client's recovery environment, linkage to supports within the client's natural environment and continued monitoring and support of each client within his or her natural environment. It could also involve working with the client to develop a more recovery-conducive environment.

Practice Changes in Recovery-Focused Clinical Supervision

In this section we will provide an overview of the changes in clinical supervision necessitated by the shift from an acute care (AC) model of addiction treatment to a sustained model of recovery management (RM). Those changes will focus on twelve dimensions: client engagement and motivation, screening and assessment, service planning and coordination, service goals and focus, service relationship, role of the client, service team, counseling and treatment, locus of services, duration of services, discharge and "aftercare" services; advocacy and recovery community development (White, Boyle & Loveland, 2002).

Client Engagement and Motivation

RM models emphasize the importance of early engagement via community screening and assertive approaches to outreach and sustained motivational enhancement. These strategies are based on several assumptions.

- *Early intervention into chronic diseases can shorten the duration and intensity of the disorder*; the earlier the age and stage at which treatment begins, the shorter the addiction and treatment careers and the longer the recovery career (Dennis, Scott, Funk & Foss, 2005).
- *Neurological impairments compromise choice-making abilities during active addiction and early recovery, increasing relapse risks*. This hijacked reward system, which imposes a higher value on compulsive drug use than on other human needs and values, continues into the early stages of recovery and raises the risk of treatment disengagement and resumption of AOD use. The health of

this reward system can be buttressed by pharmacological adjuncts, professional counseling and recovery peer support until such time as the client's capacities for healthy choice-making are restored or developed (Dackis & O'Brien, 2005; Shaman & Hope, 2005).

- *The primary responsibility for initiating motivation for recovery and sustaining that motivation during the earliest stages of recovery lies with the treatment staff, not the client.* RM models emphasize the existence of developmental windows of opportunity for change ("teachable moments"), priming motivation for recovery where none exists, and the catalytic power of mobilizing recovery capital within the client's family/social network.
- *Hope is the key.* Recovery initiation is often a synergy of pain and hope, but experienced or threatened pain in the absence of hope cannot sustain recovery initiation. RM models emphasize the importance of hope in the recovery process via empathy, rapport, encouragement and exposure of each client to recovery role models with whom he or she can identify.
- *Client motivation, like staff motivation, ebbs and flows and must be actively managed.* Both must be actively managed through the process of clinical supervision.
- *Transformational change (recovery that is unplanned, sudden, positive and permanent) is possible among clients with even the poorest prognoses.* Bill Wilson (co-founder of AA) and Mrs. Marty Mann (Founder of the National Council on Alcoholism and Drug Dependence) had ten prior treatments between them before each underwent a profound breakthrough experience during treatment that launched their successful recoveries and their historical contributions that have touched millions of lives (White, 2004c).
- *Engagement strategies must be refined for historically marginalized populations.* Outreach workers (cultural guides) nestled within natural environments and using non-traditional approaches can facilitate identification, screening and service linkage and retention (White and Sanders, 2006)

These understandings have several implications for clinical supervision. At a programmatic level, attention is given to relationship building with early identifiers: families, clergy, physicians, indigenous caretakers, and other helping professionals. Where formal and assertive approaches to outreach are used, several issues are critical in supervision, from the safety of outreach workers to processing such questions as, "When does "no" really mean "no"!? When do you give up for the time being? When should we check back with someone who cannot be engaged at this moment? A crucial question is: What sustains the motivation of the outreach worker to maintain contact with the prospective client during pre-action stages of change? The answer is the encouragement and support of the supervisor, who must serve as a cheerleader in this difficult, early engagement process. The ability of the supervisor to empathize with his or her supervises and their emotional reactions to difficult-to-engage clients is the foundation upon which effective outreach is built and sustained.

Once initial contact with clinical staff is possible, great emphasis is placed in the engagement process (empathy, rapport), relationship building skills, and strategies for identifying and managing mutually self-defeating styles of interaction between counselors and clients. Key supervisory strategies to facilitate this is to establish clear expectations for the values that guide staff interactions with clients (courtesy, respect, helpfulness, friendliness) and immediately confront behaviors that convey disregard and disrespect. Training in stages of change models, motivational enhancement therapies & strengths-based counseling and incorporating principles from these approaches within clinical supervision sessions are highly recommended. Clinical supervision in recovery-focused systems of care shifts the focus from

the diagnosis of pathology to identifying and enhancing each client's internal and external recovery capital. Training related to transformational change can help staff recognize such experiences and prevent them from intervening in ways that could abort what could otherwise be a life-changing breakthrough.

Supervisors can also use the phenomenon of parallel process by modeling the core values and behaviors they wish to see within client service relationships in their own relationships with supervisees. This focus on engagement and relationship maintenance also means greater explorations of transference and counter-transference issues during clinical supervision sessions.

In recovery-oriented systems of care, the focus in supervision of the engagement process shifts from the mechanics of the intake process to the development of a strong service relationship and working through obstacles in the engagement process. Some programs find this engagement process is enhanced by:

- Providing pre-treatment recovery support services to enhance treatment readiness and reduce attrition from service waiting lists.
- Shifting from an addictions model to an alcohol and drug problems model (as defined and understood by each client)
- Lowering the threshold of initial service engagement by truly meeting client "where they are at".
- Exploring strategies in supervision to enhance each client's investment in the treatment experience.
- Using peer supports as a way to offer hope for long-term recovery. Facilities that have treated physicians have effectively used physicians in recovery as peer coaches for years as a routine component of physician health programs (formerly known as impaired physician programs).
- Using clinical supervision as a pre-condition for administrative discharge and as a process to explore alternatives to AD (see White, Scott, Dennis& Boyle, 2005)
- Developing attitude protocol related to returning clients that conveys messages of regard, welcome, optimism and respect.
- Using community resources as sources of motivational enhancement
- Using frameworks of meaning to help clients understand that obstacles, struggles, and relapses are all building blocks in the client's recovery process.
- Sustaining the hope of staff by keeping them in touch with former clients in long-term recovery and with the larger recovery community.

Effectiveness in this area can be measured by a number of indicators: 1) increased percentage of clients entering treatment who are not under external coercion, 2) increased percentage of clients who follow through after an initial assessment and service plan, 3) decreased percentages of clients who leave against staff advice or are administratively discharged, and the percent of clients discharged unsuccessfully who maintain engagement in another level of care or later reengage in the same level of care..

In the late 1980s, the State of Illinois developed an innovative project to engage addicted women with histories of abuse or neglect of their children. One of the hallmarks of Project SAFE was an extremely assertive model of outreach that brought an unprecedented number of women into treatment. When the outreach workers within this project were asked to describe how they successfully engaged these clients, they responded as follows:

Dimensions of Assertive Outreach and Engagement
(Excerpted from White, Woll & Godley, 1996).

Expect Resistance *Resistance is to be expected; we should be shocked when it's not there and suspicious that we're getting hustled. These women initially see us as an extension of the Agency that's taking their children and forcing them to get help they don't need or want. It takes time to work through their anger and distrust.*

Demonstrate Respect *I try to remember that I'm on her turf--that I'm her guest and that I remain there only with her permission. I want to minimize my power and let her feel we=re on the same level. I try to empathize with her sense of being invaded--her feeling that all these strangers are getting in her business.*

Listen *They can't hear you until you've heard them. The trick is to shut up and listen until they're ready to hear what you have to offer. I think it's the first time they've been listened to and not judged.*

Tell Your Story *I wait for the right time and then I share my story and my gratitude about what happened to me as a result of treatment. When she figures out I been where she's at, something just seems to click. It's like they want something I got and for the first time figured out it might be possible to get it. We're from the neighborhoods. We've lived in ...public housing sites. You go to the same stores that they do. You already know what they're going through. It's not like they have to hide anything.*

Empower *Its harder for the women I see in the projects because they don't see a lot of people making it. I hope she can identify with me in a way that opens up her sense of possibilities and choices.*

Affirm *I tell her something good about herself--something I see that others may have missed. I just keep listening and telling her everything's possible until she asks me "how?" Then I tell her that her beauty's being wasted and what she can do for herself and her family. I also keep leaving those "You can do it!" notes on their doors.*

Accept *You can't be judgmental. You have to be willing to allow the clients to make mistakes and to be resistant, because that's what they are. When you do outreaching, one thing you need to do is be an equal. You have to let the client know that you're no better, that you're her equal.*

Be Tenacious *You've got to let them get all their anger out before they can hear anything you've got to say. When they're done cussing, I start talking.* [I say through a closed door:] *I know you're there. I know you're mad. But I ain't gonna give up on you. I'll be back tomorrow. I hope you have a good day.At first she didn't want to talk to me, but I just kept showing up at all her court hearings. They just surrender. They finally realize that we're not going to let off. That we'll keep at it until we give them the help they desperately need. They have to know you care enough that you won't give up.*

Problem Solve *My job every day is to resolve anything that threatens to keep this woman from getting to treatment.*

Be Real *Who am I? I'm somebody who can show you how to get those people off your ass!*

The following Philadelphia case study illustrates what might be called *institutional outreach*—an intense process of engaging an individual through hourly/daily contacts at the earliest stage of treatment.

Charlotte was a 45 year-old crack-addicted female with a serious medical condition, Bipolar Disorder, and an extensive history of sexual abuse both as a child and adult. Charlotte, after much encouragement and direction, completed short-term stabilization unit and transferred to a long-term residential facility. Her first 2 weeks of treatment were difficult and she was extremely withdrawn and uncooperative. When she did speak, she made it clear that she did not believe in the Therapeutic Community. Two female staff met with Charlotte almost on a daily basis, just to talk and build a relationship with her. As the days went on Charlotte opened up more and more and slowly became part of the community she had criticized. She successfully completed treatment 7 months later, followed that with 4 months of outpatient treatment while residing in transitional housing and then moved into her own apartment. Today, she is physically stable, continues to attend mental health therapy monthly, has a full-time job and visits the treatment facility regularly to speak with the current residents and share her story of accomplishment while encouraging them to remain in treatment in order to live a more productive sober life.

Successful engagement and retention can be enormously challenging and clients can present with chronic self-defeating styles of interacting with others that sets them up to split or get thrown out of treatment. Penetrating these styles can be difficult but rewarding as the following incident reveal.

Welcoming the Return of a "Problem Client" *Nancy was a 23 year old heroin addicted female from an affluent suburban family. Her clinical history included childhood sexual abuse, multiple rapes as an adult, a severe eating disorder and recent psychiatric diagnoses of bi-polar disorder and schizophrenia. These problems had spawned five admissions to residential treatment—each of which resulted in discharge following vicious verbal abuse of other clients. When she asked to come back for a 6th time, the initial staff reaction was that she would simply be too disruptive to the treatment milieu to consider her admission. As we processed this more, we were forced to acknowledge that, as badly as she acted out in treatment, she was doing much better than when we first met her – something was working. We met with the client and asked what she thought would help move her recovery forward and we shared our thoughts with her. Together, we developed a workable plan that included transitional housing, volunteering at the homeless shelter and at detox, attending daily groups at the residential treatment site and participating in outside individual counseling.*

Screening and Assessment

In shifting from acute care models to models of sustained recovery management, assessment processes and instruments shift from assessments that are categorical, deficit-based, individual-focused and an intake function to assessments that are global (wholistic), strengths-based, continual and family-centered. Achieving this shift requires swimming upstream against the currents of existing regulatory and service reimbursement schemes. Clinical supervisors who are so inclined will play a significant leadership role in advocating for changes in these structures as well as making changes in their own institution's assessment protocol. This often involves upgrading to global assessment instruments (e.g., Substance Abuse Severity Index, Global Appraisal of Individual Needs), further refining or supplementing these instruments for cultural applicability and implementing strengths-based assessment and

service planning procedures. The key is an assessment process that provides a complete picture of the health of each client across multiple zones of functioning, e.g., chemical/physical, cognitive/emotional, relational (intimate/family/extended family/social/cultural), ontological (spirituality, life meaning and purpose), and lifestyle (safety/security, school/work, leisure, legal, financial) health.

Traditional assessment, diagnostic and patient placement criteria have been driven primarily by the measurement of problem severity. The largest change in RM models is the inclusion of recovery capital as a major factor in the assessment and service planning process. Consider the following three examples.

1)   High problem severity, which would usually dictate a more intense and restrictive level of care, could be offset by a high level of recovery capital that would allow the client to be successfully treated in a lower level of care.

2)   Low to moderate problem severity combined with exceptionally high recovery capital might indicate a very low level of professional intervention (e.g., brief therapy) or a monitored attempt to initiate and sustain recovery without formal professional intervention, e.g., monitoring and recovery coaching without clinical services. This combination would also reflect individuals who may not need sustained recovery management or who would only need minimal recovery support, e.g., an annual recovery checkup.

3)   High problem severity and complexity (co-occurring disorders, multiple prior treatments) combined with low recovery capital would signal the need for long-term recovery management and a high level and intensity of services required for recovery initiation, consolidation and maintenance.

Where traditional supervision has focused on the identification or elimination of pathology, clinical supervision in the RM model shifts the emphasis to the identification and enhancement of recovery capital. Without systemic changes to support this shift, there is a danger we will identify a greater range of needs and potentialities only to then demoralize the client/family as we confront the limited community resources to help fulfill those potentialities.

Care will need to be taken in supervision to reconcile this broader identification of client needs with local resource limitations. The advantage in the RM model is that service priority sequencing can unfold over a much longer span of time that with AC models of care. Thus, all of those needs do not need to be addressed in a matter of a few sessions or weeks.

Another assessment dimension that changes within RM models is the shift from the individual to the family as the unit of assessment and intervention. Again, this requires moving against mainstream regulatory standards and reimbursement procedures that focus almost exclusively on service to individuals. The challenge for the clinical supervisor is to create family systems of care within the limitations imposed by these external systems (until such time as advocacy can elicit changes in those systems). This increased family focus is based on the understanding that severe AOD problems tend to cluster and move intergenerationally within particular families at the same time recovery support resources exist within nearly all families, extended families and kinship networks. It is also based on the understanding that chronic disorders tax the adaptational capacities of families and disrupt the health of individuals, intimate relationships, parent-child relationships, sibling relationships and alter the nature and frequency of the family's interactions with those outside the family. Assessing and supporting the family as a whole through the process of clinical supervision can minimize family sabotage, mobilize family support for recovery, reach other family members at an earlier stage of problem development, enhance the health of family members and the family system as a whole and potentially break intergenerational patterns of problem transmission.

Service Planning

In traditional service planning within addiction treatment organizations, assessment data is used to generate a problems list that is then used to formulate a professionally-directed treatment plan. The treatment plan is usually prepared by an addictions counselor and is often approved via the signature of the medical director. In the RM model, a treatment plan may still be indicated for the earliest period of biopsychosocial stabilization, but the treatment plan rapidly gives way to the development of a client-formulated and client-directed recovery plan. The recovery plan is broader in scope than a traditional treatment plan, encompassing such domains as physical health, education, employment, finances, legal, family, social life, intimate relationships, and spirituality. It usually consists of a master plan that identifies long-term recovery goals and a weekly action plan of steps that will be taken to move toward those goals (Borkman, 1997). Advocacy with funding and regulatory authorities is usually required to shift service planning protocol as well as the forms that constitute the medical record.

Clinical supervision is important to help staff: 1) divest themselves of the power inherent in the expert role and to move toward the role of recovery consultant, 2) develop approaches to motivating clients for ownership of recovery planning (particularly those re-entering treatment), and 3) clarifying client and counselor or recovery coach role responsibilities. Staff members are evaluated on their ability to engage clients in recognizing and identifying strengths and competencies within the recovery planning process. Dr. David Loveland, recovery coach supervisor, at Fayette Companies in Peoria, Illinois, describes the difference between traditional treatment planning and recovery planning.

Treatment planning is based on a medical model that focuses on deficit (a diagnosis) and professional interventions designed to cure or stabilize symptoms of disease. In contrast, recovery planning is based on the life goals and aspirations of each individual; deficits are a focus only to the extent they constitute barriers to these goals and the long-term recovery process. Recovery plans are generated, implemented, evaluated and refined by each client with the counselor or recovery coach serving as consultant and cheerleader. The supervision of successful recovery planning first helps staff move from hierarchical to collaborative service relationships and then cultivates the courage to allow clients to make and learn from their mistakes without threat that their decisions will be shamed or punished. The key is to avoid the intellectual debates and power struggles—to cease indoctrinating, manipulating and controlling. Staff members need guidance to replace traditional, paternalistic and materialistic interventions with more focused support and consultation roles—roles through which we plant the seeds for helping each client evaluate short- and long-term recovery pathways and strategies. We do that, not by convincing a client that he or she is making a bad choice, but by forging a recovery support partnership and asking such questions as: How will we know if this approach is working for you? What are the early signs that will tell us this approach is not working? What ground rules will assure the best probable outcome? Such questions, whether applied to a cocaine addict who wants to try controlled drinking or a client who wants to go to a wedding with an open bar, help clients develop critical thinking skills that can guide the process of long-term recovery.

Service Goals and Focus

Treatment sites that are attempted to move to a recovery management model continue to do acute stabilization when this is needed but they wrap these acute services within a larger system of support for long-term recovery.

We used to see our work as being completed at the point someone was discharged from primary treatment. Now we see this as the beginning of our work supporting the transition from recovery initiation to recovery maintenance.

Some programs report that their treatment philosophies undergo significant changes in this transition. Such changes may include the following:

1) Abstinence may be viewed as a method or strategy rather than as the goal; the goal is recovery—abstinence is one method, and, for those with severe AOD problems, the preferred method of achieving that goal.
2) Moderation goals and outcomes may be considered for those with less severe AOD problems.
3) Recovery is viewed across a much longer time perspective, with an understanding that, for those clients with the greatest problem severity and complexity, stable abstinence may come slowly and following multiple service interventions.
4) Recovery management can also involve an integration of treatment and harm reduction approaches (Kellogg, 2003; Schwartz & Balmer, 2003).

These shifts in philosophies are based on the understanding that different clients may utilize different goals and strategies of problem resolution and that the same person may embrace different goals and strategies at different points in their life. The focus that emerges from that shift in thinking is the development of a recovery-supportive relationship that can support recovery initiation and stabilization and then support the transition to long-term recovery self-maintenance. Clinical supervisors are playing a critical role in refocusing treatment from biopsychosocial stabilization to long-term recovery. They are supporting this shift by involving staff in discussions of clinical research and its implications for treatment philosophy, by introducing new service technologies and by moving staff away from a focus on control and compliance toward a focus on relationship-building and recovery support. In short, the job of the clinical supervisor is to hold recovery up as the prize that we must keep our eyes upon and use that singular goal to determine service priorities. Where recovery is likely to be a complicated, obstacle-filled process, the supervisor can help staff stay engaged by staged recovery outcomes and emphasize the potential importance of service combinations and sequences.

Service Relationships

One of the most dramatic changes in recovery-oriented systems of care is the radical reconceptualization of the role of service provider and service recipient and the nature, intensity and duration of the service relationship. Modern addiction counseling has adopted a psychotherapy model of intervention drawn from the fields of psychiatry, psychology and social work. In this model, the addiction counselor serves as a professional expert who performs such key clinical functions as screening, assessment, treatment plan preparation, client/family education, client/family counseling, discharge planning and possibly brief follow-up after discharge. There is considerable power discrepancy in the service relationship and the treatment process is directed by the addictions counselor over a relatively brief period of time. In this system of care, the client may go through multiple levels of care providing by different agencies and different service professionals.

In recovery-focused systems of care, the service relationship is less hierarchical and the role of the service professional might be more aptly described as a consultant and mentor than that of a therapist. The service relationship is less like a traditional doctor-patient relationship and more like a sustained health care partnership, with the client rather than the service provider in the central decision-making role. This means that service relationships are focused less on

the therapist and more on the client and extend much longer in time than traditional treatment relationships.

In shifting from staff/program-centered treatment to client-centered recovery support, staff members are no longer the orchestrators of recovery initiation. This transition required considerable adjustment at Dawn Farm.

Staff used to be routinely invited to a client's first open talk. This was often a point of considerable pride, particularly when clients spoke of their counselor changing their lives. This is no longer the case. Today, clients are more concerned about their sponsor, sponsees and friends in recovery being there. Staff struggled a lot with this change in status. At first, it injured their pride and left them wondering if and why they were even needed. Those in recovery gave us less credit for their recoveries, and we were also seeing more relapses close up because we were now staying in touch with people much longer after treatment. Before, what was going on with relapsed clients after treatment was invisible to us until their readmission. Now we are present to see it all: the good, the bad and the ugly. We have developed a much deeper appreciation of the intractability of addiction and the complexity of the recovery process. It first humbled and demoralized us before elevating us to a new understanding of our role in the recovery process.

A key part of this adjustment was learning to see treatment and recovery within a longer time perspective than the short-term processing milestones imposed by regulatory and funding agencies.

One of our challenges was to recognize progress even in the face of relapse. We had to get out of the mindset that every client should go through our treatment program, never use again and live happily ever after. We started recognizing clients whose successful recovery initiation spanned years rather than weeks and developing a vision of how to accelerate that process. We had to develop a clearer vision of what could be a prolonged recovery process. We also had to explore the notion of "partial recovery"—that some clients might never achieve full recovery but that their problems could be diminished, their harm to others minimized and the quality of their lives enhanced. We still worry about how to do this without lowering the bar and inadvertently diminishing hope for full, long-term recovery.

In traditional treatment, loyalty to the program structure took precedence over and frequently dominated the service relationship. It is not an overstatement to say that loyalty to the program often superseded loyalty to the needs of an individual client. That loyalty to structure provided as much support to staff as it did to clients. The shift in this prioritization of loyalties was another loss staff experience in the transition to recovery-oriented systems of care that are obsessively focused on the recovery goal and view all methods as negotiable.

We went from an unconditional commitment to the program to an unconditional commitment to each client's recovery. We had to step back and discover that recovery was not always conditioned on compliance with our "program."

It is more beneficial and less personally stressful to motivate clients than to try to control them. My role is not to force clients to see things my way; it is to help them make decisions and remain with them through the consequences of those decisions. We (therapists) are now looked upon as allies rather than jailers.

As an organization, we had to move from fear and control to faith and encouragement. Escaping our preoccupation with rules and our affinity for confrontation was a major

challenge. It was hard to think outside the box and get out of our comfort zone with individual clients.

Before when clients left against staff advice or were discharged, we never saw most of them again. Now we know what happens to all of our clients after they leave us. It's a totally different kind of relationship. Before, clients who relapsed were afraid to run into us in the community. Now they seek us out.

Such commitments require that staff engage and sustain engagement with the most impaired clients under the most difficult circumstances. If we are truly committed to helping our clients, then we must sustain the continuity of that commitment over time—being with the client and his or her family regardless of the client's successes or failures. The depth of that commitment is illustrated in the following story.

Michael was a 32 year-old heroin addict who, prior to his first treatment admission, had spent most of the last eight years estranged from his family and homeless in Seattle. He completed residential treatment, moved into sober housing and relapsed after 6 months clean. His relapse lasted only a few weeks but it ended in a severe overdose which resulted in physical limitations that lasted months and short term memory problems that persisted for several years. He was readmitted to residential treatment immediately following his discharge from the hospital, completed treatment again and stayed drug-free for 9 more months with the support of sober housing, vocational and neurological services. Relapsing again, he overdosed within one week and was readmitted to the hospital. At this point he had been abstinent for most of the last two years and had accumulated significant recovery capital but was clearly unable to remain abstinent without significant support. He did not fit into any of our programs – it made little sense to put him in residential treatment for another 2 to 6 months and it was clear that he has not stable enough for transitional housing. We met with Michael and developed a plan that started with readmitting him to residential treatment with the expectation that he would stay for 2 to 4 weeks with the goal of re-stabilizing him. His recovery plan focused on creating structure and meaning in his daily schedule and running on a daily basis so that he could achieve a previously identified goal of completing a marathon. Following this brief residential episode, he entered transitional housing with a structured schedule that included volunteer work at the homeless shelter and Detox, returning to treatment one day per week, obtaining supported employment and regular contact with our street outreach worker. Our outreach worker monitored his activity on his recovery plan, and supported him in developing solutions as new barriers to stable, long-term recovery were identified. Unfortunately, Michael once again achieved six months recovery and relapsed. Our staff talked to him regularly throughout his relapse and offered services and support. He eventually detoxed in another program and was transferred to our residential program for stabilization and developing a new recovery plan. During this stay he left treatment against staff advice and fatally overdosed. We hosted his memorial service in one of our facilities. It was attended by 350 people, including family and members of the recovering community. His mother expressed gratitude for the opportunity to reunite with her son, and other friends and family reflected on the gift he had been in their lives over the past 3 years.

Absorbing such painful losses is not easy. Moving to a recovery-oriented system of care deprives staff of some of their traditional status and rewards, generates new rewards and new stressors by more closely connecting staff to the post-treatment recovery and re-addiction experiences of clients, and replaces the structure of "the program" with demands for more individualized and sophisticated service procedures. The question then is how staff members

sustain themselves through this transition. If such transitions are to be successfully achieved, it must be done so through the vehicle of clinical supervision and peer-based supports.

Again, the concept of parallel process applies. The partnership that guides recovery support relationships must be mirrored in the supervisor-supervisee relationship. Just as the frontline service providers give up there expert role in the RM model, supervisors also give up this role and enter into partnership with counselors and clients to make the best possible decisions to further the recovery process and, when necessary, correct those decisions.

One such strategy of supervision involves the assignment of learning cases as part of each clinician's training plan. The training plan mirrors client recovery plans in their focus on strengths and barriers based on personal assessment, supervisory observations during live and formal supervision, and measures that can be used to underscore the therapeutic barriers with a particular type of case. Clinicians are assigned no more than two learning cases per caseload as part of this learning process. Through this process, clinicians are challenged to recognize and understand the sources of personal biases and other factors that can influence the assessment, treatment planning, and the recovery process. One residential therapist in Philadelphia describes the benefit of learning cases:

> *I think having learning cases is a pertinent part of our learning process. It is very difficult at times but the accessibility of supervisors along with supervision proves to be a great help in our professional development.*

Two important issues demand greater attention in clinical supervision within the recovery management model. The first involves the role ambiguity and role conflict that can come from involving a greater number of recovery support roles within the treatment experience. Supervisors may find the DBH/MRS monograph *Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity* (White, 2006) a helpful resource on how to minimize and manage such ambiguity and conflict.

A second issue is the greater degree of ethical ambiguity that can arise in reducing the power differential between service providers and service recipients and extending the duration of contact. The longer duration of contact provides greater opportunities for problems of transference and countertransference and issues of race, power and privilege to arise within the service relationship. This is particularly true within new recovery support specialist roles that have not yet formulated their own folk wisdom and ethical guidelines on the management of such issues. If behaviors are categorized ethically as always okay, never okay, and sometimes okay and sometimes not okay, the latter category is much larger within the RM model than in the acute care model where ethical standards are modeled on brief psychotherapy. The RM model requires a greater level of time to process ethical dilemmas that arise with service relationships. DBH/MRS and the Pennsylvania Recovery Organization—Achieving Community Together (PRO-ACT) are currently collaborating on development of training materials and ethical guidelines for peer-based recovery support roles.

Recovery management also engenders a paradox: at the same time treatment providers abandon the expert role, they take on greater accountability for treatment outcomes. That means that a poor outcome must be examined beyond what the client did or did not do to what we as service providers did and did not do. The partnership model demands that we examine for each service outcome how well we held up our end of the service collaboration. Such self-examination requires personal and professional courage and considerable support from the supervisor. Here's how one program is attempting to manage this challenge.

> *We are trying to abandon excessive use of our own authority and focus more on the clients' making informed decisions about their family relationships, living situations, employment, and personal relationships. In the past, we accepted the power of such decisions but were uncomfortable with such power and felt crushed by the responsibility*

that came with it. There's an intense feeling of relief at not making these decisions, not bearing the burden of making the right decision, and not trying to coerce the client into executing the decisions we want them to make. The accountability now goes both ways. In the past, I think clients and staff would point the finger at each other after a relapse. Today, both parties are much more willing to examine and accept responsibility their own decisions and actions. Today staff may feel less responsible for relapses, but more responsible for maintaining engagement.

Role of the Client

In recovery-oriented systems of care, what the client wants matters. The client is expected to become an expert on the management of their own recovery process, with professional staff serving as consultants in this process. A philosophy of choice is utilized in which each client takes progressively greater responsibility in setting his or her own recovery goals and strategies and directing their ongoing recovery process. Implementing a choice philosophy within mainstream addiction treatment faces numerous obstacles: 1) challenges in the timing the application of choice philosophy with clients whose active addiction, fragile early recovery, developmental immaturity, cognitive impairment and lack of pro-recovery social support can lead to destructive decision-making, 2) restrictions on treatment philosophies and techniques imposed by referral sources, 3) conflicts between client choices and program philosophies, 4) counselor biases, and 5) inadequate knowledge and skills to facilitate the choice process. Counselors and other service staff who possess a limited understanding of recovery pathways may have great difficulty with this transition to a choice philosophy (White & Kurtz, 2005).

This suggests the importance of the clinical supervisor in training staff on the pathways and styles of long-term recovery, processing countertransference regarding pathways of recovery, sorting the limits of choice in face of active addiction and cognitive/behavioral impairments; assessing changes in volitional control will over time; and supporting staff as clients make bad choices or go through bad choices to better choices. Perhaps more than anything, recovery oriented systems of care place great emphasis on the importance of listening— REALLY LISTENING—to each client and listening to them during every step of the service process.

When staff who have worked within systems transitioning to more recovery-oriented care are asked how the role of clients has changed in their programs, they offer comments like the following:

- *It has made me realize the importance of client input into service planning as well as the benefits of their developing goals and achieving them. It benefits client to assume responsibility and accountability for their treatment and its outcome.*
- *Clients now have a major voice in their treatment. When clients are allowed to participate in treatment planning, goals and objectives and see their goals written in their words, there is deep internal buy in to the work involved.*
- *My view of the client's role in treatment has changed from clients doing what we say to me listening to them. Clients have more say and we are more helpful because we let them tell us what they want to address. The client's role is a much more assertive one.*
- *Over the past year or so, I have noticed a greater sense of accomplishment among our clients. I feel that this is a result of the change in traditional "treatment planning" and the role of the client, which internally begins with engagement.*

The following Philadelphia case study illustrates client-focused goal-setting in the service planning process.

Marquis is a 56 year old male with a 30 year history of crack/cocaine and alcohol abuse. He's had several suicide attempts throughout his life and appeared somewhat hopeless when entering Gaudenzia. After meeting with Marquis' counselor to review clinical documentation, the treatment plan was blank. The counselor discussed with me his questions about developing Marquis service plan. Marquis' number one goal was to open a savings account. In 56 years, he had never had a bank account, nor saved more than a few dollars. The counselor had difficulty understanding why it was important to put this goal on the service plan, before discussing the "role of the client" and the recovery model with his Supervisor. Marquis is now completing our program and has a savings account at a local bank with almost $1000. Again, the sense of accomplishment from simply opening a bank account, improved the client's overall motivation towards treatment and long-term sobriety.

Service Team

Recovery management models include four dimensions that profoundly shape the service delivery team: 1) openness to multi-agency, multidisciplinary service delivery models, 2) the inclusion of new service roles (e.g., recovery coaches), 3) the inclusion of local indigenous healers within service delivery teams, and 4) inclusion of peer volunteers.

Addiction treatment organizations are part of a categorically segregated service system in which relationships between innumerable specialty agencies are often characterized by isolation, competition and conflict. In isolation, these agencies are woefully ill prepared to respond to the needs of individuals and families with multiple problems and few internal and external resources to resolve those problems. Clients with multiple co-occurring problems have become the norm in addiction treatment programs in the United States, and there is growing evidence that the integrated care of medical, psychiatric and substance use disorders generate outcomes superior to parallel or sequential care (Weisner, Mertens, Pathasarathy, Moore, & Lu, 2002; Samet, Friedmann, & Saitz, 2001; Minkoff, 1989; Muser, Noordsy, Drake & Fox, 2003).

The challenge for the clinical supervisor is most critically one of time. Brokering relationships with other organizations often falls within the responsibilities of the supervisor and creates an additional source of competition for the time to do adequate supervision of service staff. The same can be said for the development of volunteer programs. The best short-term strategy to resolve this dilemma is for the clinical supervisor to delegate some of these functions to senior clinical staff. The use of multi-agency teams is also reflected in the actual clinical supervision process in terms of minimizing parochialism and protectionism; reviewing the nature of interagency collaboration, developing strategies to resolve interdisciplinary/interagency team conflict.

The development of systems to recruit, hire, orient and train and supervise peer-based recovery support services often falls on the clinical supervisor. Fortunately, there is a growing body of literature (job descriptions, procedure manuals, etc.) to guide this process (see www.bhrm.org and http://rcsp.samhsa.gov). Working with volunteers also requires time to listen and communicate with those who volunteer, praise and honor the volunteers, and respond to an occasional volunteer whose own problems or overzealousness impair their effectiveness. RM models also rely more heavily on the involvement of recovery support roles from the broader community in the treatment process. Such roles could include sponsors, clergy, supervisors, school counselors or a community elder. Maintaining role integrity between addiction counselors, recovery coaches, volunteers, sponsors and other roles is also an integral part of clinical supervision in recovery-oriented systems of care. The goal in this process is to transfer toxic dependency on drugs to a healthy interdependency on the community, with the treatment team serving as the linking agent in that process. Below is a vignette that illustrates the power of involving the volunteer service community in the treatment and recovery support process.

James, a white 19 year old suburban heroin addict was admitted to social detox after an intervention by his family following two recent overdoses. He verbalized motivation to quit and agreed to complete a 5 day detox program, but vigorously resisted his parents pleas to enter residential treatment. The detox staff evaluated him and, based on his treatment history and recent overdoses, used motivational enhancement strategies to encourage him to consider additional treatment. He again refused the recommendation. On his 4th day of detox, James was asked to help a young tattooed and pierced volunteer from the recovering community prepare lunch. James and Garrett spent an hour and a half cooking, serving, eating and cleaning up lunch together. After Garrett left, James asked to talk to staff about arranging his admission to residential treatment. He explained that talking with Garrett changed his view of what recovery is. James' recovery career was enhanced by the creation of physical, social and temporal space where such an encounter could occur.

Moving toward recovery-oriented systems of care also requires programs to move from isolation from other agencies toward the development of multi-disciplinary, multi-agency service delivery models. As the following vignette illustrates, such a shift requires getting through old history between agencies that fuels conflict rather than collaboration. Here's an example of that process.

Mark was a 46 year old male who was court referred to Dawn Farm for residential treatment for alcoholism. His history of alcohol problems extended back to his early 20s, including several prior treatment episodes. He was released to treatment from jail after serving several months in jail for felony assault charges for choking his wife to unconsciousness. The judge ordered him to complete residential treatment and a particular local batterer intervention program (BIP). He had no prior criminal involvement and insisted that he was in a blackout (police reports indicate a high BAL), had no memory of the incident and had never abused her before. However, his wife disputed his report and his interactions in the treatment milieu quickly revealed interpersonal dynamics of power and control.

We requested that the judge consider referring him to another BIP because we were concerned that the BIP would discourage participation in mutual aid groups. Several years earlier Dawn Farm received a document from the BIP that accused treatment providers, 12 step groups and the disease model of colluding with batterers. The document went so far as to compare 12 step meetings to a men's locker room of a restricted country club. Dawn Farm decided that the BIP was a program that we could not and would not work with, fearing that any referral to the BIP would be discouraged from attending 12-step meetings and severely undermine recovery progress. As a result there had been no communication between the two programs for several years.

The judge refused the request and asked the probation officer to convene a meeting between Dawn Farm and the BIP. Both programs brought their concerns to the table, listened to each other's responses and decided that there was enough common ground to continue the dialogue. (It is worth noting that both programs were going through significant internal changes that made them much more open to questioning their assumptions and learning from each other.) After several lengthy discussions about all of the concerns on both sides, we were able to find sufficient common ground to proceed on with the assumption that we could work effectively together and not undermine the other.

We facilitated Mark's concurrent participation in the BIP and spoke weekly to discuss progress and concerns–about Mark's case and the relationship between the organizations. We talked extensively about our distinct philosophical underpinnings and how to maximize reinforcement/compatibility and minimize interference. Both agencies quickly became grateful for each other's involvement in Mark's case. He was exceptionally well defended and was challenging for staff in both programs. It was clear that his prognosis would have been poor in either program alone. We appreciated each other's reinforcement of accountability and became convinced that this collaboration dramatically improved his prognosis for both problems.

Counseling and Treatment

Programs attempting to do more recovery-oriented care find their core treatment services changing in a number of significant ways, including greater reliance on evidence-based treatment approaches, an emphasis on constant re-engagement and service retention, and a shift away from "programs" to menus of treatment and recovery support services that are individually combined and sequenced. Clinical supervisors report greater use of skill-based training (e.g., MET and CBT), more sophisticated systems of fidelity monitoring (e.g., emphasis on adherence to clinical protocol), and a decrease in "psychobabble". These shifts involve making the services fit the needs of the client and not the client fit the services. They also require cooperation from funding and regulatory agencies whose structures may inhibit such individualization of care.

Other changes are evident in the shift to recovery management. There is a shift from providing services <u>within</u> a particular recovery pathway to providing services <u>across</u> recovery pathways. This requires a greater knowledge on the part of staff in the multiple pathways and styles of long-term recovery and potentially more countertransference issues related to staff feelings about particular pathways and styles of recovery. The tenor of service planning shifts from confrontation and indoctrination to one of education, choice clarification and sustained support.

The shift from treatment planning to recovery planning also involves an expansion of resources needs (educational, vocational, housing, health, leisure, etc.). Treatment becomes viewed as something beyond inpatient and outpatient services. This requires a greater knowledge of community resources on the part of staff and the clinical supervisor and greater care in sequencing activities to avoid overwhelming both clients and staff.

Here are a few examples of how core treatment services and their supervision are changing in the move toward more recovery-oriented systems of care.

<u>Evidence versus Belief</u> *There is a collision going on between new scientific evidence and personal and program beliefs. We continue to disagree even when we are presented with sound research. People are passionate about their ideas about addiction and its treatment and reconciling those ideas and the latest research findings is a critical aspect of clinical supervision.*

<u>Out-of-the-Box Thinking # 1</u> *Thomas was a self-referred Black male addicted to injection heroin and crack cocaine with what seemed like every possible complicating factor, maternal heroin addiction, traumatic war experiences (Vietnam), years of homelessness, past prison time, past enmeshment in the mental health system, multiple prior addiction treatment episodes and chronic health problems. Everything about Thomas suggested a need to long-term, high intensity services. He was admitted to long-term residential treatment and quickly proved to be intelligent, highly motivated to recover, hard working and insightful. He also was hyper-vigilant, intolerant of his peers, constantly in conflict*

with other clients, prone to explosive outbursts that were sometimes difficult to de-escalate. Staff reached a point where they felt Thomas' presence was too disruptive to the treatment milieu and that he should be discharged. But rather than terminate Thomas' relationship with the agency, we transferred Thomas to a new transitional housing program that included no treatment or clinical programming. The idea of providing Thomas support in a less rather than more structured environment was very counter-intuitive, but his improved functioning in this setting confirmed for us that some clients with high problem severity and complexity do better with less rather than more structure.

<u>Out-of-the-Box Thinking # 2</u> *Edward was a middle-aged Black crack cocaine addict court ordered to treatment for violating his probation via several positive drug screens. He was intelligent, articulate, socially engaging and supportive of struggling treatment peers. He was also arrogant, sexist, resentful of any authority (particularly female authority) and was often disrespectful to other clients and staff. He verbalized motivation to recover and exhibited impressive insight, but questioned the need for residential treatment and resented the alternative of six months in jail.*

The counseling staff, constantly frustrated with Edward's overt refusal to yield to their authority and expertise, finally had had enough. Believing his attitude was too disruptive to the treatment milieu, they recommended his discharge for failure to progress. In staffing his decision, our program director asked how he was doing in the recovering community. After all, he suggested, our mission is "to remove barriers that prevent addicts from joining the recovering community." It turned out that Edward had developed an impressive support system. He had more than a dozen men in stable recovery with whom he spoke regularly, received rides to 12 step meetings, and spent his leisure time. When queried, these men reported that Edward was doing very well as a newcomer to 12-step recovery other than his resentment about his mandated treatment. He was eagerly doing step work, had accepted service commitments at two meetings, saved money to attend a weekend recovery retreat and participated fully in meetings.

The President challenged the staff's decision to discharge Edward by pointing out that our goal was recovery, not treatment compliance and that Edward seemed to be making significant progress toward that goal. He forced us to think beyond the question of progress in the house to look at progress in connection to the recovery community. We were achieving our mission with him. His challenges forced us to look at ways we could build on Edward's true recovery progress and more effectively diffuse Edward's resentment about being mandated to treatment. Cases like this have taught us to distinguish between treatment progress and recovery progress.

These shifts in clinical orientation have obvious implications for the recruitment, hiring, orientation, training and supervision of staff. Based on our experience to date, some individuals will have difficulty with these transitions, particularly those counselor's who must be the charismatic center of their clients' recovery experiences and those who view recovery within a very narrow recovery pathway.

Locus of Services

Recovery-oriented systems of care shift the focus of care from getting individuals into treatment (getting them from their environment to the treatment environment) to nesting and anchoring the recovery process their own natural environments or, when that is not possible, to create an alternative environment in which their recoveries can flourish. That involves a greater emphasis on home-based and neighborhood based service delivery and in creating physical communities of recoveries where support for recovery is particularly rich (e.g., developing and linking recovery homes with local recovery communities). The extension of services into natural

environments raises new issues in supervision (e.g., etiquette and ethics of home visits, safety management) that have historically not been issues in residential and outpatient treatment settings. Part of Dawn Farm's renewal process involved extending its reach into the community through assertive outreach programs. The following report from a person delivering outreach services in the jail illustrates the potential of such efforts.

> *I met Merwyn when he came to my jail program. He's a 52 year old heroin addict who has done a few prison stretches totaling about 7 years. He was in this time for theft and possession. He completed the 30 day program in the jail and was scared about the prospects of what would happen after his release. I told that if he met me at a 12 step meeting the night he was released, I'd help him get a job. When he showed up at the meeting, I connected him with some solid guys in recovery and made sure he left with several phone numbers. I also gave him my cell phone number and told him to be sure to call me the next day and I'd check some connections about getting him a job as a cook. I hooked him up with a job with someone who would respect his recovery and his need to go to meetings. When he decided he needed a safer place to live, I helped him get into a half way house. He did well there, and he's started working for them part time. He's reconnected with his kids and he's now very involved in the recovering community. The guys I meet in the jail program know that a lot of workers would be scared if they bumped into them on the street. It makes a big difference when they know you care about them, you aren't scared of them and you're willing to help connect them with jobs and stuff – it's like they're honored that you'll cash in some chips for them.*

Duration of Services

Recovery management models maintain a much longer duration of service contact than do acute care models but do so generally at less restrictive, less intense levels of care. The goal is to provide lower intensity recovery supports for longer periods of time to enhance the durability and quality of recovery, reduce the frequency and duration of any relapse episodes, and reduce the total volume of life-disrupting, expensive, acute care needed over one's lifetime. The bulk of these lower intensity services involve pre-treatment engagement contacts, in-treatment case management and recovery support, assertive linkage to communities of recovery, active recovery coaching (e.g., stage appropriate recovery education), post-treatment recovery checkups, and, when needs, early re-intervention. Here is an example of such extended contact.

> *Joe is a 51 year old male with a 34 year history of alcohol dependence. Joe is well known in the community by the police, hospitals and shelters. It is not uncommon for him to have a BAL of over .50, tell wild stories about his life, and become belligerent. We first met him in 2000 when he sought admission to residential treatment. He had 3 admissions to residential in rapid succession, eventually completed treatment and moved into sober housing. Since then, Joe has experienced what we might call serial recovery. He's achieved periods of sobriety for 18 months, 12 months and four episodes of six months. During these periods he maintains employment, housing and is a loved and active member of the recovering community. After his first episode with us, our outreach worker began working with him. Here is our outreach worker's experience with him:*

> *"Joe had numerous visits to our detox facility during relapses and was very difficult to stabilize. He often needed to be transferred to a medical facility because of his high BAL. When we were able to admit him he often left against staff advice or was discharged for disruptive behavior. When I would be doing outreach, I would often see him on the streets completely wasted and I just kept talking to him about recovery. I developed enough of a rapport with Joe that he frequently used me as an emergency contact. I visited Joe in the local emergency room countless times. He would often spend a week or more in the*

hospital being treated for physical problems caused or worsened by his drinking. During one particularly stretch, he ended up in the ER nearly every day for a month. I met with the ER staff and our detox staff and we developed a plan to get him into a hospital bed immediately (rather than being held in the ER for hours) to stabilize him medically, then move him ASAP to a social detox and then into sober housing. It took a few attempts but we finally got him restabilized and he's been sober for 6 months now. I've been staying in regular contact with him and we're working on strategies to keep him in stable recovery."

The key to the success of the RM model rests on continuity of contact in a primary recovery support relationship over time. This means within service planning that we can look beyond a single episode of service to the larger trajectory of the recovery process. This helps staff escape get staff away from the "one bite at the apple" mentality in which more and more activity is jammed into less and less service time. The ability to monitor responses to various recovery strategies allows refinement in these strategies over time and avoids each client needed to cycle through episodes of treatment until they encounter the right combination of services at the right time to solidify the recovery process. The extended period of contact also poses less risk of overwhelming client by trying to address all issues within the narrow window of recovery initiation. Sustained recovery management provides more stage-appropriate integration of issues as an alternative to the frenzy of trying to address everything in X sessions or X days.

The role of the clinical supervisor in the RM model is to help staff think beyond the frameworks of admission, treatment and discharge; establish protocol for continued monitoring and support; and monitor the quality of on-going recovery support relationships, including the maintenance of appropriate boundaries within these relationships. The latter is challenging when relationships are less formal and extended over such long periods of time. The application of ethical standards based in clinical roles and an acute model of care may not be applicable to non—clinical recovery support services provided within a model of sustained recovery management. For example, the typical prohibition against gift-giving and gift-receiving designed to prevent exploitation of clients within the acute care model may actually do harm or injury to clients and the service relationship within the recovery management model, e.g., personal or cultural offense taken at a recovery coach's refusal of a gift from a client. As the relational models and service duration change, such issues will need to be carefully reviewed in supervision, with ethical and professional practice standards evolving in tandem with new learning.

Discharge and "Aftercare"

The shift from acute models of intervention to models of sustained recovery management requires a radical re-thinking of traditional "aftercare" services. In contrast to traditional aftercare models, assertive approaches to continuing care:

- encompass all admitted clients/families, not just those who successfully "graduate," including those who terminated treatment against staff advice or were administratively ("therapeutically") discharged,
- place primary responsibility for post-treatment contact with the treatment institution, not the client,
- involve both scheduled and unscheduled contact (e.g., "I've been thinking about you today and thought I would call to say hi and see how things were going."),

- capitalize on temporal windows of vulnerability (saturation of check-ups and support in the first 90 days following treatment) and increase monitoring and support during periods of identified vulnerability,
- individualize (increases and decreases) the duration and intensity of check-ups and support based on each client's degree of problem severity, the depth of his or her recovery capital and the ongoing stability or instability of his or her recovery program,
- utilize assertive (see discussion below) linkage rather than passive referral to communities of recovery,[4]
- incorporate multiple media for sustained recovery support, e.g., face-to-face contact, telephone support and mailed and emailed communications,
- place emphasis on those combinations and sequences of services/experiences that can facilitate the movement from recovery initiation to stable recovery maintenance,
- emphasize support contacts with clients in their natural environments,
- may be delivered either by counselors, recovery coaches or trained volunteer recovery support specialists, and
- emphasize continuity of contact and service (rapport building and rapport maintenance) in a primary recovery support relationship over time (Dr. Mark Godley, Director of Research, Chestnut Health Systems, personal communication, February, 2006)(Excerpted from White & Kurtz, 2006b).

RM models of care eliminate rituals and words that communicate to clients with severe AOD problems and to staff that recovery is something to be achieved in a short period of time. RM leaders advocate abandonment of such concepts as "graduation," "discharge" and "aftercare" for those with severe complex substance use disorders on the grounds that those terms have no utility in the management of other chronic health disorders, e.g., diabetes, hypertension, asthma, chronic pain. Treating severe and chronic substance use disorders in brief, self-encapsulated episodes of care makes no more sense than treating diabetes only through repeated treatment of diabetic coma in a hospital emergency room. The "aftercare as afterthought" mentality has to be abandoned and replaced with the understanding that continuity of contact and support over time is the very essence of chronic health care management. Fulfillment of that shift will not be possible without policy, regulatory and fiscal alignment with that vision, but there is much the clinical supervision can do in the interim. Here are a few suggestions.

1) Retool the language within the treatment milieu in ways that reflect this long-term recovery vision,
2) Streamline the movement between levels of care and the ability of clients to for brief re-stabilization or support,
3) Establish simple protocol for post-treatment monitoring and support,
4) Explore the potential of using alumni and other trained recovery volunteers to provide telephone-based, post-treatment recovery coaching,
5) Collaborate with local recovery advocacy/support organizations that specialize in recovery support services.
6) Do not underestimate the enormous import of the shift from an acute care model to an RM model at programmatic, staff and client levels.
7) Actively manage demoralization of staff, clients and families by framing severe AOD problems within a chronic disease framework that holds out the promise for eventual recovery.

Referral is not linkage; it is affirmation of the need for linkage and the hope that linkage will happen. Linkage is a process that assures that the connection between an individual and indigenous recovery support systems really happens.

Members of the Philadelphia Clinical Supervision Work Group felt very strongly about the important of post-treatment monitoring and support for all clients, not just those who successfully complete treatment. The following comment is reflective of these sentiments.

> *Recovery is not always defined or conditioned on compliance with a program. If those clients who leave "ASA" or were "administratively discharged" are followed or even directed to outside/community supports, their chances for maintaining sobriety would increase. I feel this area is one that needs emphasis in transitioning to the recovery model.*

Other examples of such supports included phone contacts to clients, invitations to come back to the facility to speak about life in the early stages of transition to the community, sponsoring a client-driven support group that include current clients in treatment and those who have transitioned into the community.

Advocacy and Recovery Community Development

Recovery management blends traditional clinical models of care with models of community organization and community development. The latter seek to reduce forces in the community that promote AOD-related problems or create obstacles to recovery and to expand community recovery capital. Treatment agencies are called upon to look beyond their institutional interests and advocate for broad community changes that have enormous impact on the recovery climate and specific recovery supports but may not increase dollars coming to the agency. Such activities can range from broad recovery advocacy activities (e.g., participating in local anti-stigma campaigns and recovery celebrations) through helping expand recovery support resources (e.g., development of specialty support meetings). They can also involve organizing supports for a particular client, e.g., setting up recovery supports inside the high school that a client will be returning to upon her completion of primary treatment. Here is an example of how one program launched a recovery advocacy educational campaign.

> *One day we were sitting around venting our frustration that the public imagines all addicts as some guy who breaks into homes and steals TVs. We talked about the need to raise awareness that people come in contact with recovering people every day—that recovering people are cashiers, carpenters, chefs, doctors, clergy, teachers, nurses, homemakers, lawyers, etc. We decided to start an advertising campaign that would present recovering people and their loved ones, the goals were to normalize recovery, offer hope and reduce the stigma associated with addiction. We believed that it was important to avoid any appearance of self-promotion, so the ads deliberately excluded any mention of our organization. We eventually created posters, postcards, wristbands, calendars and CDs with ads that could be run in any publication. All of the materials are available free to anyone who would agree to use them only to promote recovery (not any programs or business interests) (See recoveryiseverywhere.com). We've asked for donations to cover our costs, but don't require them. It's been important for the organization that we live the values we talk about and take action to support recovery beyond the walls of our treatment center.*

Such activities are not without their problems. The scope of needs for expanded recovery supports can be overwhelming, leaving the clinical supervisor and clinical staff pondering how to best allocate limited time and resources. Staff time spent on unfunded, out of office activities must also be monitored in clinical supervision to avoid shifting too far from clinical support to community resource development. Perhaps more than anything, this extension of the role of clinical staff involves a major redefinition of professional identity and over time a redefinition of the role of the agency in the community.

How is this possible?

Most readers will have already declared numerous times: "How would all of this be possible?" It is an appropriate question. Many broad changes in the field are necessary to fully embrace more recovery-oriented approaches to addiction treatment, including:

1) regulatory relief on the type and quantity of service documentation
2) development of financing models for pre-treatment, in-treatment and post-treatment recovery support services
3) reduction in staff turnover at front line service levels
4) enrichment of clinical supervision via its frequency and quality
5) technical support for development of peer-based recovery support service models, e.g. hiring, orientation, training and supervision protocol, a code of ethics for peer-based recovery support specialists.

We have attempted in this paper to outline the future evolution of addiction treatment and the role of clinical supervision in the movement toward more recovery-oriented systems of care, but we must return to an initial point in this paper. As administrative demands have increased on the supervisor and as paperwork demands have increased for clinicians, supervision has become an exercise in making sure the clinician is complying with all documentation and reports. Change must come from two directions. First, funding and regulatory agencies must find a way to reduce and minimize service documentation requirements. Such relief is essential if the focus on client needs (versus institutional needs) is to be restored. Second, clinical supervisors must become activists within their own agencies in pushing for changes that maintain or restore the integrity of core recovery support services and the service relationship.

The transition from services that focus on acute biopsychosocial stabilization to services that support long-term recovery will be a difficult one, with innumerable obstacles and pitfalls. Supervisors can expect considerable resistance from staff and also from clients ingrained in old styles of treatment.

> *It was very difficult at first to make this shift from control to support. The clients were in an uproar because they felt that their peers were getting away with all kinds of mayhem, and many staff felt the same way. We had an easy way to handle the clients whenever they would not follow our direction—the shit pile [work detail]. That was our answer for just about everything…if you don't like it, then go out to the shit pile. If you don't want to do it, than go to the shit pile. If you fall asleep in group, you go to the shit pile. There was nothing more in our recovery tool box to help the clients be accountable for their behaviors. When we shifted approaches, frustration was common amongst staff. We were sure clients wouldn't get sober under this new system and that we would ruin our reputation in the community. We resisted this change. We kept asking for a list of rules. And every time the bosses left us, we would just shake our heads because we thought they were absolutely crazy in what they were trying to do. We were scared. It took a while for us to gain an understanding of what they were trying to do. As in AA, we had to fake it until we got it. After a while, we started to believe and gain an understanding of why this change was so important.*

Success or failure with such a transition rests to a great extent on the role of the clinical supervisor. For success, the supervisor must nurture development of a chain of support within the treatment milieu. Clinical Supervision must provide the support for continued engagement and service activity during early periods when staff may see little measurable progress and few words of appreciation coming from clients.Support from the supervisor, professional peer

support and feedback from clients in stable recovery are crucial to sustaining the motivation of staff in working with clients in the early stages of recovery.

One of the guiding concepts in clinical supervision has been that of parallel process. Searles (1955) first defined parallel process as the re-enactment of processes within the therapist-patient relationship in the therapist-supervisor relationship. What is important about this concept for our current discussion is Doehrman's (1976) discovery of the bi-directionality of parallel process, namely that key aspects of the supervisor-therapist relationship are replicated in the therapist-patient relationship. What this means at a practical level is that we can promote the counselors' use of a strengths-based approach by modeling that approach in our style of clinical supervision. If we want counselors to understand and utilize stages of change theory in their work with clients, we need to illustrate the application of that theory in our own work with the professional development of our counselors. If we want the counselor's work with each client to be focused on recovery, then that focus must be modeled within our supervision of each client's service process. If we want each counselor to demonstrate a depth of knowledge about diverse pathways and styles of recovery, then we must become students of and demonstrate respect for such pathways and styles. We close this article more convinced that ever that the role of the clinical supervision is critical to the development and maintenance of recovery-oriented systems of care. Clinical supervision occurs within a hierarchical relationship much the same way that the therapist/client relationship is hierarchically ordered. For clinical supervision to be effective, it must empower the staff so they can best understand the strengths they bring to their service relationships in much the same way they will empower clients by focusing on the client's strengths--a positive twist on the notion of parallel process in supervision!

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