Manual for Recovery Coaching and Personal Recovery Plan Development

Draft (without Chapter 10)
Check www.bhrm.org for continual updates
July 25, 2005

David Loveland, Ph.D.
Director of Research
Fayette Companies
Peoria, Illinois

Michael Boyle, MA.
President and CEO
Fayette Companies
Peoria, Illinois

Funding for the development of this manual was provided by the Illinois Department of Human Services Department of Alcoholism and Substance Abuse

Table of Contents

Chapter 1: Introduction to the Recovery Coach Program

An Overview of the Recovery Coach Program

The recovery coach program is an intensive, community-based case management program for people who have entered an addiction treatment program or have been screened for treatment, but have been placed on a waiting list. The program is designed as an integrated component of a comprehensive addiction treatment program. The primary purpose of the recovery coach program is to help individuals in addiction treatment gain access to needed resources, services, or supports that will help them achieve recovery from their substance use disorder (heretofore referred to as an SUD). Recovery coaches can help individuals address multiple domains in the their life that have been impacted by their SUD, but are difficult to address within the structure of most addiction treatment programs, such as returning to employment or finding stable housing. Recovery coaches can also help individuals transition through the continuum of addiction treatment (i.e., from detoxification to aftercare). Finally, recovery coaches can help individuals sustain their recovery after the formal addiction treatment component has been completed through consultation, skills training, and, of course, coaching.

Most individuals who enter an addiction treatment program present with multiple problems in living, comorbid psychiatric disorders or medical conditions in addition to their substance use disorder (Chen et al., 2004; Gutman, Ketterlinus, & McLellan, 2003; Shwartz, Baker, Mulvey, & Plough, 1997; Stein & Friedman, 2002; McLellan et al., 1994); however, most treatment providers are not equipped to address these interrelated issues beyond a person's substance abuse behaviors (McLellan et al., 1999; Friedmann, Alexander, Jin, & D'Aunno, 1999; Etheridge, Craddock, Dunteman, & Hubbard, 1995). These co-occurring conditions, disorders, and unresolved problems in daily living (e.g., lack of affordable housing, unemployment) can undermine or, at least, diminish the impact of effective treatment interventions and lead to disengagement (Blomqvist, 1996; Godley et al., 2004; Grella et al., 1996; Larimer & Kilmer, 2000). Conversely, access to and receipt of a comprehensive array of medical, psychiatric and psychosocial services has been shown to improve engagement, retention, and treatment outcomes for individuals receiving addiction treatment services (Hser et al., 1999; McLellan et al., 1993 & 1994; Pringle et al., 2002). Unfortunately, the availability and overall range of these ancillary services provided by addiction treatment organizations has diminished over time (Etheridge, Hubbard, Anderson, Craddock, & Flynn, 1997; Hser et al., 1999; McLellan et al., 1999; Friedmann et al., 1999; Durkin, 2002).

Because most treatment providers are unable to provide a comprehensive array of services on site, an alternative solution is to help individuals acquire these services in the community. The recovery coach program can be used to help individuals successfully link to and effectively use resources in the community while they receive treatment for their addiction.

Need for Comprehensive Services

Research has consistently supported the tenant that addiction treatment is generally effective at helping many individuals reduce their SUD. Research has also revealed, however, that many

individuals drop out of treatment, relapse within three to six months after completing treatment, or require multiple treatment episodes before achieving a sustained period of abstinence. Factors associated with an increased risk of relapse during or after treatment can include: (1) severity of the SUD at admission, (2) having more service needs at admission, (3) the presence of an active mood, anxiety, or personality disorder (or symptoms), (4) perceived high rates of stress, (5) being unemployed or having employment problems, (6) being of a minority status, (7) having less coping resources or a low sense of self efficacy, (8) low income or being indigent, (9) having a PTSD or ADHD disorder at admission, and (10) actively participating in drug-related leisure activities (Brewer, Catalano, Haggerty, Gainey, & Fleming, 1998; Grella, Hser, & Hsieh, 2003; Kubiak, 2004; Larimer & Kilmer, 2000; McLellan et al., 1994; Miller & Westerberg, 1996; Schutte, Nichols, Brennan, & Moos, 2003; Simpson et al., 1999; Walton, Blow, Bingham, & Chermack, 2003; White et al., 2004).

Individuals who require professional interventions to overcome their SUD experience more alcohol and drug related problems and have a more intensive pattern of drug or alcohol use, limited or no social support, lower paying jobs, higher rates of mental illness, and an earlier onset of their SUD, on average, than those who are able to achieve recovery without a formal intervention (Cunningham, 2004; Larimer & Kilmer, 2000; Sobell et al., 1996; Granfield & Cloud, 2001). These differences account for the higher rates of mental illness, medical problems, and limited resources or copings skills that characterize individuals in addiction treatment services than what we would expect to find in the general population of individuals with an SUD (e.g., see highlights from the 2003 National Survey on Drug Use and Health [NSDUH]; SAMHSA, 2004). Addiction treatment appears to be the safety net or final option for many individuals who have been unable to achieve recovery on their own and, by default, consists of people who have multiple complicated issues and minimal resources.

As noted, many of these co-occurring disorders and psychosocial problems can undermine the impact of addiction treatment, lead to relapse, or, in the case of extreme problems in living, such as being homeless or re-victimized, dwarf the goal of recovery. Research has shown that people report multiple needs upon admission in addiction treatment programs, but less than a third of these needs, which are beyond specific substance use behaviors, are treated or addressed in treatment (Hser et al., 1999; Friedmann, Hendrickson, Gerstein, & Zhang, 2004; McLellan et al., 1993; Pringle et al., 2002). However, this same research has also shown a positive and fairly consistent relationship between the total number and portion of people's reported needs that are treated (e.g., the need for food, clothing, housing, transportation, medical care, childcare, and family, psychiatric or vocational counseling), and improved treatment outcomes, including increased retention in treatment and a reduction in substance use behaviors over time (Friedman et al., 2004; Hser et al., 1999; McLellan et al., 1993; Pringle et al., 2002). Prospective research has consistently demonstrated the efficacy of either integrating ancillary services within the addiction treatment program (i.e., one-stop treatment) or providing access to these services, such as through contractual agreements with community providers.

An alternative solution to providing ancillary services under one roof has been to use case managers to link people with needed services in the community. Case management is viewed as a cost effective alternative to providing all services under one roof. Case management programs have been used to engage people in addiction treatment and to augment existing addiction

treatment programs, with the later model being used mostly to replicate the integrated models reviewed above. The recovery coach model of case management is designed to help people receive a comprehensive array of services that will keep them engaged in addiction treatment and the recovery process.

Research on Case Management in Addiction Treatment

The recovery coach model is based on multiple research studies that have demonstrated the effectiveness of combining a community-based case management program with a continuum of addiction treatment services. Two specific areas of research were used to develop the recovery coach mode: (1) Assertive continuing care research for adolescents with an SUD and (2) case management interventions for adults with an SUD.

Assertive continuing care research. Assertive continuing care (ACC) is a short-term behavioral-based case management program for adolescents with an SUD leaving residential addiction treatment programs (Godley, Godley, Karvinen, & Slown, 2001). The program combines an intensive, community-based case management program with a manualized, behavioral-based addiction treatment intervention – the Community Reinforcement Approach (CRA) – that has been adapted to the treatment needs of adolescents; i.e., the Adolescent Community Reinforcement Approach (ACRA; Dennis et al., 2004b; Godley, Meyers, et al., 2001). The program was developed to help adolescents remain engaged in the treatment continuum after leaving residential treatment and to help them maintain their treatment gains while transitioning back to the community (Godley et al., 2001). Case managers work with adolescents and their family members for three months after discharge from treatment. The ACRA component of the program incorporates goal setting based on a number of life areas in addition to persons' SUD, such as assisting individuals in attaining educational and vocational goals, improving relationships with peers and family, school, and in other life areas important to the clients. ACRA also incorporates skill training and emphasizes problem solving and the promotion of pro-social behaviors that compete with the substance using behaviors.

Results from a randomized clinical trial comparing the ACC program to usual continuing case (UCC) services and tracking adolescents for nine months demonstrated a significant impact on continuity of care after treatment (Godley, Godley, Dennis, Funk, & Passetti, in review & 2002). After discharge from a residential program, adolescents assigned to the ACC condition (n=102), compared to the UCC group (n=81), were significantly more likely to receive any continuing care sessions (94% to 54%) and more days of continuing care (14 days to 6 days), and were three times more likely to adhere to the continuing care guidelines. ACC intervention was particularly effective at maintaining engagement and continuity for adolescents who had unplanned discharges from the residential program (e.g., left against medical advice), whereas individuals with unplanned discharges in the UCC condition were significantly less likely to adhere to continuing care guidelines. Finally, regardless of treatment assignment, adolescents who adhered to continuing care recommendations and guidelines were significantly less likely to use alcohol or marijuana after leaving the residential treatment program than those with poor adherence to these recommendations.

Case management research. The second area of research has focused on case management interventions for adults with an SUD. Several studies have demonstrated the effectiveness of combining a community-based case management program with an addiction treatment program or continuum of treatment services. Researchers in one study, for instance, found that a community-based intensive case management program was effective in engaging individuals classified as high-frequency users of an urban detoxification center and were homeless at the point of enrollment into the program (Cox et al., 1998). The case management program used a consumer-centered, harms-reduction approach with participants. Case managers encouraged client autonomy through the development of social and personal skills and focused on helping clients link with community-based agencies, such as addiction treatment, housing, entitlement programs, and vocational services. Results indicated that at all four time points (every 6 months for 2 years), individuals who received case management services had better outcomes on monthly income and employment, housing stability, and substance use patterns compared to a randomized group of individuals who received standard referral services from the detoxification program.

In a second study, researchers examined the impact of using a case management intervention to help people with an SUD enter and remain in treatment after being screened at a central intake facility (Mejita & Bokos, 1997). Because the central intake agency only provided assessment and referral services, individuals were still responsible for gaining access into an SUD treatment facility. The authors added a case management component to the program to help individuals gain access into treatment after they completed the screening and referral process and to continue working with them while they were in treatment. Case managers were trained to use motivational interviewing techniques and had access to treatment dollars to help facilitate entry into treatment if the consumer was indigent. Over the course of three years, individuals who received case management services were significantly more likely than the control group (i.e., the standard screening and referral process) to be admitted into a treatment program (98% vs. 57%), admitted more rapidly into treatment (17 days vs. 188 days), and stayed longer in treatment (27 months vs. 14 months).

Siegal and colleagues (1996 & 2002; Rapp, Siegal, Li, & Saha, 1998) examined the efficacy of combining intensive strengths-based case management services with a established program of inpatient or outpatient addiction treatment programs for individuals in the VA system. The case management component was as an intensive, community-oriented and consumer-centered program that focused on developing and expanding peoples' strengths and capacities and emphasized autonomy and skills development (Rapp, Siegal, & Fisher, 1992). Results at six months after admission into the program indicated that individuals who received the enhanced model with strengths-based case management services stayed in treatment longer and had lower reported drug and alcohol use (Rapp et al., 1998); had better outcomes on multiple indicators of criminality (Siegal, Li, & Rapp, 2002); and, for those who wanted to work, had better employment outcomes compared to a randomized group of individuals who received the same addiction treatment services without the case management component (Siegal et al., 1996). The authors also found that approximately a third of the individuals assigned to the enhanced treatment condition dropped out of the addiction treatment component of the program, but stayed engaged with the case management component (Siegal et al., 1997). This subgroup within the enhanced condition had similar outcomes to those individuals that remained engaged in both

aspects of the enhanced program, such as lower drug and alcohol use, improved employment, and lower criminality compared to individuals who withdrew from the entire program. Furthermore, two thirds of the enhanced group remained engaged with their case manager whereas only one third remained engaged in the addiction treatment program, and no one who remained in the addiction treatment program dropped out of the case management component.

All three of these studies demonstrated the effectiveness of combining a strengths-based model of case management with an addiction treatment program. The following section provides an overview of the principles of effective case management practices derived from the ACC program for adolescents with an SUD and case management for adults with an SUD.

Overview of the Principles of the Recovery Coach Program

The term recovery coach is purposely used in place of the more familiar title of case manager to reflect the collaborative and strengths-based nature of the program and the primary goal of the program, which is to help people achieve sustained recovery from their SUD. The term case manager has been associated with a more traditional, hierarchical or professionally based service delivery model that is commonly found in both the addiction and mental health treatment fields. Moreover, in the mental health field, the term case manager has been associated with a paternalistic model of care wherein people are "cases" that need to be "managed". On the other hand, the recovery coach title is intended to imply that the staff member will help "coach" or "consult" with people who are working on their recovery. Nonetheless, because the term case manager has currency in both the mental health and addiction treatment fields and is used in the research, we will continue to use the term when referring to specific research findings; otherwise, we will use the term recovery coach or RC to refer to the program and job role described in this manual.

From the research reviewed above and other published studies, we derived nine principles of effective case management in the addiction treatment field that comprise the recovery coach program.

(1) Intensive services (small caseloads). The research indicates that case management programs with smaller caseloads are more effective than larger caseloads (Kirby et al., 1999; Vanderplasschen, Rapp, Wolf, & Broekaert, 2004). Vanderplasschen et al., (2004) recommend a caseload size of 15 to 20 clients. Godley and colleagues (2001) recommend an ACC caseload size of 15 to 20 clients when working with adolescents in large urban centers and 8 to 11 clients in more rural areas. The benefits of using an intensive case management program compared to a less intensive model are well established in the mental health field (Mueser et al., 1998; Drake et al., 1998). Case managers need time to teach people the skills to manage their SUD and achieve their goals in life, such as returning to the workforce or navigating through social services. The small caseload also provides case managers with the flexibility they need to address crisis situations with clients. People only need the intensive level of case management for six to 12 months after completing an addiction treatment program, but may require a less intensive connection with a case manager for 12 to 36 months (this will be discussed in more detail in the ninth principle).

(2) Clearly defined role for case managers. The role of case managers should be clearly defined and separated from the role of primary addiction treatment clinicians. It is important to

distinguish between "case management activities", which are often used by existing addiction treatment clinicians and "case managers", which are staff members hired and trained specifically to implement the 9 principles of case management outlined here. In two out of three studies that failed to find support for case management, the job role was poorly defined or existing addiction treatment counselors were asked to perform both roles (Conrad et al., 1998; Friedman et al., 2004). In either situation, clinicians often revert back to existing professional roles and behaviors. To avoid this drift in fidelity, it is essential that the role of case managers be clearly defined and delineated from other positions in the agency, such as a clinical counselor. Following the other principles noted in this review will help to maintain the integrity of the case management position and role.

(3) Community-based service delivery model. Case management services are provided in the client's community, rather than in the office building that houses the case managers or the primary addiction treatment program. There are many advantages to a community-based model compared to an office-based program, such as the ability to observe clients' behaviors in their natural environment, the opportunity to teach daily living or recovery management skills in real-world settings, and increased engagement through assertive outreach (i.e., bringing the treatment to the client). A subtle benefit of a community-based model is that it helps to achieve the second principle of effective case management services; i.e., separating the role of case managers from primary addiction treatment counselors. Furthermore, community-based case managers can assist clients in completing their self-defined goals or steps, such as attending a physician's appointment or a job interview, whereas office-based clinicians are usually limited to providing only verbal support and indirect guidance.

(4) The provision of strengths-based services. Another core principle of effective case management services is the application of a strengths-based model of care. Most of the successful case management interventions used a strengths-based or consumer-centered approach with clients (Cox et al., 1998; McLellan et al., 1998; Siegal et al., 1996; Hall et al., 2002). The strengths model consists of two basic principles: a) people have strengths and capacities that can be nurtured and enhanced, and b) people can grow and prosper if given access and control over resources necessary for them to thrive in the community (Rapp, 1998). The model aligns well with the community-based goals of intensive case managers, which are to help people with an SUD increase their skills and resources to manage their recovery and, subsequently, their life. Additionally, the strengths perspective emphasizes that the community, like individuals, is an oasis of resources waiting to be discovered and used (Kisthardt, 1997; Rapp, 1993). The goals, needs, and desires of consumers drive a strengths-based program, rather than the clinical expertise of the case manager or the addiction treatment counselor. The case manager is viewed as a partner and consultant with the consumer in attempting to achieve the consumer's self-defined goals (Kirstardt, 1993). Finally, the strengths model views individuals in terms of recovery rather than maintenance (Wilson, 1992).

(5) The application of motivational interviewing skills. Effective case management programs also used motivational interviewing techniques to keep people actively engaged in treatment (e.g., Kirby et al., 1999; Mejita & Bokos, 1997). Motivational interviewing (MI) is an empirically established practice for treating people with an SUD (NIDA, 1999; Miller, Wilbourne, & Hettema, 2003; Moyers, 2003). MI is a structured, non-confrontational, client-centered therapeutic technique that is designed to engage people in addiction treatment who are ambivalent about or even resistant to changing their alcohol or drug use behaviors (Miller & Rollnick, 2002). MI is rooted in the transtheoretical model of cognitive change (Prochaska,

Norcross, & Diclemente, 1995). The transtheoretical model posits that people are in one of six possible cognitive stages of readiness to change a particular behavior, ranging from being unaware that change needs to occur (i.e., pre-contemplation) to actively and effectively managing and sustaining a change (i.e., maintenance). The primary premise of the model is to work with people in their current stage of readiness and to help people move into an active stage change. MI fits well with a strengths-based or consumer-centered orientation while providing case managers with a specific technique to deal with the ebb and flow of peoples' motivation to manage their SUD. MI can also be used to address other problem areas, such as motivating people to better manage their mental illness or chronic medical condition (e.g., diabetes or high-blood pressure).

(6) Integrate case management with existing addiction treatment services. The most successful case management programs were combined or integrated within a continuum of addiction treatment services (e.g., McLellan et al., 1999; Seigal et al., 1996; Sosin et al., 1995). As discussed previously in this proposal, many people with an SUD need access to comprehensive array of addiction treatment and ancillary services, concurrently. Combining standard addiction treatment services with a community-based case management program can approximate or, at least, approach a comprehensive model without the substantial cost associated with providing ancillary services under one roof. Case management services can also keep people engaged in the continuum of addiction treatment services while concurrently helping them address other interrelated issues, such as housing or employment (Mejita & Bokos, 1997; Siegal et al., 2002).

(7) Develop or enhance resources (recovery capital). Probably the quintessential function of a community-based case manager in mental health or addiction treatment is to help individuals gain access to needed resources in the community, usually by overcoming or removing barriers or otherwise helping people bridge the gap between their needs and available resources. A primary function of case managers in most of the studies reviewed in this manual was to help clients connect with service providers, including addiction treatment, and to assist people in acquiring resources that would directly or indirectly facilitate their recovery from a SUD, such as acquiring childcare services or stable housing.

(8) Behavioral skills training. Another common theme among effective case management programs was the application of behavioral skills training to help people manage their SUD (Cox et al., 1998; Godley et al., in review; Hall et al., 2002; Vaughan-Sarrazin et al., 2000; Kirby et al., 1999; Rapp et al., 1992). Behavioral skills training is a core component of several evidence-based practices in addiction treatment, such as the Community Reinforcement Approach for adults (CRA; Meyers & Smith, 1995) and adolescents (ACRA; Godley et al., 2001), Cognitive Behavior Therapy (Monti, Kadden, Rohsenow, Cooney, & Abrams, 2002), and Relapse Prevention training (Marlatt & Gordon, 1985) and strengths-based case management programs in the mental health field (Rapp, 1998). Examples of behavioral skills training include a functional analysis, problem-solving, shaping, modeling, cognitive restructuring, and rehearsing. Structured skills-training is used to increase or enhance peoples' human capital (i.e., coping skills), using Cloud and Granfield's (2001) terminology. It can also be used to help guide case managers' activities with consumers, including involving family and friends in the ongoing behavioral plan. Skills training is the bridge between the access to resources, which is what an office-based model of case management can achieve, and helping people optimally use these resources to achieve the long-term goal of recovery from an SUD, which is a what a community-based case management program can accomplish using these training methods.

(9) Ongoing relationship. One of the few consistent findings in addiction treatment research over the past 30 years is that people have better treatment outcomes the longer they stay engaged in treatment (Simpson, 1979; Simpson, Joe, Fletcher, Hubbard, & Anglin, 1999; Siegal, Li, & Rapp, 2002). Therefore, a primary goal of any community-based addiction treatment program is to keep people engaged in the recovery process over time. Furthermore, longitudinal research has revealed that the effects of any single treatment episode on most individuals with an addiction to alcohol or other drugs is usually short lived and that many individuals require multiple treatment episodes before they can achieve an extended period of abstinence beyond three to six months (Anglin, Hser, & Grella, 1997). On the other hand, this area of research has also revealed that multiple treatment episodes appear to have a cumulative effect and that eventually leads to an extended period of recovery.

Anglin and colleagues (1997) argued that a clinically and cost effective model of addiction treatment should include a holistic and long-term view of care. In other words, instead of discharging and reopening individuals in multiple short-term and expensive single episodes of care, such as a 28-day inpatient program or a six-week outpatient program, create a program that keeps people actively engaged in a continuum of care until they have mastered the skills and acquired the resource capital to sustain their recovery. Because most individuals will relapse within three to six months after completing a single episode of treatment, it is critical to keep them engaged in a community-based program for at least six months to one year after completing a formal treatment intervention.

Purpose of this Manual

These nine principles provide the framework for implementing and operating the recovery coach program. The following eight chapters can be used as a guide to help providers implement the recovery coach model of case management and as a training manual for recovery coaches. Chapters 2 - 5 provide information for the initial start up of the project. Chapters 6 – 9 provide information and clinician guidelines for instituting the nine principles of the recovery coach program.

This manual is not intended to be a comprehensive training guide for all the techniques that are reviewed in the following chapters. Each chapter provides an overview of effective treatment techniques and principles along with recommendations and references for further training. This manual should be used in combination with a coordinated training program and ongoing supervision.

Throughout this manual we use the terms individual, client, and consumer interchangeable to reflect the people who enter our treatment facilities looking for help with their SUD or mental illness and hope of recovery. Because no single term appears to be universally accepted to represent this diverse and large group of individuals, we purposely include multiple terms to define the treatment population or potential treatment population.

Chapter 2: Structural Aspects of Implementing the Recovery Coach Program

Implementing the RC program will likely require modifications to existing addiction treatment policies, guidelines, and funding structures in most states and possibly the culture within existing treatment organizations. Traditional addiction treatment programs have been structured around a professionally-driven, short-term (e.g., four to six weeks), and residential- or outpatient-based model of treatment. Although therapeutic communities tend to have a substantially longer duration of care (e.g., 12 to 24 months), they are organized as a highly structured residential milieu. State policies, guidelines, licensures, and funding streams have evolved to support these traditional treatment programs and, as a result, will require some changes to support the application of a more client-centered, longer-term (e.g., 12 to 24 months), and community-based program.

In addition to these state-level issues, the culture and philosophical or ideological orientation of the treatment program will also need to be modified to incorporate a community-based, client-centered model of care. Just as states have evolved to support the traditional model of addiction treatment, staff and agencies have evolved overtime to sustain funding, licensure, and job security. Existing staff members have been trained to deliver traditional residential- or office-based addiction treatment services. Both the collective organization and the staff members within all levels of the agency will be impacted by introduction of the RC program. The implementation of the RC program will require the involvement of staff from all levels of the organization and modifications to how the agency engages and provides services to its treatment population.

Establishing Billing Policies

The opportunities to fund recovery coaches will vary widely depending of the financing mechanisms of individual states. Below are examples from states that have implemented or modified their funding structures to support and disseminate recovery-based models of care similar to the recovery coach program. It is suggested that providers contact these state systems for more information regarding the implementation and dissemination of recovery-based services.

- **Arizona**: In 2004, the Arizona Department of Health Services-Division of Behavioral Health Services provided funding and guidelines for recovery support services within their Medicaid managed care program. These services may be delivered pre-treatment, during active treatment or post-treatment. The original $200,000 set aside in contracts for peer delivered services is being increased by an additional $700,000 in 2005 (http://www.azdhs.gov/bhs/tr_resources/psp_training.htm).
- **Oregon**: In 2005, Oregon provided funding via contracts for recovery support services. These recovery support services can include case management services and aftercare services to cover needs that are generally thought to be outside the realm of substance abuse treatment (http://egov.oregon.gov/DHS/addiction/recovery.shtml).
- **Connecticut**: In 2004, the Dept of Mental Health and Addiction Services provided funding for Recovery Management Services within their Access To Recovery (ATR)

program (described below). The recovery management program model in Connecticut as a dedicated staff person to provide referral, linkage, and coordination of multidisciplinary services according to an individualized recovery plan incorporating the input of persons and their natural supports. The recovery management program is intended to assist the individual to work on integrating relapse prevention skills and achieving autonomy – gainful employment and independent living in the community. The ATR vouchers will fund recovery management services up to $2,000 per slot. The ATR program in Connecticut requires providers of all levels of services to promote a recovery-oriented system of care (http://www.dmhas.state.ct.us/recovery.htm). These include:

- Embracing recovery-oriented principles and guidelines
- Delivery of person-centered, strengths-based and community-focused care
- Optimizing natural supports and community involvement
- Utilizing best or evidence-based practices

Recovery coach supports will be reportable or billable as case management in states that cover this service level. The services provided such as assistance in vocational activities, housing and accessing other recovery supports will usually qualify as case management. In Illinois, for example, case management may be billed to the state general revenue funding but is not covered under Medicaid.

The Recovering Community Support Program (RCSP) of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) supports organizations operated by persons in recovery from addictions (http://rcsp.samhsa.gov/). An opportunity exists for partnership to be formed between the RCSP's and treatment organizations for the provision of peer recovery support. Another funding opportunity from CSAT is the Access To Recovery (ATR) program (http://www.atr.samhsa.gov/). The ATR program provides vouchers to individual clients for the purchase of substance abuse treatment and recovery. The goals of the program are to expand treatment and recovery capacity, support client choice, and increase the array of providers among both community based-and faith-based providers. Funding is provided to individual states from the Substance Abuse and Mental Health Administration through a competitive application process. Several states have received funding to implement this voucher program.

Overcoming Documentation Barriers

Most states have extensive documentation requirements for licensure, certification and funding. These requirements may be experienced as a barrier to maintaining individuals as "open" for billing and reporting requirements. For example, continued treatment plan updates may be required or closure of cases may be mandated if services are not provided for a specified time period.

One option to overcoming these barriers is to request specific exceptions from the state. For example, a request could be made to utilize a personal recovery plan in place of the treatment plan for post active treatment recovery support. A longer-term approach is to work with state officials to change the language in the rules to support a recovery management approach. The

second author of this manual (MB) has been working with the Illinois Division of Alcohol and Substance Abuse (IDASA) to pilot and fund a recovery coach program in Peoria, IL, referred to as the Behavioral Health Recovery Management (BHRM) project. A component of the project is a State waiver to allow a not-for-profit service provider – Fayette Companies – to maintain recovery coach services and the subsequent billing protocol for women who enter one of the company's addiction treatment programs, even after they have been discharged from the primary addiction treatment program. The nine-principles of the RC program and the subsequent forms outlined in this manual are being tested in this project.

Another option, which is also being used in the BHRM project, is to use both a treatment plan and a recovery plan for individuals who are enrolled in a traditional inpatient or outpatient addiction treatment program and are also receiving RC services. Treatment providers will still need to use a formal treatment plan for billing purposes and for state and national standards. The existing treatment plan can be easily modified by staff to incorporate the inclusion of RC services without altering the established structure of the plan. The recovery plan, on the other hand, is a more dynamic, client-directed, and comprehensive document that is developed collaboratively between the client and RC and will not be easily incorporated into the existing planning process. The structure of the recovery plan will be discussed in chapters 7-9 of this manual. The two plans can be used concurrently while clients are receiving both types of services. Once an individual leaves the formal treatment program, the recovery plan becomes the primary plan from which services are directed.

A note of caution on this option is that primary service providers should avoid the tendency to incorporate the two plans into one document or to simply rename the existing treatment plan as a recovery plan. The two plans serve different purposes and should be treated as separate documents to maintain this distinction and to avoid confusion among staff members in both programs (the issue of maintaining program fidelity for the RC program will be discussed in Chapter 10).

Establishing an Advisory Committee

The RC program will be viewed as a new and somewhat radical innovation to established addiction treatment providers. Administrators, supervisors, and frontline staff will need extensive help in implementing the RC program and adopting a conceptually different model of treatment and recovery. The establishment of an advisory committee, particularly during the design and implementation of the recovery coach model, is highly recommended. This committee can be invaluable in providing information and ideas to the organization and can help staff within all levels effectively assimilate this information.

An advisory committee consists of key stakeholders in the community and the organization that could be impacted by the RC program. Key stakeholders can include frontline clinicians and administrators from the organization, advocacy groups (e.g., Faces and Voices of Recovery), staff members from community-based agencies, such as public housing, primary healthcare, Medicaid, religious-based programs, or the legal system, and current and past consumers of addiction treatment services. The committee serves as a tool for oversight and evaluation of the

implementation process and as a resource-exchange center for the distribution of information coming into the organization and going out to the community.

The advisory committee should be chaired by a senior ranking member of the organization implementing the recovery coach model to assure investment in the change. One cautionary note is that members need to be screened regarding their ability to embrace a variety of paths to addiction recovery. A person who believes their own experience in gaining recovery through AA or a person who believes faith or a certain religious experience is the only means to recovery may be unable to support the variety of personal recovery plans individuals may wish to pursue.

The advisory committee is expected to meet on a monthly basis for the first year of the implementation process and quarterly, thereafter.

Involving Staff in the Implementation Process

After organizing an advisory committee, the next step in the implementation process is to involve staff within all levels of the organization in developing a recovery coach program. As noted, the recovery coach model of case management will be new to most service providers and frontline clinicians. It is important to address potential misperceptions and resistance that can be encountered when implementing an intervention that is conceptually different from the primary treatment program.

An effective technique for removing staff resistance or confusion is through consensus building. The process begins with a series of educational seminars to provide staff with an introduction and orientation to the recovery coach program. A key component of this process is allowing staff members the freedom and support to voice their opinions and concerns about the proposed project. There are many potential areas of conflict or friction that can occur as a result of implementing a community- and strengths-based model within an established, office or residential-based and professionally-driven addiction treatment program. Many of these potential areas of friction are listed here.

- Conflict between the treatment goals of the addiction treatment program and recovery coaches.
- The likely possibility that a client will leave treatment against medical advice (AMA) or be administratively discharged for ongoing use of alcohol or other drugs, but remain open and active with a recovery coach.
- Ideological conflict between the professional-based primary addiction treatment model and the strengths-based, consumer driven model of recovery coaches.
- Rules within the residential program that may conflict with recovery coach services, such as meeting off grounds, leaving a group to work on another activity, or working on other issues before completing specific phases of treatment.
- Rules within the outpatient programs that discourage working with other agencies or programs during hours of treatment.

- Changes in peoples' treatment needs as a result of receiving recovery coach services during a waiting period (e.g., no longer needing residential treatment after achieving some level of control with a recovery coach).
- Increased ambiguity in the definition of "actively enrolled in treatment" as a result of offering the recovery coach program as an alternative to primary treatment; e.g., can people who are court ordered to addiction treatment receive only recovery coach services and still be classified as "actively enrolled in treatment"?

These potential areas of friction between an existing program and the recovery coach model need to be discussed in an open and supportive environment. The initial consensus building meetings can be used to generate a list of potential barriers and obstacles that need to be addressed.

The next step involves organizing a series of small workgroups consisting of staff members from all levels of the organization. The workgroups are given the task of developing an implementation plan based on the list of barriers or problems that need to be addressed and the RC model. Staff members within these workgroups are assigned specific tasks to accomplish, such as updating policy manuals, developing flyers or pamphlets, supervising recovery coaches, and training recovery coaches. The workgroups also keep the advisory committee and other staff members updated throughout the process.

Evaluation experts estimate that it takes between six months and two years to fully implement a multi-dimensional intervention, such as the RC program. Therefore, it is also important to treat the process longitudinally, rather than attempting to implement all the elements at once. The RC Fidelity tool, which is described in Chapter 10, is organized to reflect the suggested order of the implementation process. The first section of the fidelity tool addresses the structural or organizational dimensions that are needed to sustain the RC program.

Establish Procedural Guidelines

The workgroups are used to construct agency guidelines and policy manuals to support the implementation and daily operations of the RC program. Written procedures and policy manuals are essential, yet commonly neglected components of the implementation process. The policy and procedure manual should specifically address the following components:

- Roles and responsibilities of the recovery coaches
- How the role of recovery coach differs from clinical staff
- Supervision of recovery coaches
- How identified conflicts between a recovery coach and a clinical staff member will be addressed and resolved
- Confidentiality expectations for recovery coaches
- Criteria for persons being offered a recovery coach (i.e., inclusion and exclusion criteria)
- Referral protocol
- Procedures and forms (i.e., documentation)
- Expected length of involvement in the RC program
- Discharge criteria

Housing the Recovery Coach Program

The next aspect of the project to be addressed is establishing the home base for the recovery coaches. Recovery coaches are viewed as members of a comprehensive addiction treatment team, but their role in the program is unique and distinctly different from the roles of the primary addiction treatment staff. It is recommended, therefore, that the recovery coaches work out of a location that is physically separate from the primary addiction treatment program or programs. One reason for separating recovery coaches from the primary treatment program is to avoid any confusion in the roles of staff members in either program and to avoid the potential drift of recovery coaches toward the office-based or residential model that is being provided by the primary addiction treatment staff. This issue relates to the fidelity of the recovery coach model. Office-based case management programs are usually less effective than community-based case management programs. It is important, therefore, that recovery coaches keep their focus on working with people in the community. The other related issue is that office-based case managers are often required to perform many of the same functions as addiction counselors, which again, can result in further decline in case management-specific activities. Separating recovery coaches from the primary addiction treatment program is a practical first step to maintaining high fidelity of the model. This separation also helps to clarify the roles of recovery coaches among other counselors in the program and clients.

Recovery coaches may or may not be employed by an addiction treatment provider. For example, they may be part of a separate organization such as the Center for Substance Abuse Treatment's Recovery Community Services Program that funds peer based recovery support or other peer operated recovery organizations. Recovery coaches may also be associated with a faith-based organization. Further, recovery coaches may be volunteers rather than paid staff members.

Recovery Coach Supplies

Recovery coaches will require resources that are specific to their community-based model. These resources include:

- funds to cover mileage reimbursement (based on experience, this may range from $2,000 to $4,000 per year).
- a cellular phone
- access to a desktop or laptop computer
- discretionary funds that can be used to purchase small items, such as food or a bus pass, or can be used as part of contingency management program (see a discussion in Chapter 6 for more information about contingency management).

Staff Qualifications

Staff qualifications will vary across states depending on guidelines and licensure policies. Being a person in recovery is assumed to be a benefit to the position due to inherent understanding of addiction and recovery, though this is not considered to be a mandatory requirement. The most important consideration is the individual attributes the person brings to the job (Godley et al.,

2001). A list of attributes from the ACC manual (Godley et al., 2001) and research at Fayette Companies include:

- Positive and enthusiastic about working with the target population
- Nonjudgmental of adolescents or adults who have an SUD or psychiatric disorder
- Ability to establish empathy with the individual
- Ability to work with diverse populations and cultural backgrounds
- Comfort in working independently in community settings
- Willingness and open-mindedness to follow established RC procedures
- Acceptance of extremely flexible working hours

Care should also be taken that the person applying for the position does not have rigid views or personal bias regarding the paths to recovery. A person who believes that true recovery may only be achieved through a 12-step mutual aid program or any other singular view of recovery will not be able to support a menu of options and personal choices.

The funding and licensure/certification rules of the state in which the service is planned to operate should also be considered before establishing staff qualifications. Some states may have specific requirements for education or staff certification.

The following is a list of the competencies for training purposes.

General professional competencies

Knowledge of:

1) aspects of addiction treatment and how to access it,
2) the Stages of Change Theory (described in chapter 6),
3) motivational interviewing or motivational enhancement techniques (described in chapter 6),
4) behavioral problem solving techniques for addiction treatment (described in chapters 7 & 9),
5) principles of recovery from either an SUD or mental illness, and
6) case management activities and applications particular to recovery management.

Indigenous and community competencies

Knowledge of:

1) community resources for social support and how to access each,
2) resources for food, clothing, shelter and other distal needs and how to access,
3) resources for medical care and how to access,
4) resources for mental health care and how to access,
5) mutual aid recovery groups, their functions, values and beliefs and how to access, and
6) faith based organizations and how to access.

Chapter 3: Training and Supervising Recovery Coaches

Training of recovery coaches involves two overlapping phases. The first phase is the initial training given to RCs before they begin to see clients. The second phase is the ongoing supervision, training, and quality improvement procedures for RCs after they begin to work with clients.

Initial Training Protocol

The training protocol consists of two skill areas. The first area consists of basic skills for any community-based case management program. The second skill area consists of evidence-based or empirically established interventions for people with an SUD, mental illness, or both.

Basic Skills

The training protocol should include three basic skill areas for recovery coaches: (1) crisis management, (2) involving family and friends in the program, and (3) time management and staying on task.

Crisis management. The ability and flexibility to deal with crisis situations as they are encountered in the community is an invaluable skill for RCs. Crisis, by definition, is an unplanned and distressing situation that cannot be easily resolved. Many of the individuals who enroll in a recovery coach program will experience crisis situations in their life, which means that recovery coaches will inevitable encounter clients under these circumstances. Crisis situations can include encountering a client who is intoxicated in their home, finding emergency housing on a Friday night, encountering an abusive partner, dealing with a client who is reporting suicidal ideations, or dealing with a client who is experiencing a panic attack or psychotic symptoms. Crisis management involves learning how to handle various situations and knowing the difference between a dangerous situation (e.g., encountering an abuse partner in the home) and a manageable situation (e.g., dealing with a panic attack). Crisis management also involves being aware of services in the community that can be used to resolve the situation, such as emergency housing (e.g., Salvation Army or a homeless shelter) or a shelter for victims of domestic violence, pharmacies that take Medicaid or Medicare and have extended evening hours, Emergency Response Services (ERS) for dealing with psychiatric issues, detoxification services, food banks, and law enforcement services. Training in crisis management should also include suicide assessment skills and knowing how or what to do when encountering clients who are under the influence of alcohol or other substances.

One common crisis or, at least, an unplanned situation will involve encountering clients who are under the influence of alcohol or other drugs during a planned or unplanned meeting. In the ACC manual, Godley and colleagues (2001) recommend that the staff member reschedule the session for another day. RCs should avoid confronting, accusing, or shaming clients under the influence and, instead, calmly set up another meeting with them when they are less likely to be under the influence. The follow up session can be used to problem solving the relapse and how to avoid the occurrence in the future. As described next, part of the problem solving solution could be to include a significant other in the meeting to further discourage alcohol or drug use prior to the appointment time.

Involve family and friends. Involving significant others, such as family members and friends in the clients' recovery program is another important skill to acquire. Though most

providers and programs support the idea of involving family and friends in the treatment program, most do not emphasize this involvement or provide the structure to sustain it. As a result, family and friend involvement is often neglected or relegated to the final stages of treatment (e.g., discharge planning). Involving family and friends in the recovery coach process is considered to be an essential aspect of the program and is based on established research, including the Assertive Continuing Care (ACC) program (Godley et al., 2001) and the Community Reinforcement Approach (CRA; Meyers & Smith, 1995). RCs will require formal training and ongoing supervision to consistently and naturally incorporate significant others in the recovery coach program and planning process. Specific elements of the training process should include:

- helping clients develop a list of supportive people in their lives,
- helping clients find supportive people in their lives if they don't have anyone at the beginning of the program,
- creating communication bridges to significant others through signed releases and through written agreements (e.g., calling family members every week as a function of the recovery plan),
- integrating family and friends in the engagement process (e.g., making phone calls or home visits, handing out flyers about the RC program or the recovery process),
- establishing recovery planning meetings that include significant others in the meeting, and
- involving significant others in problem solving plans (discussed in chapters 6 – 9) or in developing new skills (e.g., participating in leisure activities without alcohol or other drugs), and
- sustaining contact through weekly or monthly meetings to review the recovery plan and progress.

Developers of a recovery coach program will need to emphasize that involvement of significant others in the RC program is a necessary and essential component and that it should be incorporated in all aspects of the program.

Deliver services in the community. Providing community-based services to clients and learning how to manage time while in the field are also essential skills for the RC intervention. The hallmarks of most professional models of addiction treatment are the provisions of a highly structured and consistent treatment program and environment. On the other hand, community-based programs, such as intensive case management are characterized as being unstructured, dynamic, and individualized. Community-based clinicians will require a set of skills that are rarely used within most conventional addiction treatment programs and difficult to acquire without training and supervision. Below is a listing and description of skills associated with community-based interventions.

- **Time management**: Managing time is an important clinical skill in any treatment program, but it is more challenging in the community when dealing with clients who are difficult to engage or have multiple issues to address. In most conventional addiction treatment programs, clients come to the clinician or can be easily and quickly located within the walls of the program. In the RC program, RCs will almost always travel to meet the clients in their community or living environments. Moreover, clients are more difficult to locate in the community and frequently forget or purposely avoid appointments or are easily distracted by other issues and people in their living

environment (distractions that do not occur in treatment settings). RCs will require training to learn how to maximize their time by organizing client meetings by geography (e.g., meeting both clients who live on the south side on Monday and meeting with all three clients at the Salvation Army on Tuesday), calling ahead to re-confirm the meeting or calling a family member to remind the client about the appointment, planning ahead and bringing necessary paperwork or supplies (e.g., application for Medicaid or Workforce Development), and knowing when to end a meeting with a client (described next).

- **Staying on task**: A related skill to time management is staying on task. Again, this is an important skill in any treatment intervention, but it is easier to achieve in a structured program where clients are already assigned to specific groups and activities throughout the day and the focus of treatment is primarily on the issue of addiction. Staying on task is more challenging in the community and with clients who have multiple needs, beyond their addiction. RCs will be challenged to stay focused when dealing with clients who have overwhelming issues and also clients who don't seem to have any goals, issues, or plans. In the first scenario, RCs can get overwhelmed when dealing with clients who have multiple pressing issues, such as living in extreme poverty, having no transportation, living in an unstable housing situation, chaos in the home environment, psychiatric problems, or dealing with the needs of children or other family members (e.g., a father who is also an alcoholic and living with the client). These situations will be common among the clients who need the RC program. RCs will need training to manage these situations and avoid getting drawn into the chaos. RCs will need to learn how to limit meetings with clients and to assertively keep clients on task during each meeting (and when to say no to clients who are being unreasonable in their demands). This skill also requires the ability to avoid digressing into other unplanned issues, such as dealing with children in the home when the planned meeting was to look for a job. RCs will also need training and ongoing supervision to avoid taking on more responsibility for problematic clients than is reasonable or warranted. RCs will need to understand that their role is that of a coach or consultant and not as a savor, free taxi-service, or a best friend. In the second scenario, RCs can struggle with clients who don't seem to have any pressing issues or goals. Clients without any direction often struggle with boredom, low self-esteem and self-efficacy, apathy, fear or learned helplessness. RCs will need training to keep clients on task and to keep them motivated to overcome their fears and lack of self-efficacy. Chapters 6 – 9 provide a range of techniques that RCs can use to keep people engaged, motivated, and empowered to work on their recovery plans. Finally, RCs will need to be reminded that all contacts and meetings with clients should be based on a recovery goal or planed activity related to the recovery process. RC services should end if clients have no recovery goals left to accomplish or they no longer need an RC to sustain their recovery plan. In other words, RC services should not occur or be provided without a specific goal or activity to accomplish and should not be based on arbitrary guidelines, such as one-home visit per month or one hour of contact per week (these are common State standards for mental health case managers).
- **Modeling recovery-based skills**: RCs also need to be able to model and teach a healthy lifestyle that clients can observe and learn from. Managing time and staying on task are skills that will help both RCs and clients. Clients, like RCs, will require training to master the organizational skills needed to sustain their recovery over time, and this

training will come, in part, from their interactions with RCs. Stated another way, the skills needed to be an effective RC are the same skills needed to implement and sustain an effective recovery plan.

Evidence-based Skills

Below is a recommend training protocol for recovery coaches based on the ACC manual (Godley et al., 2001), case management research in the addiction treatment field, and addiction treatment technology.

1. Principles of strengths-based case management
2. Motivational interviewing (MI)
3. Contingency management (CM)
4. Community Reinforcement Approach (CRA) and other behavioral-problem solving approaches (e.g., CBT)
5. Illness Management and Recovery (IMR) for people with a co-occurring mental illness

Recovery coaches can begin working with clients before completing the entire protocol. It is recommended that the recovery coaches receive an extensive orientation on the first two skill areas and an overview of the remaining three skill areas before working with clients. Chapters 6-9 provide instructions and resources for skill areas 1-4. Illness and Management and Recovery training and implementation manual can be acquired for free at http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/illness/. The IMR manual is designed for people with a serious mental illness and can be used for individuals with co-occurring SUD and psychiatric disorders enrolled in an addiction treatment program.

Training process. The training protocol should include on-the-job training with a staff member who has already been trained in the particular topic area. Recovery coaches in training work with the primary addiction treatment program to gather information and experience on how the program works and to develop a working relationship with counselors within the various programs. If the organization provides more than one program, recovery coaches should spend approximately one workweek within each program that will be working with recovery coaches.

RC trainees should spend approximately 33% of their time each week working on classroom instruction of the various skill areas (described in the following chapters), 33% working with the existing addiction treatment programs, and 33% working with an RC trainer in the field with clients. It is estimated that RC trainees will require approximately six to eight weeks of preliminary training before they are ready to take on a caseload of clients without direct supervision.

Training protocol for treating adolescents with an SUD. We recommend the ACC and ACRA training manuals in addition to this manual for providers interested in working with adolescents with an SUD. The ACC and ACRA manuals include most of the elements noted for the adult training protocol. We recommend the ACC manual for developing the recovery coach program for adults, as well; however, the ACC manual is specifically tailored to treating adolescents with an SUD who are leaving a residential treatment program.

Additional Resources and Recommended Readings

The following list of manuals provides resources for training of recovery coaches.

- *The Assertive Continuing Care Protocol: A case manager's manual for working with adolescents after residential treatment of alcohol and other substance use disorders* by Godley, S.H., Godley, M.D., Karvinen, T., & Slown, L.L. (2001) and published by Chestnut Health Systems (available for free via PDF download at http://www.chestnut.org/LI/downloads/Manuals/ACC_MANUAL_09-24-03.pdf).
- *The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users* by Godley, S., Meyers, R., Smith, J, et al. (2001) and published by Chestnut Health Systems (available for free via PDF download at http://www.chestnut.org/LI/cyt/products/ACRA_CYT_v4.pdf).
- *A Coummunity Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction (NIDA Therapy Manuals for Drug Addiction)* by Alan J. Budney and Stephen T. Higgins (1998) and published by the National Institute of Drug Abuse (available for free via PDF download at http://www.nida.nih.gov/pdf/CRA.pdf).
- *The Strengths Model: Case management with people suffering from severe and persistent mental illness* by Charles A. Rapp and published by Oxford University Press, NY (1998).
- *Basic Case Management Training Manual for Providers of Adult Mental Health Services in Kansas* and *Strengths Model Case Management Trainers Manual* by the University of Kansas School of Social Welfare (publications can be acquired through the School's webpage at http://www.socwel.ukans.edu/publications/Strengths/index.shtml)
- *Motivational Interviewing: Preparing People for Change, 2nd Edition* by William Miller and Stephen Rollnick and published by the Guilford Press, NY (2002).
- *Clinical Guide to Alcohol Treatment: The Community Reinforcement Approach* by Robert Meyers and Jane Ellen Smith and published by the Guilford Press, NY (1995)
- *Treating Alcohol Dependence: A Coping Skills Training Guide, 2nd Edition* by Peter Monti, Ronald Kadden, Damaris Rohsenow, Ned Cooney and David Abrams and published by the Guilford Press, NY (2002).
- *Integrated Treatment for Dual Diagnosis,* Kim Mueser, Douglas Noordsy, Robert Drake and Lindy Fox and published by the Guilford Press, NY (2003).
- *Illness Management and Recovery: Implementation Resource Kit* by Susan Gingerich and Kim Mueser (2004) and published by SAMHSA (available for free via PDF download at http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/illness/)

Ongoing Supervision and Staff Development

RCs will require ongoing supervision and training to effectively implement the RC intervention and associated skills. All evidence-based practices, such as behavioral problem-solving and the strengths-model of case management (explained in chapters 6 – 9) require the application of structured supervision and ongoing training to maintain the integrity or fidelity of these interventions. Structured supervision is needed to maintain the fidelity of complex interventions and to provide support for clinicians working in the field. Supervisors are expected to provide four hours per week of supervision, guidance and training for each recovery coach (group supervision, as discussed below can be counted toward the four hours). For instance, the RC

supervisor would be expected to commit eight hours a week in supervision, guidance, and training in a recovery coach program that has hired two full time RCs. A description of supervisor activities is provided below.

Despite the importance of supervision, it is common to see this aspect of a treatment intervention applied inconsistently. A common scenario in public or non-for-profit programs in both mental health and addiction treatment is the slow drift away from scheduled supervision sessions after a new program has been implemented and the gradual increase in "hallway" or "shotgun" supervision and other types of impromptu forms of feedback and guidance. In addition, supervisors are often required to maintain their clinical responsibilities and productivity standards and are rarely encouraged or supported to maintain regularly scheduled supervision meetings with staff. These factors usually lead to a substantial reduction in clinical supervision over time.

Administrators need to build into the RC program the capacity to sustain supervision over time to avoid drifting away from structured supervision meetings. Protecting supervisors' time during group meetings or providing coverage for supervisors while they provide supervision are useful practices for maintaining the group supervision format. Administrators can also make supervision a mandatory component of the program and build it into the productivity standards for supervisors.

Structured Supervision Protocol

The supervision model presented in this manual follows a structured group format developed by Rapp and colleagues at the University of Kansas and can be acquired through their website (http://www.socwel.ku.edu/mentalhealth/case%20management%20training.htm). Group supervision is provided for two hours on a weekly basis and on a regularly scheduled meeting time. It is recommended that RCs begin receiving regular group supervision meetings as soon as they are hired so that they become accustomed to the format and understand that supervision is an essential component of the program.

Focus of supervision. Supervision is used to help RCs continually develop their job skills and to maintain the fidelity of the RC model. Supervision should be viewed and treated as fun and engaging forum for learning and team building. The group format is used to disseminate information, maintain cohesiveness and a shared vision of the program, share experiences and knowledge, and role-play situations and responses. Elements of the supervision include:

- A written schedule for the entire two-hour session (a standard format that will be used during each session),
- A brief review of all cases (no more than 15 minutes to review the entire caseload and withhold discussion on problematic cases until later),
- A brief review of RC activities, such as weekly contacts with clients or the total number of sessions that occurred with family members in the past week (10 minutes),
- A review of any RC learning plans (described below; 10 minutes),
- A review of field shadowing reports (described below; 10 minutes),

- One or two case presentations with role playing (as needed), this activity includes a review of recovery plans and how the plans are integrated within RC activities (15 minutes for each case),
- A discussion of two or three problematic cases (usually the last 30 minutes of supervision), and
- Specific assignments (e.g., doctors appointments) and coverage patterns.

Supervision is used to integrate the principles of the RC program with the practices of RCs. It is not necessary or feasible to cover all clinical issues and concerns in the two-hour session. Use supervision to teach clinical principles that can be generalized to other cases, rather than attempt to solve every clinical issue that arises. The purpose of each session is to constantly improve the skills of RCs, not to solve all their clinical challenges. To maintain the purpose of the session, supervisors should:

- follow a schedule and stay within the timeframes of each element (not all elements need to be covered at every meeting, but always have a schedule or agenda),
- encourage participation and creativity, respect opinions and ideas,
- create opportunities for laughter (i.e., have fun),
- encourage punctuality and reward promptness (and address or problem solve chronic tardiness; i.e., don't ignore it),
- encourage understanding of the RC program; in other words, teach problem solving to RCs, but don't fix the problems for them,
- keep staff on track and avoid extended digressions into other topics,
- link RC activities to recovery plans, or vice versa,
- take notes on all problematic clients and reserve discussion on daily clinical issues until the second half of the supervision meeting; in other words, get through the agenda first before addressing a particular client, and
- limit discussions on any one client to a maximum of 15 minutes and keep staff members focused on the primary issue of the client; in other words, avoid discussing non-related issues or irrelevant information to the case.

Supervisors can use information and feedback gathered in each group session to generate individualized learning plans for RCs. Learning plans are focused trainings on a particular topic or skill area that an RC needs to acquire, as revealed in the supervision meeting. The specifics of a learning plan are described below.

To maximize the effectiveness of the two-hour session, supervisors should avoid introducing topics, issues, or discussions that are not related to improving the RCs skills. Topics and issues that should be avoided from the supervision meeting include:

- discussions about salaries or benefit packages of employees,
- agency level policy issues; e.g., parking information,
- excessive complaining about particular clients, other staff members or other agencies,
- social events among staff members that don't include clients, or
- discussions about RC supplies; e.g., acquiring a company car or getting a new cellular phone.

Many of these non-clinical issues that are brought into the supervision meeting can be disseminated through other channels, such as through email or bulletin boards. Supervisors will be responsible for maintaining the integrity of the group supervision and to weed out spurious

information and discussions that serve only to distract RCs from the educational purpose of the meeting.

Supervisor activities and interventions. Supervisors can also provide individualized supervision and training to all RCs in addition to coordinating the weekly group meeting. Supervisors can use a range of teaching tools to help RCs improve their skills that include (1) learning plans, (2) shadowing RCs in the field, (3) modeling clinical skills, (4) chart reviews, and (5) consumer/client feedback.

1. **Learning plans**: As noted, learning plans are generated from information gathered in the group supervision session or by simply observing RCs with clients. Learning plans are written contracts that describe the specific skill to be acquired, what information was used to initiate the plan, how the skill will be acquired and what materials or trainings are needed, a deadline for reviewing the learning plan, and one or more measurable objectives indicating that the skill has been acquired. Learning plans are developed with RCs and are usually generated within a day of the supervision meeting.
2. **Field shadowing**: Another effective technique for supervising and training RCs is to shadow them in the field to observe their performance with clients. Shadowing consists of observing RCs in the field with clients during a normal shift. Supervisors can use a field-rating form (an example of one is provided in Chapter 10) to score the RCs performance with clients, such as using motivational interviewing or problem solving skills when appropriate or maintaining a strengths-based view of clients. It is also helpful if the supervisor independently documents all activities that the RCs are expected to record during the shadowing time and compare these recordings at the end of the shift. A specific service documentation form (SDF) for RCs is provided in Appendix B of this manual and is described in detail in Chapter 10. It is recommended that RCs use this form to document their activities with clients. Supervisors can share feedback and discuss the results of the shadowing process during the weekly group supervision with RCs.
3. **Modeling clinical skills**: Supervisors can use modeling to help RCs master a specific skill area. Modeling simply consists of having the Supervisor demonstrate the skill area with clients while RCs observe (i.e., RCs shadow supervisors). Modeling and shadowing techniques can be combined in one teaching session and repeated, if needed.
4. **Chart reviews**: Chart reviews are used to help RCs link recovery planning and service documentation with the goals of the RC program; e.g., are services linked to the goals of the recovery plan and do clients agree with the plan. Chart reviews are most effective when done with the entire team and as a tool for learning. For example, supervisors can have RCs perform chart reviews and share feedback with other team members.
5. **Consumer/client feedback**: Client feedback is an invaluable source of information regarding the effectiveness of RCs. In deed, consumer feedback may be the most accurate indicator of an RC's abilities and competence. Client feedback can be derived through informal channels, such as through impromptu meetings and in the course of shadowing RCs or through formal channels, such as through alumni meetings, focus groups, or random, but regular interviews with clients. It also recommended that supervisors or administrators avoid using satisfaction surveys as the primary source of client feedback. Standardized satisfaction surveys are usually used to meet the requirements of funding sources or State guidelines, and rarely generate useful or

accurate information. In addition, standardized satisfaction surveys tend to overestimate peoples' true opinions about a program or a specific staff member.

All these tools can be used to help RCs continually improve their skills and, as noted, maintain the fidelity of the RC model.

Chapter 4: Recruiting Candidates for the Recovery Coach Program

Establishing Admission Criteria

Any individual receiving, exiting or waiting for addiction treatment services can receive recovery coach services. The admission criteria will be based mostly on available resources, such as the number of recovery coaches hired for each program and specific program design such as pre-treatment support for engagement versus post treatment support to enhance recovery gains made in treatment. The two criteria that are used in most programs are consumer choice and the persons' place of residence after discharge from a residential program (described in the following section).

The essential criterion that is used for the recovery coach program is consumer choice. Individuals who have enrolled in an addiction treatment program or have at least completed screening for a program are offered the recovery coach program as an adjunct to addiction treatment.

The second essential criterion to consider is the persons' residence upon completion of a residential program. Many individuals will travel substantial distances to enroll in a residential program; therefore, before offering the RC program to all individuals, it is important to consider if they can receive these services once they have completed or otherwise leave the residential program. Individuals who live outside of a reasonable distance from the RC program will need to be excluded from consideration. Most individuals who are screened for a Level II or I program; i.e., outpatient services based on American Society of Addiction Medicine (ASAM) criteria, will by default live within a commutable distance.

Referral Process

The optimal point of referral is immediately after an individual has completed the agency's screening process. Individuals who complete the screening process can be provided with information about the recovery coach program. The recovery coach can assist the person with addressing and removing barriers to entering treatment such as arranging child care, assisting in finding reliable transportation (if going into outpatient), or help in completing forms for public aid or Medicaid.

Recovery coaches can also be offered during treatment. RCs can help clients transition through the continuum of addiction treatment services and continue to work with them after they leave treatment to provide ongoing recovery support and monitoring. This support could include assistance in finding employment, locating safe housing or expanding social networks.

A third option is to offer RCs to individuals who have left treatment against medical advice (AMA) or from administrative discharge (AD). RCs can attempt to develop an ongoing relationship with individuals who have left treatment with the goal of helping them return. Another option would be to help achieve their treatment and recovery goals without returning to treatment.

Engagement Process

The optimal point of engagement is immediately after a person has completed the assessment process and has agreed to talk to an RC about the program. Chapter 6 will provide more detailed information on techniques RCs can use to keep people engaged in treatment.

Rapp and colleagues (1992) recommend that case managers meet with potential candidates before they review each client's medical records, treatment history or clinical assessments. This is to insure that each client is given the opportunity to present themselves to case managers in an unconditional manner and without labels; i.e., diagnoses, that may bias the RCs' opinions about each individual. This "blind" meeting also helps the RC to hear the client or consumers' perspective on their self-defined goals.

Establishing Caseload Size

The maximum caseload size should not exceed 15-20 active clients in the program. The term active refers to clients who are either receiving addiction treatment services, waiting for a treatment opening, or were discharged from a treatment program (complete, AMA, or AD) within six months and are open to receiving weekly contacts with RCs. It is possible to maintain contact with other individuals who are further along in the recovery process, as long as they do not require the same intensive level of services as the active caseload.

Specific caseload sizes will be determined by the complexity of issues presented by the treatment population and the availability of ancillary services in the region, such as each access to supported employment, transportation, housing, childcare, medical care, or mental health services. Although RCs could work with a larger caseload than 20, it is important to consider that the skills training and problem-solving approach presented in this manual will require an extensive amount of time with each individual. As is the case in the mental health field, as caseloads increase, case managers or RCs loose their capacity to effectively teach these behavioral skills. The effectiveness of the RC program will be compromised by exceeding a reasonable caseload size.

Chapter 5: Integrating Recovery Coaches with Addiction Treatment Services

The recovery coach program is integrated with an addiction treatment program. This integration is achieved through frequent interactions between RCs and addiction treatment counselors and through collaborative treatment planning. RCs are expected to attend weekly team treatment planning meetings and to meet with counselors individually or by telephone or email to discuss each client's case and to coordinate treatment planning when clients are in active treatment. If the treatment program and the recovery coach are not components of the same organization, consents to release information will be needed.

Coordinating Phases of Treatment

Most clients who enter an addiction treatment program will need or will receive more than one level of care that can include detoxification, residential, intensive outpatient, less-intensive outpatient, and continuing-care services. Clients can enter through any of these levels of care and they can also be lost or disengage from treatment during the transitioning phase between levels of care. An essential task of RCs is to help clients stay engaged through the continuum of addiction treatment, which may include multiple treatment providers, locations, and treatment philosophies. Keeping people engaged in the addiction treatment continuum requires ongoing coordination between the RC and addiction treatment programs.

Coordination of the two programs is achieved through the efficient application of services based on each staff member's role and purpose. The primary tasks of the addiction counselor are the identification and treatment of the individuals' SUD. The recovery coach, on the other hand, focuses on helping people apply their newly acquired recovery skills in their living environment and to help them resolve any issues or problems that can impact their recovery, but are not directly addressed in treatment, such as being unemployed, living in an unstable housing situation, or in need of medical care. The counselor focuses on cognitive, emotional and behavioral factors that impact addiction. The RC assists individuals in a much broader arena, particularly in building their resources and community support networks.

There are three overlapping stages of coordination based on where individuals are in the addiction treatment continuum.

1) **Pre-treatment or community outreach**: In the first stage of coordination, RCs can be used to help people engage in treatment through community outreach to engage people in treatment (e.g., working with a homeless shelter) or after individuals have been screened through a central intake program, but prior to enrolling in a treatment program. During this pre-treatment phase, RCs can help prepare people for treatment or use motivational skills and case management services to encourage people to enter an addiction treatment program. RCs can also help remove barriers to treatment initiation, such as arranging for childcare, transportation (if outpatient), assist in acquiring funding for treatment (e.g., public aid or Medicaid), or obtain needed medications required for a medical condition. The RC can work directly with the admissions staff to link the person to treatment when the barriers are removed.
2) **Active treatment**: In the second stage of coordination, RCs work directly with addiction treatment counselors to provide clients with a comprehensive array of services. If the

person is in a residential setting, the RC would begin their relationship with the client within that facility during non-treatment hours, such as in the evenings or during breaks. Based on the identified needs of the client and their stage of treatment, the RC may take the client out of the residential treatment setting to begin establishing the community supports needed for the transition to an outpatient setting and return to the community. This could include activities such as locating a safe place to live or beginning exploration of employment interests and options. The RC would be working with the person to develop a personal recovery plan during this period of time. Once an individual transitions into an outpatient program, RCs can work with them during non-treatment hours to address their self-defined goals, such as acquiring a GED or returning to college, receiving treatment for a mental illness or medical problem, or learning how to manage a mental illness or chronic medical condition while abstaining from alcohol and other drugs. A description of how addiction treatment and RCs can be coordinated during active treatment is described in the following section.

3) **Post treatment and monitoring**: The third stage of coordination, RCs work more independently with clients as they transition from addiction treatment and back into the community. RCs can help individuals in this post-phase of treatment to implement a relapse prevention plan and to modify the plan in the event of a slip (i.e., a brief relapse that does not return to pre-treatment levels of drug use). RCs can also help people achieve some of their self-defined goals, such as acquiring a competitive job, resolving any legal problems, or acquiring-reacquiring a driver's license and a car. RCs can help individuals return to an outpatient program or favorite group for occasional "tune-ups", when needed, or to help them return to treatment if they experience a prolonged relapse. RCs can coordinate with admission staff if they observe people experiencing a relapse in the community.

Team Planning of the RC Program

Coordination between the RC program and the various levels of addiction treatment will require ongoing team planning. Coordination can be achieved by organizing monthly team-planning meetings that consist of the RCs, the RC supervisor, and administrators involved in the different levels of addiction treatment. The team-planning meetings can

- Review policies and procedures involving the RCs, such as what to do in the event that a client leaves the addiction treatment program, but may stay engaged with their RC.
- Develop and disseminate an RC pamphlet for staff and clients of all addiction treatment programs.
- Coordinate quarterly educational seminars and training sessions with the addiction treatment programs to keep staff updated on the policies of the RC program or to educate new staff.
- Problem solve issues, misperceptions, or barriers that undermine the coordination of the RC program with the addiction treatment programs.

Recovery Planning

RCs can also clarify their roles with clients by helping them develop a recovery plan that incorporates elements of the addiction treatment program they are in as well as more global

issues, such as housing, employment, or medical care. Examples of the recovery plan format are in Appendix A.

RCs are expected to begin the recovery planning process with clients as soon as they are willing to participate in the program. The plan will evolve over time, but it is helpful to begin the process as soon as clients are ready to work with an RC. The RC and client can coordinate services in the recovery plan while the client is enrolled in treatment. This plan can be disseminated among addiction treatment clinicians involved in the client's treatment.

The recovery plan format and process are described in detail in chapters 7 & 9. The primary purpose of the plan is to formalize the relationship between RCs and clients and to provide both individuals with a clear guide and mission for their collaboration. The recovery plan will also help RCs to organize the intensity and duration of their contacts with clients. RCs are not expected to meet with clients unless there is an identified reason for the meeting in the recovery plan.

Chapter 6: Engaging People in the Recovery Coach Program

Engaging people in the RC program requires an individualize approach that is tailored to the clients' readiness for addiction treatment and the recovery process. People entering or already engaged in addiction treatment vary in their levels of motivation, awareness, knowledge, and capacity for dealing with their SUD. People also enter treatment through various levels of coercion. All these factors and levels of readiness for treatment need to be considered when engaging people in the RC program.

RCs can use a variety of interventions and techniques to keep clients actively engaged in the recovery process based on the individuals' level of readiness and capacity for addiction treatment. This chapter providers an overview of the concept of stages of change or readiness for recovery from an SUD and the techniques that can be used by RCs to keep people engaged in treatment and motivated for a life of recovery from alcohol and other drugs.

Transtheoretical Model of Change

The RCs' first task is to assess the individuals' readiness for change or their present capacity to benefit from addiction treatment. If people are not ready to fully grasp the concept and the subsequent work that will be required to obtain extended abstinence during or after treatment, RCs can help people to cognitively move toward a level of readiness to change while maintaining an ongoing relationship with the clients.

Prochaska, Norcross, and DiClementi (1995) proposed a stage model of motivation based on individuals' level or phase of cognitive readiness for change. The model consists of six progressive phases of readiness to change or levels of motivation toward making a change with regards to a particular behavior, such as abstaining from drinking, learning to manage a chronic medical condition, such as diabetes, or acquiring a job after being out of the workforce for many years. The six stages or phases of readiness include:

(1) **Precontemplation**: This is the first or lowest level of readiness to change. People in this stage of change are not aware that they need to change or that they even have a problem. In addiction treatment, individuals in this stage of cognition do not believe they need to modify their drinking or drugging behavior; e.g., "My wife tends to overreact to my drinking", "I was being picked on by the cops when I got arrested for cocaine", or "I'm here because the judge told me I had to take either treatment or prison."

(2) **Contemplation**: Individuals in this second level of readiness are beginning to acknowledge that there may be a problem or a need to change something in their lives; e.g., "I need to cut down on my drinking" or "I'm spending to much of money on marijuana." However, they are not ready to acknowledge that a full change needs to occur. In addiction treatment, individuals in this stage of change may be willing to talk about their problems, but they are not ready to acknowledge the need or the desire for recovery or abstinence; e.g., "I don't think I'm an alcoholic, but I am spending to much time drinking" or "I can quit if I want to, but right now I think I

need to slow down." As the title implies, people in this stage of change are contemplating their options, but they haven't made up their minds.

(3) **Determination-Preparation**: In this third stage of change, people have made the determination that a change is needed and are preparing themselves mentally for the behavioral change; e.g., "I need to stop drinking and change my life" or "I need to get out of the house and look for a job." It is important to note that people in this stage are verbally acknowledging the need for change or the need to move toward a goal, but they are not yet ready to move from thinking and talking about it and putting their thoughts into physical action. This is noted because many treatment plans fail at this stage of readiness because clinicians often confuse verbal commitment with the actually readiness to move into action. People in this stage of readiness still have internal barriers (i.e., low self-efficacy, fear, or lack of knowledge) or external barriers (e.g., lack of child care, no insurance, unstable housing situation, or no access to transportation) preventing them from acting on their ideas or goals. If clinicians move too fast while people are in this stage of change, they can set people up for failure by asking them to achieve a goal that is beyond their present capacity or readiness for change.

(4) **Action**: The fourth stage of change is so titled because people at this level of readiness are finally acting on their ideas or physically moving toward their goal. In addiction treatment, a person in this stage of readiness has moved past the idea that he or she has an addiction and has voluntarily entered an addiction treatment program and is making the changes necessary to achieve the goal of abstinence and recovery. People in the action stage of change are still using alcohol and drugs, but they are clearly working on a plan to eventually abstain from these substances. Addiction treatment is, by default, an action stage of change intervention for people with an SUD.

(5) **Maintenance**: The fifth stage of change is the highest phase of readiness or motivation because it involves mastery of the skills developed in the action stage of change. In addiction treatment, people in the maintenance stage of change have achieved abstinence, but continue to build upon their recovery plan to insure longevity of the plan; i.e., sustained recovery. For someone who has acquired a job after years of being out of the workforce, this stage represents ongoing employment or the ongoing development of vocational skills.

(6) **Relapse**: The sixth stage of change reflects that relapsing nature of addiction. The relapse stage of change is not a higher level of readiness than maintenance, but can occur after someone has been in the maintenance phase, as is common with people who were able to abstain from cigarettes, alcohol, or other drugs for over a year before returning to use. Within the transtheoretical model, relapse is considered to occur only after individuals have moved into the maintenance stage of change. Prior to the maintenance stage of change, substance use or a return to use is considered part of the stage, including the action stage. In other words, relapse cannot occur until individuals have acquired a substantial period of abstinence.

The six stages of change are used to guide the engagement process. It is not important to accurately measure individuals' level of readiness to change, but rather to view people on a continuum of readiness and to provide interventions accordingly that keep people moving up

through the stages of readiness to change. Moreover, the transtheoretical model can be used as a guide for RCs who are working with people at different levels of readiness to change in regards to their SUD. People can move forward or backward in the stages of readiness to change and can also be at different levels of change depending on the behavior or the drug of choice. For instance, it is common to observe a client wanting to abstain from alcohol or cocaine while still wanting to smoke marijuana. Clients can also be at different stages of readiness for different behaviors. Again, it is common to observe a client with co-occurring mental illness and substance use disorders who is willing to change or address one of the disorders, but openly resistant to changing the other.

RCs can determine where people are in their stage of readiness based on the clients' conversations and actions with a particular behavior. People can enter addiction treatment at any cognitive stage of readiness to change, except of course maintenance (if people need treatment, they can't be in the maintenance stage). Nonetheless, it is common to see people in one of the first three stages of readiness to change, particularly for individuals who have been legally coerced into treatment. RCs can help people in the early stages of treatment become more aware of their need for addiction treatment and to promote the benefits of recovery. RCs can use two empirically established behavioral techniques to keep people engaged in treatment and help them continually progress to a higher stage of readiness or motivation to deal with their SUD: (1) motivational interviewing and (2) contingency management. In addition, RCs can also tailor their services to keep people connected and engaged. All three techniques are described in the following subsections.

Motivational Interviewing and Practices

Motivational interviewing (MI) is a non-confrontational, cognitive-behavioral intervention that is used to help people become more aware of their SUD (or any other behavior that needs to be modified) and to increase internal motivation to address the problem (Miller and Rollnick, 2002). MI was specifically designed to help individuals progress through the first three stages of cognitive change – pre-contemplation, contemplation, and determination. Although MI can be used in action and maintenance stages, the technique was designed to help people move into the action phase of change. MI consists of four therapeutic components.

(1) Express empathy. The expression of empathy refers to accurately reflecting what clients are trying to say. Empathy is not to be confused with sympathy. Empathic listening means that the RC is able to understand how clients are feeling and what they are saying in their own terms. Too often, clinicians assume they know how clients are feeling, what they want, or what they are saying, when in fact, the two views are incongruent. To effectively communicate empathy, the RC needs to employ active listening skills.

(2) Develop discrepancy. A key component of MI is to develop discrepancies between substance use or other destructive behaviors and other more valued aspects of clients' lives. The purpose of developing a discrepancy is to illuminate how the destructive behaviors, such as substance use are at odds with the more valued aspects of the persons' life, such as obtaining and maintaining a job. Many individuals in the early stages of change are unable to see fully the connection between their ongoing substance use and the loss of valued goals and people in their lives as a result of the substance use. RCs and other clinicians can help people make the

connection and, therefore, create a discrepancy. To create a discrepancy, RCs need to first understand what is important to clients or what they value. The next step is to compare the two conflicting goals for clients using their own language and value system. Examples of potential conflict can include:

- Wanting to continue to drink with friends after work and wanting to improve the relationship with a partner who no longer approves of his or her drinking
- Wanting to smoke marijuana and wanting to save money for a car
- Wanting to smoke cocaine and wanting to be a better parent
- Wanting to use heroin and wanting to return to college
- Wanting to drink alcohol or smoke cocaine and wanting to manage an anxiety or depressive disorder
- Wanting to smoke crack-cocaine and wanting to complete probation or parole

To be successful at creating conflict, RCs need to use items that clients value rather than attempt to impose values that may not be meaningful to clients. For instance, using employment as a potential conflict or discrepancy for drug use will not be effective with clients who are not presently interested (i.e., value) returning to work. Therefore, take the time to understand what clients really value as opposed to what they have been told to say or report is valuable.

When creating discrepancies, present the potential conflict in a subtle and matter-of-fact manner. Simply highlight the conflict as a basic question for clarification, such as "I thought you wanted to save up some money to get a car, will your ongoing cocaine use be a problem to achieving this goal"; " I thought your girlfriend won't let you in the house if you come home drunk, has that changed?"; or "will your drinking at the party this coming weekend affect your depression or can you drink alcohol at a party without feeling sad or shameful the next morning?"

The goal is to simply illuminate the discrepancies in the clients' own thinking and planning process. It is helpful if the RC keeps a list of goals that clients would like to work on and to highlight these goals when clients indicate that they would like to use alcohol or other drugs.

(3) Roll with resistance. An important component of MI that differentiates this model from more traditional addiction treatment interventions is that confrontation is avoided rather than created. RCs are encouraged to use reflection rather than confrontation to deal with, roll, or go with resistance. Through the process of reflection, RCs create opportunities to further explore the clients' reasons for resistance or ambivalence. If RCs or addiction counselors are arguing with clients, they are not using motivational interviewing. Rolling with resistance is a useful technique for keeping people engaged while they work through their own ambiguity. By avoiding a direct argument, RCs can keep people talking and communicating. Below are three examples of how this technique can work while working with clients who are not cognitively ready to address their substance use disorder or other problems.

Client statement	Confrontational approach	Rolling with resistance
I don't have a drinking problem, everyone else is the problem	You just received your third DWI last month and you were fired from your job for missing work; you have a	It sounds like a lot people have been hassling you about your drinking, can you tell me what other people have been

	drinking problem	saying or what are some of the issues that led you to coming into treatment?
I don't want to take the medications; they don't work and I don't like taking them	You have been diagnosed with a bipolar disorder and you need to take the medication as prescribed by the doctor; the medications will help you	It sounds like your frustrated with the medications and that they are not working as you had hopped, can you tell me more about the medications that you don't like or what is not working?
I can continue to smoke a little pot now and then, it relaxes me and it keeps me from wanting to smoke cocaine	Marijuana is a drug, just like cocaine, and you are not in recovery if you continue to smoke pot; you need to quit all drugs, including pot.	Okay, so you feel that pot helps you to relax and that it helps you stay off of cocaine. Can you tell me more about how you need to relax and how pot helps?

The purpose of rolling with resistance is to better understand the clients' position or perspective. Instead of challenging clients, explore the issues with them, so that both parties have a better understanding of the problem and why clients may still be unaware of the severity of the problem.

(4) Support self-efficacy. The essence of motivational interviewing is to nurture and promote self-efficacy in the process of change. Clients are more likely to change or to attempt to change if they feel that they have the capacity and power to do so. Self-efficacy is how people view their own capacities and strengths. MI is used to increase self-efficacy by allowing individuals to develop successful strategies for changing their behaviors. This can be accomplished by examining clients' past successes and reminding them of these experiences as they take on new activities and behaviors. Self-efficacy can also be accomplished by helping people take and achieve baby steps that promote positive learning experiences (both techniques are described in detail in chapters 7 & 9).

Motivational interviewing utilizes five general therapeutic skills.

- **Ask open questions**: Avoid, if possible, close-ended questions that lead to limited or one-word responses. Use open-ended questions that create conversation and allow for exploration of issues.

- **Listen reflectively**: Reflective listening is an essential technique that all clinicians should use when working with any treatment population. The technique involves expressing empathy (which is not to be confused with sympathy), expressing an understanding of what clients are saying, and keeping the conversation moving through extending what people are saying (i.e., continuing the sentence or paragraph). Empathy is the capacity to understand or accurately assess what individuals are presently feeling or the emotions that they experienced around a particular event, such as when someone is retelling an incident. Empathy is expressed by clinicians throughout the conversation with clients.

Reflectively listening is used to keep people talking and expressing their thoughts, feelings, and behaviors about a particular topic. The technique is used to assure clients that RCs or other clinicians are listening to them and understanding what they are saying. Reflectively listening also implies that the listener (i.e., clinician) is interested about the person and their topic. Another component of reflective listening is avoiding conversational roadblocks that can inhibit or shut down the person from talking more about the topic, such as giving advice, warning, arguing, shaming, agreeing, humoring, distracting, changing the subject, moralizing, judging, criticizing, or disagreeing with clients. Reflective listening is an invaluable yet difficult clinical skill to learn that requires training and practice.

- **Be affirming and empowering**: Affirming consists of verbally acknowledging clients' strengths. Remember that the core element of MI is to enhance self-efficacy. Affirming peoples' strengths and effective strategies helps to promote or increase self-efficacy.

- **Constantly summarize information**: Summarizing is a technique to help clients collect information, to link different pieces of information presented at different times, and as a transitional summary to mark a shift in focus. Summarizing is a skilled technique that helps people by framing multiple pieces of information in a coherent and chronologically organized story. The story is used to help clients reflect on what they have said and to increase awareness of discrepancies and linkages between destructive behaviors and outcomes.

- **Elicit self-motivational statements**: The key to change is getting clients to initiate self-motivation statements. People are more likely to change if they argue for the change themselves. Thus, the task of the RC is to elicit self-motivational statements from clients. An effective technique for eliciting self-motivational statements is to have individuals discuss and write down the good (i.e., pros) and bad (i.e., cons) associated with substance use (or other behaviors). A partial goal of this task is to openly acknowledge some of the benefits, as seen through the clients' view, of continued substance use. The other goal is to compare the costs versus the benefits of continuing to use or abuse alcohol and other drugs. This can be accomplished by using a simple table (i.e., form) with two columns. The first column is the pros of the behavior, such as the pros or benefits of drinking. The second column is the cons of the behavior, such as the negative consequences of drinking alcohol. If the list of pros or benefits is larger than the list of cons or negative consequences, the pro behaviors are more likely to occur or continue to occur and the opposite will be true if the list of cons or negative consequences is larger than the pros. Writing down the lists helps clients to organize and visualize the issue they are struggling with, such as the decision to stop drinking or the decision to return to work.

RCs can use MI extensively throughout the early stages of the engagement process and during active treatment with other life style changes, such as returning to work, treating a medical condition (e.g., diabetes), or learning how to better manage a psychiatric disorder. The key theme of motivational interviewing is to work with people where they are in their readiness to change and not where the RC or the addiction treatment provider thinks they should be.

Contingency Management Principles and Practices

Contingency Management (CM) is a behavioral intervention based on the principles of operant learning theory (Axelrod & Hall, 1999). An operant behavior is a voluntary action by human beings. The learning component results from linking a consequence to the behavior. The central tenets of learning theory are that behavior is learned and controlled by its consequences and that the behavior can be changed by changing the consequence (Bigelow & Silverman, 1999). CM, as it is applied in behavioral health, is a technique that motivates people to learn new or alternative behaviors by providing positive reinforcement (i.e., positive consequences) for the new behaviors. The two primary therapeutic goals of CM are to provide individuals with behavioral contingencies that selectively reinforce and promote healthy behaviors, such as engaging in treatment, abstaining from alcohol and other drugs or achieving self-defined goals, and the extinction of counterproductive or destructive behaviors, such as drinking and drugging or disengaging from or avoiding treatment (Bigelow & Silverman, 1999; Griffith et al., 2000). The ultimate goal of CM is for the target behavior, such as abstinence or participation in treatment and the intrinsic rewards gained through these activities, to become self-reinforcing (Petry, Petrakis, & Trevisan, et al., 2001). RCs can use principles of contingency management to keep people engaged in the recovery process until the process itself becomes reinforcing to the clients.

Case managers in the mental health field already use principles of contingency management in practice, such as managing and disbursing consumers' disability funds (Dixon, Turner, Krauss, Scott, & McNary, 1999; Luchins et al., 1998; Rosenheck, Lam, & Randolph, 2001; Ries & Dyck, 1997). Shaner et al., (1999) and Petry, Petrakis, Trevisan et al. (2001) demonstrated the effectiveness of using SSI income in a CM program for individuals with co-occurring mental illness and substance use disorders.

RCs will have access to a wide range of positive reinforcers, such as access to transportation, clothing, social services, public assistance, or better housing that they can use for contingency management. These non-critical services and resources could be used as conditional reinforcers to motivate individuals to achieve their own self-defined goals or to simply keep them engaged in the program. RCs can also include family and friends in the process of providing their loved ones with positive reinforcers and encouragement. Family and friends provide the most meaningful and highly valued reinforcers for people with an SUD. The RC's task is to help family and friends coordinate a plan for rewarding clients for performing recovery-based activities and to avoid rewarding substance use behaviors (many family members unknowingly reward or support the family member's substance use behaviors rather than their abstinence). It is also important for the RC to help family and friends learn to avoid punishing their loved one if they return to using alcohol or drugs. Punishment rarely achieves the desired goal; i.e., abstinence, and, instead, can push the person further away from the recovery process.

Several researchers have argued that contingency management can enhance the therapeutic alliance between clinicians and their clients because they must work collaboratively on the contingency management plan; the goals, expectations, and responsibilities of both parties are clearly delineated in the plan; and the relationship is focused on positive, achievable goals, rather than on clients' deficits and disability. Client involvement in decision-making is considered to be essential component of the RC program, as well be discussed in chapters 7 - 9, and that

increased involvement in the treatment planning process can enhance treatment outcomes, including engagement.

Contingency management has been shown to improve participants' adherence to the medication regimen in addiction treatment (Bickel et al., 1989; Carroll et al., 2001; Petry, 2000). Improving adherence to pharmacotherapy is a central and reoccurring theme in most intensive case management programs and, as a result, a frequent source of conflict between case managers and consumers. RCs can use contingency management as a non-confrontational method of encouraging clients to adhere to prescribed medications.

Contingency management can be used to help people achieve weekly behavioral plan goals (this will be described in more detail in Chapter 9) and this process offers individuals opportunities for positive learning experiences. The weekly behavioral plan model is specifically designed to help people win rewards through the achievement of their self-defined goals. Many individuals with an SUD or a mental illness have been conditioned to a state of learned helplessness and chronic apathy due to experiencing numerous and substantial losses in their life, including the loss of a sense of self and personal control, as a result of the illness and society's response to them. Contingency management can provide external motivation until internal motivation for recovery evolves. Moreover, contingency management can help people learn that they are capable of accomplishing their goals, including learning how to more effectively manage the symptoms of their SUD or mental illness.

Finally, several studies have also demonstrated the efficacy of using contingency management to engage individuals with co-occurring SMI and substance use disorders in addiction treatment and promote increased abstinence over time (Carey & Carey, 1990; Milby et al., 2000; Peniston, 1988; Petry, Petrakis, Trevisan et al., 2001; Roll, Higgins, Steingard, & McGinley, 1998; Shaner et al., 1997; Sigmon et al., 2000). Considering that as much as 50 to 60% of individuals receiving addiction treatment services have a mental illness, contingency management could provide RCs with a practical tool for treating this population.

Weekly contingency management plans. Contingency management plans can be used on a weekly basis or as a standardized plan that is designed to reinforce a reoccurring activity or behavior over time, such as attending a group every day for six weeks. The basic plan would involve writing down one, two, or three activities that a client will achieve on a weekly basis (it is helpful to narrow the timeframe down to seven days). Everyone who will be involved in the plan, including the client, meet to decide on the structure of the plan, who is responsible for providing any needed supports (e.g., transportation to an A.A. meeting, assistance in getting up for the job interview), who will help record the event or behavior (e.g., who will observe the client performing the targeted behavior or what type of documentation will be used to verify the activity), and what type of reward will be provided and by whom (e.g., a family member spending time with the client or a $5.00 coupon for subway provided by the RC). The contingency management plan is always written down and everyone, including the client receives a copy of the plan.

The basic contingency management plan is based on ten principles:

1) Clients always agree to perform the target behavior or activity and it is preferable if they come up with the idea (RCs can help clients select weekly activities). If a client is not motivated to work on a particularly activity or behavior, avoid selecting it as a step or goal for the plan. Contingency management is a collaborative endeavor between clients and RCs (or other clinicians). Contingency management plans are client driven and support their long-term goals.
2) Link weekly steps or activities to the clients self-defined goals. In other words, all activities should be structured to achieve a long-term goal of the clients, such as acquiring a job, learning how to manage depression, getting their children back, getting a car, finishing college, or achieving sustained recovery.
3) Clients also select the rewards that they value. As noted, clients often value rewards that are affordable and easily accessible, such as increased attention with family members or transportation to valued events or activities. Department and grocery store coupons are also highly valued as are Goodwill, restaurant (e.g., Subway), bus-passes or gas coupons. Again, if the client does not value the reward, don't use it as the reinforcer for achieving the activity. Of course, family and friends need to be involved in the contingency management plan if they are going to provide the reward or participate in confirming that the targeted behavior has occurred or the activity has been achieved.
4) Behaviors or activities are clearly defined and described and within the capacity of the client. Avoid using target behaviors that are difficult to understand or easily misinterpreted. Also, make sure that clients will be able to succeed in achieving the goal or completing the activity. The purpose of a contingency management plan is to have clients win every time and, in turn, develop a sense of self-efficacy and hope.
5) All behaviors or activities are measurable and can be accurately confirmed by observation (a second individual, not the client) or with some type of physical evidence, such as a receipt for a book purchased at a store, an application from a job, pamphlets, or a written letter.
6) Anyone involved in the plan is identified on the plan and is present or has agreed to participate in the plan (specific roles are clearly documented on the plan).
7) All target behaviors or activities have a clear timeframe for being completed (usually seven days, but other timeframes can be negotiated). Avoid using vague timeframes, such as ASAP, on an upcoming weekend or before the client returns to work.
8) Rewards are given immediately upon completion of the plan or on the date agreed upon in the plan. If a reward, such as an activity cannot be given upon confirmation or the date of review, the client is given a voucher that he or she can exchange for the reward in the near future. Rewards are always given if the plan is achieved as written, even if the client does something that may anger the RC or family member. For example, the client still receives the established reward for attending a job interview, even if he or she decides to not take the job.
9) Avoid using essential services as rewards or making essential services contingent upon behavioral changes. Essential services can include access to detoxification and treatment, food and shelter, medical or mental health care or access to medications, or any other services that clients need to maintain their physical or mental health. Rewards can be non-essential services, such as transportation to a social event or access to better housing, or items that the client would like to possess, such as a CD walkman player, coupons for a department store, or a weekly bus-pass.

10) Avoid using punishment or a plan to withdrawal a valued item if a client fails to complete an activity. Contingency management plans should be worded and structured in positive language and to support the learning of new behaviors and activities.

A basic contingency management plan consists of six components recorded on a single page.

1) Target behavior or activity
2) A reward or reinforcer
3) People involved in achieving the activity
4) How the behavior or activity will be confirmed
5) An established date for reviewing the plan (again, the timeframe is usually one week from the day the plan was established).

An example of a plan with three activities is provided below (a blank copy of the plan is also available in Appendix C).

Weekly Contingency Management Plan

Individual's Name: **John Smith** Date of Plan: **6/1/05**

Recovery Coach: **Dan Williams**

Date of next planning meeting to review this plan: **6/8/05**

The first activity or step is related to my long-term goal of: **Getting a job**

The first step or activity that I would like to accomplish is: **I will collect three job applications by next week**

When I accomplish this step or activity I will receive: **One $5.00 coupon for Goodwill that will be supplied by my recovery coach**

Confirmation of this step or activity will include: **I will bring in all three applications to my meeting with the recovery coach next week**

To accomplish this step or activity I will receive assistance from (describe who and what the assistance will be): **My sister, Carol, will give me a ride around town to collect job applications at Kroger Supermarkets, Johnson's Construction, and Sears at the new mall. If my sister has to work, my recovery coach will help me with transportation**.

The second activity or step is related to my long-term goal of: **Recovery from alcohol**

The second step or activity that I would like to accomplish is: **I will attend the AA dance on Main St. on Saturday night (6/4/05) and write down my experience**

When I accomplish this step or activity I will receive: **A trip to go fishing with my brother, Bob on Sunday**

Confirmation of this step or activity will include: **My sponsor will pick me up and drop me off at my brothers house (my brother will be around when my sponsor comes by). I will also write up a brief summary of my night at the AA dance and bring this to my next meeting with my recovery coach**.

To accomplish this step or activity I will receive assistance from (describe who and what the assistance will be): **My sponsor will pick me up for the meeting.**

Tailoring RC Services

RCs can also tailor their services to people based on their stage of readiness for addiction treatment or other issues, such addressing a mental illness or chronic medical condition. In addition to using motivational interviewing and contingency management, RCs can modify the type of contacts they have with clients and the frequency and intensity of these contacts. These modifications can include:

- RCs can use telephonic contacts for clients who have declined other types of contacts and services (or don't feel the need for these services) or for clients who have recently disengaged from treatment and are not ready to return.
- RCs can focus temporarily on non-addiction issues with clients who are resistant to address their SUD (or mental illness), such as helping them with medical issues or housing.
- RCs can use letters and phone calls to family members (with permission and written consent from clients) to stay in contact or updated on each client.
- RCs can also mail clients letters or reading materials if they are incarcerated in prison or visit them in person if they are incarcerated in the county jail.
- RCs can also visit clients if they become hospitalized or need detoxification.
- RCs can offer to help clients when they meet with probation officers, DCFS workers, or during court dates.

All these activities and types of services can be used to maintain contact with clients while they work through their ambiguity regarding their SUD and the need for treatment. The primary goal is to keep a line of communication open with individuals who are not ready to enter treatment, but are willing to at least discuss their problems and consider options.

For additional reading on the Transtheoretical Model of Change we recommend James Prochaska, John Norcross, and Carlo DiClemente's (1995) book, *Changing for Good*.

For additional reading on motivational interviewing we recommend the book by William Miller and S. Rollinick's (2002) *Motivational Interviewing (2nd ed.)*. For an overview of motivational interviewing we recommend the paper by Daniel Squires and Teresa Moyers (2001), *Motivational Interviewing*, which can be downloaded for free at www.bhrm.org.

For additional reading, we recommend the contingency management guidelines of Nancy Petry's (2001), *A Clinician's Guide for Implementing Contingency Management Programs* and Patricia Bach and Stan McCracken's (2002), *Best Practice Guidelines for Behavioral Interventions*, both of which can be downloaded for free at www.bhrm.org . For a more detailed overview of contingency management in addiction treatment, we recommend the edited book by Higgins, S. T. & Silverman, K. (Eds., 1999). *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions*.

Chapter 7: Strengths-based Recovery Planning

The goal of the strengths model of case management is to promote individual empowerment through the acquisition of resources and skills that help people manage their substance use disorder or psychiatric disability. As the title denotes, the model places an emphasis on building peoples' strengths and skills.

Principles of the Strengths Model of Case Management

There are five principles of the strengths model of case management as outlined by Rapp (1998) and adapted to the specific recovery needs of people with a substance use disorder:

Principle 1: The focus is on individual strengths rather than pathology. The core feature of this model is the view that all individuals have goals, interests, experiences, and strengths. In essence, it is the individual's goals or strengths that drive the services. The other interrelated component of this principle is a de-emphasis on peoples' pathology or other related deficits. Instead of focusing on the reduction of pathology; e.g., substance use behaviors or symptoms of a mental illness, the RC focuses on promoting peoples' interest, abilities, and goals. This is not to suggest that peoples' substance use disorder or mental illness are ignored or denied in this model, but rather that RC-client interactions focus on building or promoting strengths and goals, which in turn leads to an improved sense of control and empowerment.

The strengths-view is a difficult principle to translate into action because most service delivery models focus on reducing peoples' deficits and pathology, rather than building or nurturing strengths. Most clinicians, therefore, have to unlearn their patterns of service delivery and learn a new style of interactions with clients. Moreover, many clients will also need to unlearn their own deficit-based views, which they were conditioned to accept through multiple treatment episodes in both the addiction and mental health treatment fields. This will be particularly challenging when working with clients who need case management services in addition to primary addiction treatment services. Many of these individuals will have an extensive array of problems or deficits that could easily occupy the attention of both the recovery coach and the clients.

Principle 2: The community is viewed as an oasis of resources. The second principle of the strengths model implies that service providers should help people in treatment connect with community-based services and other resources that they cannot acquire or receive in treatment. Most individuals who require an addiction treatment intervention will need other services, such as housing, medical care, education, vocational training, and access to social, spiritual or leisure activities. These services exist in each person's community, but most individuals with an SUD have struggled to find or gain access to these services. RCs help people tap into this oasis of community resources. The main tenant of both the strengths model and the recovery coach program is that recovery from either an SUD or mental illness occurs in the community. Treatment can help people acquire some of the tools needed for sustained recovery, but the process itself occurs in each person's community after they leave treatment; therefore, an

essential task of the RC program is to help people access the community-based resources that they will need to sustain their recovery over time.

Principle 3: Interventions are based on client self-determination. The third principle of the strengths model indicates that services are based on the needs and desires of clients rather than on a pre-determined level of services based on professional standards or program guidelines. RCs will be expected to maintain frequent contacts with clients during the early stages of the program; however, it is the client who will ultimately determine the frequency of contacts with RCs. Case management services are tailored around the specific goals of individuals and their related needs, such as the need for stable housing or employment. All contacts with clients should be based on a specific recovery plan goal.

Principle 4: Aggressive, community outreach is the preferred model of intervention. The fourth principle implies that RC services should be delivered in the individuals' living environment or community. The fourth principle also implies that RCs bring the program to people where they are at, particularly for those individuals who are not ready or capable of maintaining engagement in treatment.

Principle 5: People suffering from a substance use disorder or a mental illness can continue to learn, grow, and change. The fifth principle asserts that people can recover from either an SUD or a serious mental illness if they are given the skills and access to the resources needed to achieve this goal. The fifth principle is the essence of hope; therefore, a core feature of the RC program and the strengths model is to promote hope. Hope can be translated into specific behavioral responses, such as verbally reminding clients that many people with their condition have achieved recovery or that they have skills or capacities that can be used again. Another way of promoting hope is by helping break down their long-term goals into a series of simplified behaviors (i.e., baby steps). If someone fails at achieving a self-defined step or goal, the RC helps the individual break down the goal in to two, three, or more steps that are within their reach.

A good analogy for this technique is that "Rome was not built in a day". In other words, recovery does not occur in one overarching behavioral move, but rather through a series of behavioral and cognitive steps or building blocks. An indirect benefit of using the building block or baby-step model of recovery is that people develop a sense of self-efficacy when they achieve or accomplish simplified behavioral steps that lead toward the long-term goal. Self-efficacy is a component of hope and can be defined as a belief in one's own capacities or abilities. Compiling small victories, by achieving baby steps, enhances self-efficacy. The task of the RC is to help people develop a recovery-based plan that creates opportunities for enhancing self efficacy by providing sufficient detail or by tailoring the plan to the specific skills and capacities of each individual. Finally, the third aspect of the fifth principle is that the RC-client relationship, and subsequent planning process, is ongoing and dynamic. In other words, the relationship and the plan evolve overtime.

Developing a Recovery Plan

The strengths-model is used to formulate a recovery plan for individuals enrolled in the RC program. The first step in using a strengths-model of case management is to assess individuals' goals and their strengths and capacities that they will use or rely upon to achieve these goals. The core feature of this assessment and probably the most difficult concept to grasp is that the assessment focuses on highlighting each person's skills, talents, aspirations, and resources that they have acquired over time. The strengths assessment can be difficult to accomplish because most case managers and counselors have been trained to assess peoples' deficits and illness-related behaviors; i.e., the addiction or mental illness, and to base all treatment services on these assessments. Indeed, a diagnosis and assessment of problem areas is usually required by funding sources and state guidelines. Assessing strengths, on the other hand, requires a focus on capacities and positive learning experiences and healthy disregard for people's diseases or diagnostic labels.

Clients of mental health or addiction treatment services will also struggle to focus on their own strengths because they have been conditioned within the same treatment culture as their case managers to focus on their deficits and illness-related behaviors. Consumers of these services will require training and the skill of the case manager or recovery coach to uncover their aspirations, talents, and abilities. People in recovery or attempting to achieve recovery are often poor historians of their own accomplishments and achievements. Recovery coaches will need to help people rediscover their skills, talents, and dreams.

The strengths assessment occurs through a series of conversations between the recovery coach and client. The assessment process is more of an ongoing journey than a task to be completed at the beginning of the program. The purpose of the assessment is to uncover and organize peoples' resources and assets that they will use to build their recovery plan. As such, the strengths assessment and overall recovery plan will be revisited throughout the recovery coach program in order to update peoples' strengths and resources and to modify their goals and dreams as they evolve.

Both the clients' goals and strengths assessment are included in the recovery plan (a copy of the plan is provided in Appendix A and is displayed below). The recovery plan is organized into three categories and eight life domains.

Individual's Name **Individual Goals and Aspirations: Recovery Plan** Recovery Coach

_____ Date:_____ _____

Life Domains	**Individual Goals and Aspirations** What do I want?	**Resources, Strengths, and Skills** What do I have access to or what have I used in the past?	**Barriers and Problems** What barriers or issues do I need to remove or overcome to achieve my goals?
(1) Recovery from substance use or abuse			
(2) Living and financial independence			

(3) Employment and Education			
(4) Relationships and social support			
(5) Medical health			
(6) Leisure and recreation			
(7) Independence from legal problems and institutions			
(8) Mental wellness and spirituality			

The three categories of the form include:

(1) Individual goals and aspiration: The first column is used to record peoples' goals, dreams, or aspirations within each life domain. These goals or aspirations can be immediate (e.g., I need to get a job when I get out of IOP) or long-term (e.g., I would like to return to college and get a bachelors degree in business). Clients should be encouraged to write down any goals, desires, or dreams that they have, even if they are not ready to pursue them, such as finding a partner or having children in the future. Also, it is extremely important that the RCs avoid discouraging clients from writing down goals that the RCs believe to be unreachable, such as a client who reports a goal of being a lawyer someday, but doesn't even have a high school diploma. The RCs role is to inspire hope and to help people rekindle their dreams and desires.

(**2) Resources, strengths and skills**: The second column is used to record a person's resources and assets that they have now or used in the past. Present assets can include wide range of personal attributes, resources and skills, such as having a part-time job, living independently, having a sense of humor, being a quick learner, being friendly, having a supportive partner, friend or family member, attending AA meetings, or attending church services every Sunday. This column can also be used to record any past experiences or behaviors that can be used or reacquired to achieve the persons' goals listed in the first column. For example, it is always helpful to find out what people did to sustain periods of abstinence in the past; in other words, what worked in the past to remain sober, even if the person eventually returned to their substance use behaviors. It can be a challenge for clients in the early stages of treatment to accurately recall past successes and assets because they often maintain negative views of their past. People struggle to list anything positive about their past or that they may have acquired useful skills. The RC will need to help people overcome this mindset and refocus on their achievements. RCs will be able to use this list of past successes and assets to encourage people to achieve new goals or adopt new behaviors.

(3) Barriers and problems to achieving goals: The third column is used to list any barriers or problems that could prevent individuals from achieving the goals listed in the first column. Barriers and problems are not deficits, per se, but specific issues that have been identified by clients as preventing them from achieving their goals. For instance, having a mental illness is not, in itself, a barrier to getting a job, but being unable to afford or otherwise

acquire medication needed to manage the symptoms of the illness while working is a barrier. Or, being in recovery from a heroin addiction is not a barrier to acquiring federally supported housing, however, having one or more felony convictions as a result of the addiction, is a barrier to getting access to HUD funded housing. Finally, having a limited income is not a barrier to getting into addiction treatment, but not having access to reliable transportation, public aid, or an indigent treatment slot are clear yet removable barriers to treatment. The purpose of presenting these examples is to help RCs effectively differentiate real barriers and problems preventing people from achieving their self-defined goals from labels and perceived deficits that are not preventing them from their goals, such as being labeled mentally ill, unemployable, or poor. Accurately identifying barriers is the first step to removing them through problem solving procedures, which are discussed in more detail in chapters 8 and 9. RCs will help people identify specific barriers and problems and help them overcome or remove these roadblocks over time.

Goals, assets, and barriers can be categorized into eight life domains. The eight categories are provided to help people organize and prioritize their goals as well as to help them to see that recovery requires a holistic approach that will impact all dimensions of their lives. Stated another way, the eight categories are provided to help people understand how their addiction or mental illness has impacted multiple dimensions of their lives and that sustained recovery will require work in many, if not all of these dimensions.

The eight life domains include:

(1) **Recovery from substance use or abuse**: The first category includes a person's goals directly related to obtaining and maintaining abstinence from alcohol or other drugs.
   - Goals within this category can include entering or completing a treatment program, learning how to access and use AA or NA meetings, developing a relapse prevention plan, or acquiring a prescription for Naltraxone or other medications used to treat an SUD.
   - Assets and strengths can include any periods of abstinence (and what worked during those periods), experience with and access to a self-help/mutual help group and having a sponsor, having access to supportive people (e.g., partner, parent, pastor, or friend), or being assertive.
   - Barriers to recovery can include living in an area that has easy access to illicit drugs or living within a household where other residents drink or use drugs, working in bar or as a stripper, having not ability to pay for treatment or having no access to transportation for treatment, having no access to childcare while attending treatment, or having no identified person to call for help.

(2) **Living and financial independence**: The second category can include any self-defined goals associated with acquiring, maintaining, or improving a persons' independence in living and finances.
   - Goals within this category can include improving a persons' current living situation (e.g., location, affordability, proximity to public transportation, and safety); specific features of the residence (e.g., cleanliness, clutter, size, furniture, comfort and density); other occupants (e.g., children, parents, roommates, or a significant other); and access to basic necessities, such as food and clothing. The category can also include improving sources of income (not including illegal activities) or the potential for acquiring sources of income (e.g., application submitted for public aid or a job), improving the management of finances, paying

off debt or legal fees, and acquiring medical insurance. Goals specific to employment, which can result in the improvement of finances, are included in the next domain.

- Assets and strengths can include past experiences of living independently, having a place to live upon discharge or having someone to live with during treatment, being frugal or good with managing limited funds, being a great cook, having no debt, having access to medical insurance, owning a car, or having easy access to transportation.
- Barriers to living or financial independence can include being homeless or living in an unstable living situation, living with an abusive partner or family member, having limited or no access to transportation, having substantial debt or legal fees, having a felony conviction, an inability to manage symptoms of an anxiety, mood, or psychotic disorder, no access to child support, or limited access to food and clothing for the person or his or her children.

(3) **Employment and education**: The third domain can include any activities directly related to acquiring or improving employment options or education.

- Goals can include finding a job and the multitude of activities associated with searching for and acquiring employment, learning how to work on a computer, purchasing work-related supplies (e.g., clothing, computer, or tools), enrolling in a vocational training program or technical school, completing a GED or high school diploma, or enrolling in and completing a college degree.
- Assets and strengths can include having a job, previous work history and vocational skills, having a car or tools for a job, having computer skills, current educational level, certificates acquired, being enrolled in educational classes, being a good student, being intelligent or a quick learner, possessing organizational skills or an attention to detail, loving school, or having access to financial aid for school.
- Barriers to employment or education can include having a felony conviction, limited or no access to transportation, an untreated or unstable medical condition (e.g., diabetes, high blood pressure, obesity, migraine headaches or lower back pain), an inability to manage psychiatric symptoms that can occur while working (e.g., social phobia, panic attacks, paranoia, or hallucinations), having an untreated attention deficit disorder, or having a general fear of returning to or entering the workforce (e.g., fear of failing or losing SSI or SSDI benefits).

(4) **Relationships and social supports**: The fourth domain can include any activities associated with peoples' relationships and social networks.

- Goals can include improving or expanding sober social networks, finding friends, finding a romantic partner, mending relationships with partners or family members, or learning the skills to socialize without alcohol or other drugs. Goals can also include improving relationships with children or resolving an ongoing DCFS case.
- Assets and strengths can include positive or supportive members of the consumers' social network, such as family, friends, significant others, clergy, or counselors. Strengths can also include being funny, friendly, kind-hearted, assertive, adventurous, or athletic. This list should not include people who are detrimental to the persons' recovery, but are in their social network, such as drug

dealers or an abusive spouse or family member. This category can also include access to social outlets, such as support groups (e.g., GROW Inc.), church, weekly family outings, or a club (e.g., Sierra Club or American Legion).

- Barriers to improving social supports and relationships can include social phobia or panic attacks that occur in public places, lack of access to transportation, lack of child care, living in an unsafe or unstable environment, or limited social skills.

(5) **Medical health**: The fifth domain includes any goals or activities associated with medical or primary care issues, including medical issues of the persons' children.

- Goals can include acquiring medication, receiving a medical evaluation or access to pre- or postnatal care, loosing weight or learning how to improve diet, learning how increase exercising, learning how to manage pain or a chronic medical condition (e.g., arthritis), learning how to manage stress, or acquiring medical insurance.
- Assets and strengths can include having good health, having access to a primary care physician or psychiatrists, having the ability to manage a complicated medication regimen, having a good diet and eating habits, enjoys exercising, knowledge and skills associated with stress management and meditation, and disease management skills for a chronic medical condition, such as diabetes.
- Barriers to achieving good medical health include limited access to a kitchen or having limited cooking or shopping skills, an eating disorder, experiencing side effects from prescribed medications, limited or no access to medical care or having no medical insurance, poor memory associated with taking medications as prescribed or having a complicated medication regimen, or limited time management skills.

(6) **Leisure and recreation**: The sixth category of life can include any activities associated with improving or expanding leisure activities, hobbies, or artistic interests.

- Goals can include learning new hobbies (or picking up an old one), taking a photography or art class, attending a concert, going fishing or hiking, joining a softball league or playing golf with some friends, going to the movies or reading a new book, learning to manage time, writing poetry, or playing the guitar.
- Assets and strengths can include having hobbies, sources of entertainment, or recreational activities; having access to social events (e.g., going out dancing with a friend or camping with family); or being musically or artistically gifted.
- Barriers to achieving leisure and recreational goals can include lack of access to transportation, physical impairments (e.g., obesity or chronic back pain), poor or limited time-management skills, side effects from psychotropic medications (e.g., drowsiness or fatigue), or panic attacks or social phobia.

(7) **Independence from legal problems and institutions**: The seventh domain includes any activities associated with the resolution of legal problems or sentences.

- Goals can include attending court hearings, having minor felonies sealed by the state (not all states offer this option), following the guidelines of probation/parole or completing the requirements, following the guidelines of DCFS, paying off legal fees, obtaining a lawyer, following the guidelines of a drug court or similar problem-solving court program, or completing community hours.

- Assets and strengths can include a demonstrated ability to complete the requirements of probation or parole.
- Barriers to resolving legal problems can include an open DCFS case, tendency to miss court dates or appointments with parole/probation officers, difficulties with a probation/parole officer, or continued participation in illegal activities.

(8) **Mental wellness and spirituality**: The final domain of life can include any activities associated with the management of a mental illness or improving mental wellness and spirituality.

- Goals can include learning how to manage the symptoms of a mental illness (e.g., managing an anxiety disorder or symptoms of depression), acquiring psychotropic medications, receiving a psychiatric evaluation or access to mental health treatment, learning meditation skills or stress management and relaxation skills, learning how to manage anger, reconnecting with a church or other religious organization, working on spirituality and dealing with shame, receiving couples counseling, gaining access to treatment for a post traumatic stress disorder (PTSD), or gaining access to legal counseling to get out of an abusive relationship.
- Assets and strengths can include presently receiving treatment for a mental illness, established skills for managing symptoms of a mental illness, presently attending a church or other religious organization, established skills for meditation, having access to various groups or intellectual activities that promote the development of spirituality.
- Barriers to achieving mental wellness and spirituality include limited or no access to needed psychotropic medications or psychiatric services, living in an unstable or unsafe environment, continued exposure to trauma (e.g., living with an abusive partner or family member), an inability to manage anger, or experiencing side effects from psychotropic medications (e.g., lethargy or weight gain).

Again, the purpose of the recovery plan is to highlight and organize a person's goals, strengths and capacities and to determine what barriers need to be removed or problems resolved to help people achieve their goals. The information in each cell of the recovery plan, therefore, should be as detailed as possible so that the client and recovery coach can use the information to accomplish various tasks. Below is list of effective interviewing techniques that recovery coaches can use to develop the recovery plan with clients.

- View the client as the expert on their life, goals, and recovery plan and remind yourself that you are a consultant that will work with the client to achieve his or her long-term goals. Express this idea of equality and collaboration to the client at all times. Recovery planning is similar to building a house from a collection of ideas. The client will be the owner of the house and the one with the ideas of how the house is to be designed; you are the building contractor who will help the client (homeowner) build the house they want. There are numerous behavioral techniques that you can use to express the idea that you and the client are collaborating on the client's recovery plan. These techniques include:
    - Establish a relationship with clients before proceeding into any formal assessment procedures. It is helpful to simply have an open-ended conversation with clients during the initial meeting.

- Explain your role in detail to clients and don't assume that they know who you are or why you are meeting, even if they report that they know who you are or what you be will doing. Emphasize your role as a consultant.
- Set up formal appointments with clients and maintain the appointments as planned. Remind yourself that you should treat clients the same way you expect your dentist or primary care doctor to treat you. That is, call your clients in advance if you cannot make the appointment and minimize the use of unplanned meetings; e.g., dropping in on the client unannounced.
- Maintain eye contact with clients when you are meeting in person and position yourself so that your body is also facing them.
- Avoid staring at a form or turning your back on a client while completing paperwork. Take brief notes during face-to-face meetings that don't disrupt the flow of the conversation. You can go back to the form after the meeting to complete the information as needed. When working on a paper-and-pencil form or computer-based version that requires input from the consumer, such as the strengths assessment form, work side by side with the consumer and position the form or computer screen between the two of you (e.g., place two chairs in front of the computer table). Always keep the form in view of consumers, so that they know they are working on the form with you rather than being interviewed or assessed by you. It is okay for the RC to do most of the writing on the strengths assessment form (or other forms), but keep the form angled in their view and constantly check for their approval of what you are writing.

- Be enthusiastic about talking to people about their goals, assets and positive attributes. People are more likely to talk about themselves if they sense that they are talking to someone who really cares about what they have to say. Remember to thank people for sharing with you and that you value their trust in you. Encourage people to talk about themselves and to share their goals with you. Provide people with verbal praise to facilitate the conversation. For example, compliment people who have already developed and practiced useful behaviors, such as abstaining from alcohol and drugs for four weeks or completing three job applications last week. When providing verbal praise, be sure to connect the compliment with the behavior by paraphrasing what the client reported. In other words, don't just say "great job"; be sure to say what the "great job" was for.
- Be patient with people who may be fearful about sharing their hopes and dreams. Many individuals in the early stages of recovery lack the confidence or self-esteem to openly share their goals and desires or they may fear that their goals will be discounted or minimized if revealed (note that this may be a justifiable fear based on previous experiences with family, significant others, or even past experiences with treatment professionals).
- Ask open-ended questions that won't lead to simple yes/no responses. In other words, avoid asking specific or narrow questions that require a minimal response or thought from the client. For example, instead of asking individuals if they like to read or play games, ask them what kinds of hobbies they have or what they do for fun. Always assume that a person has something to offer in each life domain; therefore, ask the questions as if you know individuals have something to offer. For example, ask individuals what they do for entertainment, instead of asking them, do they do anything for entertainment; or what types of work experiences have they acquired, instead of asking them if they have ever worked. Ask yourself the question before you ask the consumer and see if you can answer it with a

yes/no response. If the question can be answered with a one-word response, try to expand the scope of the question before asking the client.

- Ask for specific timeframes or frames of reference if people struggle to provide an answer. For instance, if someone cannot think of something they like to do for fun, follow up the question with a specific timeframe, such as last weekend or during the 4th of July Weekend, or a frame of reference, such as the last time they were with their sister or during the last time they were abstinent. The specific timeframe is used to cue memory and to help people overcome a negative mind set.
- Probe answers for more detail to better understand behaviors associated with the event or setting. For instance, if someone reports that they enjoyed attending an AA meeting, follow up their response with probes regarding the time of day, who they went with, and aspects about the meeting that were enjoyable. The goal is to produce a clear picture of the behavior, so that they person can easily reproduce the behavior when needed. Common probes include:
    - names of people involved in the behavior (i.e., who)
    - timeframes (i.e., when)
    - description of settings (e.g., fun, relaxing, inspiring, or stimulating; i.e., what or what type)
    - description of behaviors or activities that occurred in the even or setting (i.e., how)
    - how the event or activity can occur in the future (i.e., how to replicate).
- Avoid using the word "why" when using a probe. The word or question "why" can be misinterpreted as an inquisition or needing justification on the part of the client. For example, instead of asking someone why they like attending an AA meeting, use a more inviting and open question, such as "what are some of the aspects of the AA meeting that are enjoyable". Also, be sure to use the descriptors provided by the client or consumers. For example, if the consumer describes an AA meeting as enjoyable, use the word when probing for more detail.
- Maintain the natural flow of the conversation with clients; go where they want to go in the conversation. Don't worry about completing specific cells of the assessment form in any particular order. Feel free to travel new roads or off-ramps in the conversation when the client provides an invitation. In other words, stay with the client and their present thought processes. People have an easier time recalling events and behaviors if they are allowed to travel within their own road maps of memories. The recovery coach can help people by asking probes that enhance recall, but don't force people to jump from established linkages to memories that are not easily connected.
- Use active listening skills while conversing with clients. Active listening involves reflection; e.g., paraphrasing what people have just said, summarizing ideas; e.g., "okay, let me see if I understand……", and expressing empathy; i.e., acknowledging that you understand their feelings throughout the process (e.g., that sounds scary or it seems like you really enjoy that).

In addition to following these steps, RCs should avoid the following:

- Don't complete the assessment form or any strengths-based or recovery based plans without the client. If the assessment or plan can be completed without the client, you're not using the strengths-model of case management.

- Don't include past experiences that can undermine the recovery process, such as noting in the employment/educational domain that the client acquired money through prostitution or drug dealing. Although these statements may be accurate, they should not be confused with vocational skills or resources that can help people in the future.
- Don't list people in the strengths assessment who could undermine the recovery plan, such as an abusive spouse, even if this individual plays a significant role in the consumer's life. If the person is not an asset to the client, don't list them on the assessment form.
- Don't attempt to convert a negative experience into a positive statement, such as suggesting that a person acquired good business skills while dealing drugs or that losing their children through DCFS helped them better understand their addiction. Neither experience will help a person recovery from their SUD and could even be a trigger to relapse.
- Don't worry about completing all the cells of the strengths assessment form if the client is not ready or capable of providing information. It is okay to leave cells blank. The RCs task is to help people complete the cells over time when they are ready or willing to do so.
- Don't combine the recovery plan with the program's treatment plan or simply re-title the treatment plan as the recovery plan.

Specific Steps of the Recovery Plan

After the initial recovery plan has been developed, the next step involves organizing long-term goals into a series of achievable steps or removing barriers through a series of action plans. Below is a sample of the recovery plan-steps form (the full version is in Appendix A).

Specific Steps of the Recovery Plan

Name:_____ Date:_____

Step to be achieved or barrier to be removed	Action Plan (how will the step be achieved and who will help)	Objective and measurable outcome
(1) In the area of recovery from alcohol or other drugs I would like:		
(2) In the area of living and financial independence I would like:		
(3) In the area of employment and education I would like:		
(4) In the area of relationships and social support I would like:		
(5) In the area of medical health I would		

like:		
(6) In the area of leisure and recreation I would like:		
(7) In the area of independence from legal problems and institutions I would like		
(8) In the area of mental wellness and spirituality I would like		

The recovery plan-steps form includes the eight domains of the recovery plan. Each domain includes spaces for establishing multiple steps, if needed, followed by a specific action plan, and a measurable objective. The form is used to develop a detailed action plan for each client-driven goal. RCs can help clients establish reasonable and logical steps that will lead to the achievement of long-term goals. The action plan column includes a detailed description of activities associated with the step and who will be involved in implementing the plan. The third column is used to record the objective of the step and what will occur, be accomplished, or be achieved if the plan is implemented. The third column is provided to help RCs and clients focus on measurable outcomes.

If an activity or step cannot be determined or measured, it needs to be modified or dropped from consideration. For example, having more fun or wanting to be happier are not measurable or reasonable steps; however, going to the library and purchasing a book on hobbies, joining a community theatre group, or taking a class on painting are measurable and reasonable steps that may help the client to have more fun or to feel happier in life. Another problem is establishing a step that is too broad or incorporates a series of steps. For example, acquiring a job is probably an important and reasonable goal to select, but it rarely involves a single behavioral activity or step, but rather a series of steps that leads to the acquisition of a job. The steps, therefore, could include:

1. calling around for job openings (week 1),
2. securing transportation to pick up three applications (week 2),
3. driving around town and picking up at least three job applications (week 3),
4. developing a job resume and storing it on a computer, (week 3),
5. practicing job interviewing skills and learning what to say about a felony conviction (week 4),
6. attending a job interview and possibly securing transportation for the interview (week 5),
7. getting an alarm clock or having someone help the person get up in time for work (week 5)
8. shopping at Goodwill or Dress-for-Success to acquire work clothes (week 6), and
9. acquiring a bus-pass or a bike for transportation for work.

All these activities lead to the goal of acquiring and maintaining employment. Moreover, all nine steps are reasonable and measurable.

The recovery plan-steps form is used to organize the RCs activities with each client. Clients and RCs can work on any domain or prioritize steps as needed, but the RC's services should be linked to at least one planned activity or step listed on the form. Clients can add or modify steps overtime. Both the RC and client keep an updated copy of the plan and refer to it on a weekly basis. The RC is expected to keep an updated recovery plan-steps form and to record if and when steps have been achieved or modified. Chapter 9 provides an overview of behavioral problem-solving techniques that RCs and clients can use to address difficult barriers to remove or steps to achieve.

Information presented in this chapter is based on the strengths model of case management developed by Charles Rapp and colleagues at the University of Kansas, School of Social Welfare (http://www.socwel.ukans.edu/publications/Strengths/index.shtml). This chapter provides an overview of the model. Detailed information regarding the model will come from Rapp's (1998) book *The Strengths Model* and training manuals that are available at the School of Social Welfare website. Both the book and the training manuals are strongly recommended for the RC program. In addition, the University of Kansas, School of Social Welfare provides onsite training of the strengths model of case management. The training division can be contacted through their website.

Chapter 8: Expanding Recovery Capital

The RC's primary function is to help people in addiction treatment acquire the resources and skills they need to sustain their recovery over time. The RC can help clients overcome barriers to accessing needed services and resources in the community. The long-term goal of the RC program is to help people develop an indigenous (i.e., community-based) recovery support system that facilitates their transition from the professional or formal treatment realm and into a life of self-autonomy and, of course, sustained recovery. The recovery plan and steps forms will help RCs and clients highlight specific resources or skills that will be needed to achieve each person's self-defined goals.

There are three interrelated activities associated with resource development. The first activity is to identify or clarify the skills and resources that are needed to achieve the individuals' goals. The second activity involves locating the resources or identifying the skill training programs that are needed and a subsequent plan for how these resources or training programs will be acquired. The third activity involves the actual task of helping people acquire resources or services and helping them, in the process, learn how to retain these resources or services over time. Most addiction treatment programs address, to varying degrees, the first two activities of resource development; however, office-based addiction treatment programs usually lack the capacity to perform the third activity that, by default, requires assistance in the community where the resources or ancillary services exists. For example, many people in addiction treatment acquire resources through standard procedures, but quickly loose them, such as being discharged from sober housing for using drugs, loosing a job because of an inability to manage anger or arrive at work on time, or loosing medication or not remembering to take medications as prescribed. The RC's task, therefore, is to help clients through all three activities or phases of resource development with an emphasis on helping people retain the gains they make in treatment and the resources they acquire.

Resource development, like recovery planning, is an individualized and dynamic process. Resource acquisition is based on the needs and goals of individuals, which will change and evolve over time. It is also important to identify essential resources that people need to support their recovery process from items or valued commodities that they simply want to possess. For instance, most people would like to have cable or satellite television in their home; however, access to multiple TV channels is probably not necessary to sustain a person's recovery. The RC will need to optimize their time with clients by focusing on the acquisition of essential resources that promote the recovery process.

Cloud and Granfield (2001) used the term "recovery capital" to refer to resources that support peoples' recovery from an SUD. In their research, the authors found that people who achieved "natural recovery" – recovery without the use of formal addiction treatment – had substantial recovery capital to achieve prolonged abstinence, such as a strong social support network of sober friends and family members, well-paying jobs, education, and a range of coping skills (Granfield & Cloud, 2001; Cloud & Granfield, 2001). The authors postulated that people who require formal addiction treatment services (i.e., are unable to achieve abstinence on their own)

have less recovery capital and that the goal of treatment should be to increase these recovery-based assets. Recovery capital, in the authors' model, consists of three subcategories:

(1) **Social capital**: This subcategory consists of supportive people in the recovering-persons' social network, such as a spouse or significant other, family members, friends, clergy or church members, members of a self-help group, a supportive employer, a family physician, or a recovery coach. Like the other two categories of recovery capital described next, social capital has to be developed. People in treatment usually need help in developing, expanding or improving supportive social contacts and concurrently reducing or avoiding social contacts that sustain the addiction. Most addiction treatment programs actively promote the development of positive or recovery-based social networks; however, very few can actually help individuals develop these connections in the community or teach people the skills needed to expand their social network in the community.

(2) **Physical capital**: This category consists of the tangible resources used in the recovery process, such as wealth, stable employment or housing, a car or easy access to public transportation, access to a healthy diet, access to fulfilling hobbies or musical instruments, or comprehensive medical insurance and access to mental health services.

(3) **Human capital**: The third category of recovery capital consists of peoples' internal capacities and skills that will help them sustain their recovery over time. Human capital covers a wide range of skills and capacities, such as the aforementioned communication skills, assertiveness, problem-solving; managing stress or relaxation skills; spirituality (e.g., learning how to meet the needs of spirituality); managing physical pain, anxiety or depression; job skills; or educational or vocational knowledge. Human capital can be viewed as the glue or catalyst for securing more recovery capital. For instance, many people in the early stages of recovery have limited communication skills or experiences in communicating or socializing without the aid of alcohol or other drugs. Consequently, many individuals in treatment require skills training in socializing or simply communicating without alcohol. These skills will, in turn, be used to expand peoples' social capital, such as meeting new friends or asking for help at an AA meeting, getting involved in church groups, or completing a job interview. Furthermore, many individuals in treatment loose access to their physical capital because they lacked the skills (i.e., human capital) to sustain them. For instance, many individuals loose their housing or jobs because they lacked the skill or capacity to remain abstinent in these environments or they were unable to manage the stress associated with these elements of their life, which resulted in a relapse.

Translating Cloud and Granfield's (2001) recovery capital concept into a formalized intervention, the goal of treatment is to improve peoples' resources and tools so that they can sustain their recovery after the formal treatment program has been completed (Blomqvist, 1996). An essential function of the RC, therefore, is to help people build their recovery capital.

RCs can use the recovery capital model to help clients build an effective recovery plan. Individuals in treatment should be encouraged to examine all three recovery capital categories in

the process of developing a recovery plan. The recovery capital model can be translated into specific RC activities.

- **Activities to promote social capital**:
  - An essential activity of the RC is to help clients' bring family and friends into the recovery planning process. This activity should be used early often in the engagement and planning process
  - Helping people gain access to social activities, such as AA meetings, church functions, or clubs. This activity will also be combined with behavioral skills training in communication skills (human capital) and gaining access to reliable sources of transportation (physical capital).
  - Exploring and testing social functions in the community or relearning to interact in familiar social settings without being under the influence of alcohol or other drugs.

- **Activities to promote physical capital**:
  - Assisting clients in all phases of vocational development, which can include traveling around the community to collect job applications, assisting/teaching people how to properly complete applications or a resume, practice job interviewing skills (i.e., human capital), linking people to the local workforce development board or Workforce Investment Act One Stop Centers, acquiring work clothes, or organizing or establishing reliable transportation.
  - Assisting clients in all phases of acquiring stable, affordable, and safe housing, which can include traveling around the community looking at housing options, assisting clients in completing applications for subsidized housing, acquiring furniture, learning how to be assertive with landlords and asking for help (i.e., human capital), or managing finances or resolving bad credit and existing debt (i.e., human capital).
  - Helping clients gain access to educational opportunities, such as completing a GED or High school diploma, returning to college, and locating funding sources that can support the clients' educational goals.
  - Helping clients gain access to primary care or mental health services, which can include assisting them in completing entrance forms and applications, applying for Medicaid, navigating through social service systems (i.e., human capital), finding funding sources for medication, acquiring medication, or maintaining appointments.
  - Helping clients gain access to dental and eye care services.

- **Activities to promote human capital**:
  - Practicing and role playing skills in the community, such as drink/drug refusal skills (discussed in Chapter 9), communicating effectively with family members or an employer, asking for help in an A.A. meeting, or talking with judge.
  - Assisting clients in their preparation for returning to high school or college.
  - Learning how to manage stress in different situations.
  - Developing relaxation skills.
  - Helping clients practice parenting skills.

- Providing learning opportunities for having fun without the use of alcohol and other drugs.

This list of activities is provided to demonstrate the range of interventions that RCs can use to help clients achieve their recovery-based goals. All RC activities and interventions are based on and linked to specific steps and goals in the individuals' recovery or strengths-based plan.

The RC's task is to help clients secure essential resources, such as housing, medical care, or employment and to teach them the skills needed to continue building and adding to their recovery capital.

Chapter 9: Behavioral Problem Solving

Behavioral problem solving is a set of techniques used to help individuals with an SUD or mental illness understand and solve everyday issues that arise in their lives. The problem solving techniques reviewed in this chapter can be used for any issue or problem in peoples' lives, such as managing an SUD, mental illness, or chronic health condition (e.g., diabetes or high blood pressure). The purpose of teaching people behavioral problem solving skills is not to solve all their problems, but to provide them with the skills to more effectively solve their problems as they are encountered.

There are core assumptions of behavioral problem solving that RCs can use to guide their planning sessions with clients.

(1) Every one uses some type of problem solving method to achieve their goals, even if they are not aware of it. This is important to know because people need to be aware of what led them to select a particular plan of action or behavior.
(2) Many individuals who have struggled to manage their SUD or mental illness could use some help in developing more effective problem-solving plans and that they can learn to manage these conditions with more effective planning.
(3) People are motivated to change particular behaviors, such as substance-abusing behaviors, if they find that the change is reinforcing. Conversely, people will continue to use or perform certain behaviors, such as drinking alcohol, if they find that the behavior continues to provide reinforcement (perceived or real). Combining these two assumptions, people will be more willing to change a behavior if they can find an alternative behavior that is equally or more reinforcing than the original behavior.
(4) Relapse or problems in a persons' recovery plan are usually the result of gaps in a problem-solving plan; i.e., poor planning. Most individuals who struggle to maintain abstinence from alcohol or other drugs do so because of poor planning and not because they lack motivation or a desire to remain sober.

Assessing Behavior-Functional Analysis

The first step in developing a problem-solving plan is to thoroughly assess the existing problem or behavior that the client wants to address or change. Behaviorists refer to this process as a functional analysis: a structured interview (and form) that examines in detail the causes (antecedents) and outcomes (consequences) of a specific behavior. For substance use behaviors, a functional analysis is used to help clients identify their triggers for cravings and using alcohol and other drugs.

A thorough functional analysis of a behavior or problem is essential to developing an effective problem-solving plan. We recommend the following interviewing techniques when completing a functional analysis.

- Play the role of a naive detective who has been placed in charge of uncovering the events that led to a behavior occurring. Keep asking questions regarding the behavior until you understand how and under what conditions the behavior occurred. If you don't

understand why or how the behavior occurred, continue asking questions until it makes sense to both of you.

- Don't accept an individuals' explanation that the behavior just happened, was spontaneous, or that they don't know why they did it. For instance, many individuals will report that they don't know why they
  - ended up drinking alcohol after work;
  - binged on junk food all night;
  - forgot to take their medications as prescribed;
  - had a panic attack while shopping;
  - got into a fight with their wife; or
  - failed to show up for work on Monday.

  None of these behaviors are spontaneous or random; in deed, most of them are firmly established responses to underlying thoughts and feelings (i.e., triggers). The goal of the RC is to help clients become more aware of the chain events that caused these behaviors to occur and, subsequently, identify the triggers before the behavior occurs in the future.
- Maintain a matter-of-fact tone with clients while asking questions and recording responses. Avoid using a judgmental tone, an expression of shock, a look of dismay, or any other emotional response that could alter or inhibit an individual from completing the analysis. Treat all problems the same way; as a plan that simply requires modification. Complete a functional analysis like you would solve a complex mathematical equation.
- Pick a specific event when the behavior occurred or the last time the person can recall the activity or behavior to initiate the functional analysis, such as a specific night that an individual used cocaine with her friends or the last time they remember having a panic attack.

The functional analysis is completed in two phases: (1) analysis of antecedents of the behavior and (2) the perceived and real consequences of the behavior.

Antecedent factors. The analysis of antecedent factors involves two components: (1) understanding the context around the behavior; i.e., what, who, where, and when, and (2) the person's internal thoughts and feelings associated with the behavior. For substance use, these two components are also referred to as external and internal triggers to using alcohol and other drugs. The RC's job is to continue ask questions until a clear picture of the behavior emerges. Questions of context include:

- Where does the behavior occur; e.g., where did you go when you drank alcohol on Tuesday after work or where were do you like to go when you smoke pot?
- What are you doing when the behavior occurs; e.g., what was going on or what were you doing when you felt the urge to smoke crack cocaine last Sunday or what were you doing when you got in an argument with your boss?
- Who are you with when the behavior occurs; e.g., who were you drinking with after work on Tuesday or who do you tend to get into arguments with (mention specific names and their relationship to you; e.g., boss, boyfriend, or parent).
- When does the behavior occur; e.g., when do you feel the need or like to drink or what time of day do you usually experience depression, anger, or anxiety?

The goal of these questions is to reveal response patterns or trends in behaviors. People usually repeat behaviors overtime and most behaviors are triggered or initiated by reoccurring environmental stimuli; i.e., people, places, or things (or times of day).
Questions of internal thoughts and feelings include:

- What are you thinking about when the behavior occurred; e.g., can you recall what you were thinking just before you agreed to meet your friends at the bar for a drink or what were you thinking about prior to experiencing the panic attack in the supermarket on Friday? Can you remember what you thought might happen when you went over to your cousins house to hang out (the cousin who also sells pot)? Can you remember what you were thinking about when you woke up yesterday before you used cocaine? What was on your mind before you went into work on Wednesday before you got into the argument with your boss? Do you remember what you thought might happen if you used alcohol, drugs, or food at that moment?
- What are you feeling when the behavior occurs or what emotions are associated with the behavior; e.g., can you recall what you were feeling a couple of hours before you met up with your friends for a drink and can you recall what you were feeling just before you started drinking? Also, can you recall when the specific feeling began that day; did you wake up feeling angry, depressed, happy, overjoyed, or hopeless?
- Is the behavior associated with some of the symptoms of your mental illness; e.g., do you notice the behavior occurring when you are depressed, anxious, hopeless, or when you are hearing voices?

The goal of asking these questions is to understand the internal drives and thought processes that lead individuals to the behavior. It is particularly enlightening to find out what individuals think will happen if the behavior occurs. The RC and client should have a good idea of what triggers the behavior to occur when they complete this phase of the functional analysis. In turn, these triggers, red flags, or list of stimuli will be revisited to develop a problem-solving plan, such as relapse prevention plan.

Consequences of behavior. The second related phase of the functional analysis is an examination of what happens when the behavior occurs or is initiated. This part of the analysis involves understanding the pros and cons of the behavior and the pros and cons of changing the behavior or eliminating the behavior entirely. This phase of the functional analysis serves two purposes. The first is to highlight and review what happens when the behavior occurs, so that individuals have a better understanding, through a written account, of what to expect in the future. The RC can use this account to remind individuals of the cons of returning to the behavior. The RC can use this information to help clients mentally walk through the chain of events, starting with the behavior; i.e., develop foresight and proactive planning skills.
The second purpose is to understand what is still reinforcing about the behavior or what is considered to be the downside or con of avoiding or eliminating the behavior. People will continue to perform behaviors or activities that they perceive to be rewarding, including using alcohol and other drugs. It is important to understand what type of reward; i.e., consequence that will increase the likelihood of the behavior occurring in the future. For example, people use drugs or alcohol to relieve depression, pain, or loneliness or to increase happiness, socialization-companionship, or intimacy. It is essential that the RC understand what the client believes to be the benefit or consequence of the behavior or, again, what is perceived to be the negative, punitive, or downside of not performing the behavior. Once the RC has uncovered the rewarding

aspects of any behavior, they can help the client acquire the reward through other behaviors or options that can compete with the original behavior. In other words, the RC can help the client select behaviors that are equally or more rewarding than the present behavior. For example, people are less likely to drink alcohol if they can learn to acquire the rewards associated with drinking, such as laughter, socializing with friends, dating, or enjoying sexual intimacy, using other behavioral options.

Both purposes are accomplished by asking clients detailed questions about what happens after the behavior occurs. Questions to ask include:

- What do you feel as soon as the behavior occurs; e.g., how did you feel after you started smoking crack cocaine, drinking alcohol, or screaming at your boss?
- What do you think about after the behavior occurs; e.g., what was on your mind when you starting drinking or what were you thinking after the panic attack occurred?
- What happens after the behavior occurs; e.g., can you tell what happened with you and your friends after you started drinking? Also, can you walk me through what happened that evening after you started drinking? Now, can you tell me what occurred the next day?

Follow up each question with a probe for the positive and negative consequences of the behavior. Clients will either recall positive or negative consequences associated with a behavior, but they usually cannot provide a balanced description of all outcomes; therefore, the RC can help individuals frame the events in terms of positive and negative consequences. Also, use probes to clarify or to better understand the positive and negative consequences of a given behavior. For instance, use a series of probes in response to the client's answer, "I like to drink or smoke pot". Try to delineate what is appealing about alcohol, marijuana, or any other drug. The specific details for why people like to use alcohol or other drugs will help the RC develop a problem-solving plan with the client that can address the specific area or type of reward. For instance, if a person uses alcohol to be more sociable, the RC can use this information to develop a plan with the client that incorporates social skills training (described next) as well as homework assignments that require the person to pilot test certain social situations without drinking.

The final task of the functional analysis is to examine the pros and cons of the behavior not occurring. The same questions are used for this part that were used to answer the pros and cons of the behavior, but now the RC and client examine what happens when the individual does not use the behavior or experience the event, as in experiencing a panic attack. It is helpful to understand the benefits and negative consequences of the behavior not occurring, such as what happens when a client decides to not meet up with his friends after work to drink or when the client chooses to walk away from an argument instead of standing her ground and screaming at her partner. This final step is useful to understand the potential downside of eliminating or modifying the targeted behavior. For example, many individuals who quit smoking cigarettes have noted an increase in agitation, drowsiness, confusion, and weight gain. Also, many individuals who refuse to take their psychotropic medications do so because of the serious side effects associated with them and that these side effects often outweigh any benefits derived from the medication. Thus, there are serious consequences associated with eliminating the behavior, which in this case is resistance to taking medication. These potentially negative consequences will need to be addressed in the problem-solving plan.

Attached to this manual are two forms or templates that RCs can use to organize the functional analysis for each problem area selected by clients (Appendix D, Form A was developed by Meyers and Smith (1995) and Form B was developed by Budney and Higgins (1998). Both forms can be used for any problem area, although we recommend the Meyers and Smith form for RCs who are not familiar with the problem-solving process.

Developing a Problem-solving Plan

The next step is to develop a problem-solving plan based on the functional analysis. A problem-solving plan is a written document consisting of a set of behavioral tasks or activities designed to modify the target behavior or replace the target behavior.

Below is a list of guidelines for developing problem-solving plans.

(1) Pick easy problems to solve first. Recall from Chapter 7 that an important task of goal planning is to create learning experiences that promote self-efficacy. Self-efficacy is promoted by helping people experience winning situations (i.e., small victories) or the achievement of steps that are within their control. Address small problems first then slowly progress to larger problems.
(2) Work on the problems or behaviors that clients want to change or modify. Like the strengths model described in chapter 7, behavioral problem solving is client-centered. In other words, do not impose ideas and areas of change for clients to address, such as complying with medication or treatment that clients are unwilling to address. It is okay to offer suggestions and ideas, but make sure clients are clearly motivated or interested in addressing a particular problem area. If the RC perceives that a particular problem is extremely important to be addressed, they may use motivational interviewing to assist the client to consider this issue.
(3) Breakdown complex problems into smaller steps or components. For example, breakdown the task of abstaining from alcohol into a series of behavioral steps. Stated another way, abstinence or the goal maintaining abstinence is not one behavioral step to achieve but rather a complex collection of behavioral steps.
(4) Phrase and write behavioral steps or goals in positive, action-oriented language and in terms of achieving or acquiring a behavior rather than eliminating or stopping the behavior. For example, the goal is not to stop drinking or drugging but to maintain abstinence or to acquire activities and behaviors that will replace or conflict with drinking. People are more likely to remain abstinent if they have an array of reinforcing behaviors that can effectively compete with drinking or drugging. Always attempt to add a new reinforcing behavior to a persons' repertoire.
(5) Use specific timeframes when developing each plan or specific dates when the action steps are to be accomplished or mastered.
(6) Involve other people in developing and implementing any behavioral problem-solving plan. Family and friends will be needed to implement and monitor behavior problem-solving plans and will be relied upon to provide essential reinforcers that will compete with drinking and drugging behaviors, such as companionship, access to children, friendship, or verbal praise.

(7) Always have a back-up plan or options A and B for any problem-solving plan. This is particularly useful when developing relapse prevention plans.
(8) View the initial problem-solving plan as a pilot test (described next) that will require modifications over time. Let clients' know that the plan will evolve over time and that it is okay if the initial plan fails or is incomplete.
(9) Select only measurable or observable behaviors to change or modify. Avoid selecting cognitive thought processes or feelings, such as improving motivation or reducing fear. Convert these feelings and thoughts into specific action steps, such as getting up at 7:00am every day next week or talking to one new person at an AA meeting. Also avoid using vague goals, such as exercising more or loosing weight. Both of these steps should be converted into specific action steps, such as walking for 20 minutes in the park or loosing one pound every week or five pounds in three weeks (note the specific date).
(10) Avoid using punishment in a behavioral plan. Punishment is a component of learning and social learning theories, but is usually ineffective as a tool for motivating behavioral change. Punishment can discourage engagement in treatment, increase frustration and feelings of hopelessness and, if used alone, does not provide for learning of alternative behaviors.

Developing Weekly Behavioral Plans

The first rule of behavioral problem solving is to write the plan down on paper or record it in a database program that can produce a printed copy for the RC and client. The form should be one page, easy to read, and consisting of enough detail to implement the plan as intended. Below is a sample behavioral problem-solving plan. The plan consists of a long-term, client-centered goal, such as sustaining abstinence, acquiring a job, or completing an associate's degree in accounting, and short-term or weekly actions steps that lead or build toward the long-term goals.

Most of the long-term goals will have already been established while developing a strengths-based or recovery-based plan with clients. The weekly behavioral plans are used to help clients overcome barriers, resolve problems, or acquire skills in route to achieving their long-term goals. Probably the most common long-term goal of clients in the addiction treatment field is to achieve recovery from alcohol or other drugs. Weekly behavioral problem-solving plans can address peoples' problems or barriers that could undermine the long-term goal of recovery.

Weekly behavioral plans consist of the following elements:
(1) A client centered goal.
(2) A measurable and observable step that the client would like work on for the week (it can also be two or more weeks)
(3) A projected date of completion
(4) An indicator of how the step will be determined (e.g., spouse report, documentation, or receipt)
(5) Assignment of responsibility for individuals participating in the plan (e.g., spouse, friend, the RC, or an employer)
(6) A reward or other clearly described outcome or consequence that will occur if the step is achieved

(7) A check box or summary box indicating if the step was achieved (to be reviewed after the plan expires [discussed next]).

Practicing the Problem-solving Plan: Developing Behavioral Skills

After clients have developed a problem-solving plan, the RC can help clients implement the plan, evaluate and modify it over time, and develop various skills required to achieve the desired goal or behavior change.

An essential component of the problem-solving process is teaching individuals the skills they will need to achieve their goals and solve future problems. The RC plays an active role in the teaching process. Specifically, the RC will use several cognitive behavioral training strategies to help clients achieve their goals, particularly recovery from an SUD or a mental illness. The IMR training manual developed by Gingerich and Mueser (2004) provides a good overview of effective cognitive behavioral training strategies that include:

- **Reinforcement**: An effective and appealing technique is to provide people with clear rewards or reinforcers for achieving various activities. The most effective types of rewards come from family and friends, such as companionship, praise, and support, but can be coordinated by the RC and client on the weekly behavioral plans. RCs can also use more tangible rewards for clients to keep them engaged and motivated, such as providing coupons to supermarkets and department stores, providing transportation to desired activities, or taking the client out to lunch after they completed a difficult task.
- **Shaping**: Shaping is also referred to as successive approximation of steps or, using more common terms, selecting baby steps toward accomplishing a goal. Shaping is a highly effective technique to help people overcome imposing barriers or problems. Shaping is used commonly to help people overcome phobias and other anxiety-producing situations, such as public speaking, riding a bus, or attending a job interview. The basic strategy is to write down a list of steps of increasing difficulty starting with one that requires minimal effort and is easily accomplished and ending with the step that the client is not presently capable of achieving or performing. The RC and client can test one step each week until the client masters the highest or most difficult step, which is the goal, such as shopping by themselves in a supermarket, riding the bus, re-establishing relationships with relatives, talking to a new person at an AA meeting, or completing a job interview without assistance.
- **Modeling**: Probably the most effective teaching tool in the RC arsenal is to demonstrate or model the behavior for clients. Modeling should be used in all situations where the client is unclear how to perform a target behavior, such as asking for help at the library, getting their needs met at the doctor's office, communicating to an employer in a job interview, effective communication during an argument, or drink-drug refusal skills (i.e., learning how to assertively say no to drug dealers and friends who have alcohol). Modeling is usually paired with role playing with the RC modeling the behavior first, allowing the client to role play or rehearse the behavior themselves, and repeating this pattern as needed until the client feels that they have mastered the skill. Modeling and role playing (described next) are brief exercises that should last 1 to 3 minutes.
- **Practice/role playing/rehearsal techniques**: Modeling is the most effective technique for teaching a skill, but practice is the most effective technique to acquire the skill.

Therefore, clients are encouraged to practice any skills that they are trying to master. As noted, practice should occur immediately after the RC models the behavior. A good habit to get into is to ask the client to practice or role play any activity that they have agreed to work on, but the RC has not observed in the past. A good example is observing the client practicing drink or drug refusal skills. Most clients will report that they can effectively say no to drugs, but this is rarely the case for people in the early stages of treatment and the recovery process. Most individuals cannot accurately evaluate their own skills or they often overestimate their skill level, such as their ability to say no to a drug dealer. Therefore, it is helpful and illuminating to observe the client perform the behavior in a role play. The role play helps both the client and the RC accurately evaluate the client's skill level. The RC's task is to help clients improve their skill level by providing supportive and constructive feedback and modeling the suggested changes. Another effective technique is to ask clients to write down a script for what they want to say and to keep the script with them when they perform the activity, such as what to say to friends when they want to go out drinking with the client or instructions of what to do during a panic attack at the shopping mall.

- **Cognitive restructuring**: Another effective technique that is used in conjunction with the other behavioral teaching skills is cognitive restructuring, which involves challenging and correcting peoples' misperceptions and false assumptions that can impede their ability to achieve a goal. In the addiction treatment field, this technique has been referred to as changing one's "stinking thinking". Individuals in treatment for an addiction or a mental illness can harbor beliefs or cognitive processing styles that may be based on inaccurate or distorted ideas of the world around them.

Information presented in this chapter is based on three empirically established cognitive-behavioral training programs: (1) Cognitive Behavioral Training (CBT) in addiction treatment (Monti et al)., (2) the Community Reinforcement Approach CRA) (Meyers & Smith, 1995); and (3) Illness Management and Recovery (IMR) (Gingerich & Mueser, 2003). The three corresponding training manuals of these programs include:

- CBT Monti, et. al. (see page 19 for full reference)
- CRA from Meyers (see page 19 for full reference)
- Illness Management and Recovery by Susan Gingerich and Kim Mueser which can be acquired for free from the Substance Abuse Mental Health Services Administration at www.samhsa.gov.

References

Anglin, M.D., Yih-Ing, H., Grella, C.E. (1997). Drug addiction and treatment careers among clients in the drug abuse treatment outcome study (DATOS). *Psychology of Addictive Behaviors, 11*, 308-323.

Arizona department of health services website (2005), retrieved on May 18, 2005 from http://www.azdhs.gov/bhs/tr_resources/psp_training.htm

Axelrod, S. & Hall, V. R. (1999). *Behavior Modification: Basic Principles, 2nd Ed*. Austin, TX: Pro.Ed.

Bigelow, G.E. & Silverman, K. (1999). Theoretical and empirical foundations of contingency management treatments for drug abuse. In S.T Higgins & K. Silverman (Eds.), *Motivating Behavior Change Among Illicit Drug Abusers* (pp. 15-31).Washington DC: American Psychological Association.

Blomqvist, J. (1996). Paths to recovery from substance misuse: Change of lifestyle and the role of treatment. *Substance Use & Misuse, 31*, 1807-1852.

Brewer, D.D., Catalano, R.F., Haggerty, K., Gainey, R.R., & Fleming, C.B. (1998). A meta-analysis of predictors of continued drug use during and after treatment for opiate addiction. *Addiction, 93*, 73-92.

Chen, X., Burgdorf, K., Dowell, K., Roberts, T., Porowski, A., & Herrell, J.M. (2004). Factors associated with retention of drug abusing women in long-term residential treatment. *Evaluation and Program Planning, 27,* 205-212.

Cloud, W. & Granfield, R. (2001). Natural recovery from substance dependency: Lessons from treatment providers. *Journal of Social Work Practice in the Addictions, 1*(1), 83-104.

Conrad, K.J., Hultman, C.I., Pope, A.R., Lyons, J.S., Baxter, W.C., Daghestani, A.N.,

Lisiecki, J.P., Elbaum, P.L., McCarthy, M., &Manheim, L.M. (1998). Case managed residential care for homeless addicted veterans: Results of a true experiment. *Medical Care, 36* (1), 40-54.

Cox, G. B., Walker, R. D., Freng, S. A., Short, B. A., Meijer, L. & Gilchrist, L. (1998). Outcomes of a controlled trial of the effectiveness of intensive case management for chronic public inebriates. *Journal of Studies on Alcohol, 59,* 523-532.

Cunningham, J.A. & Breslin, F. C. (2004). Only one in three people with alcohol abuse or dependence ever seek treatment. A*ddictive behaviors,* 29 (1), 221-223.

Dixon, L., Turner, J., Krauss, N., Scott, J. &McNary, S. (1999). Case managers' and clients' perspectives on a representative payee program. *Psychiatric services, 50* (6), 781-787.

Drake, R.E. & Brunette, M.F.(1998). Complications of severe mental illness related to alcohol and drug use disorders. *Recent developments in alcoholism, 14*, 285.

Durkin, E.M. (2002). An organizational analysis of psychosocial and medical services in outpatient drug abuse treatment programs. *Social Service Review, 76*, 406-429.

Etheridge, R.M., Craddock, S.G., Dunteman, G.H., & Hubbard, R.L. (1995). Treatment services in two national studies of community-based drug abuse treatment programs. *Journal of Substance Abuse, 7*, 9-26.

Etheridge, R.M., Hubbard, R.L., Anderson, J., Craddock, S.G., & Flynn, P.M. (1997). Treatment structure and program services in the drug abuse treatment outcome study (DATOS). *Psychology of Addictive Behaviors, 11*, 244-260.

Friedmann, P.D., Alexander, J.A., Jin, L. & D'Aunno, T.A. (1999). On-site primary care and mental health services in outpatient drug abuse treatment units. *The Journal of*

Behavioral Health Services Research, 26, 80-94.

Friedmann, P.D., Hendrickson, J.C., Gerstein, D.R., & Zhang, Z. (2004). The effect of matching comprehensive services to patients' needs on drug use improvement in addiction treatment. *Addiction, 99*, 962-972.

Godley, S.H., Funk, R.R., Dennis, M.L., Oberg, D., & Passetti, L. (2004). Predicting response to substance abuse treatment among pregnant and post partum women. *Evaluation and Program Planning, 27,* 223-231.

Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R., & Passetti, L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, *23*, 21-32.

Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R. & Passetti, L. (under review). The Effect of Assertive Continuing Care on Continuing Care Adherence and Substance Use Following Residential Treatment for Adolescents

Godley, S. H., Godley, M. D., Karvinen, T., & Slown, L. L. (2001). *The Assertive Aftercare Protocol A case manager's manual for working with adolescents after residential treatment of alcohol and other substance use disorders*. Bloomington, IL Lighthouse Institute.

Godley, S. H., Meyers, R. J., Smith, J. E., Godley, M. D., Titus, J. M., Karvinen, T. et al. (2001). *The Adolescent Community Reinforcement Approach (ACRA) for adolescent cannabis users* (DHHS Publication No. (SMA) 01-3489, Cannabis Youth Treatment (CYT) Manual Series, Volume 4). Rockville, MD Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Granfield, R. & Cloud, W. (2001). Social context and "natural recovery": The role of

social capital in the resolution of drug-associated problems. *Substance and Use Misuse, 36* (11), 1543-1571.

Grella, C.E., Hser, Y., Hsieh, S. (2003). Predictors of drug treatment re-entry following relapse to cocaine use in DATOS. *Journal of Substance Abuse Treatment, 25*, 145-154.

Gutman, M.A., Ketterlinus, R.D., & McLellan, A.T. (2003). Characteristics of substance abusing women on welfare: Findings from the evaluation of Casaworks for families pilot demonstration. *Evaluation Review, 27* (6), 597-628.

Hall, J. A., Carswell, C., Walsh, E., Huber, D. L. & Jampoler, J. S. (2002). Iowa case management: Innovative social casework. *Social Work, 47,* 132-141.

Higgins, S. T. & Silverman, K. (Eds., 1999). *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions*. Washington, DC: American Psychological Association.

Hser, Y., Polinsky, M.L., Maglione, M., & Anglin, M.D. (1999). Matching clients' needs with drug treatment services. *Journal of Substance Abuse Treatment, 16*, 299-305.

Kirby, M. W., Braucht, G. N., Brown, E., Krane, S., McCann, M. & VanDeMark, N. (1999). Dyadic case management as a strategy for prevention of homelessness among chronically debilitated men and women with alcohol and drug dependence. *Alcoholism Treatment Quarterly, 17,* 53-71.

Kisthardt, W. (1993). An empowerment agenda for case management research: Evaluating the strengths model from the consumers' perspective. In Harris, M., & Bergman, H.C. (eds.). *Case management for mentally ill patients: Theory and practice*. Harwood Academic Publishers, (pp. 165-181).

Kisthardt, W. (1997). The strengths model of case management: Principles and helping

functions. In Saleeby, D. (Ed.). *The Strengths Perspective in Social Work Practice: Second Edition*. New York: Longman, (pp. 97-114).

Kubiak, S.P. (2004). The effects of PTSD on treatment adherence, drug relapse, and criminal recidivism in a sample of incarcerated men and women. *Research on Social Work Practice, 14*, 424-433.

Larimer, M.E. & Kilmer, J.R. (2000). Natural history. In Zernig, G., & Saria, A. (Eds.). *Handbook of Alcoholism, Pharmacology and Toxicology*. Boca Raton, FL:CRC Press (pp. 13-28).

Marlatt, G.A. & Gordon, J.R. (Eds). (1985). *Relapse Prevention.* New York: Gilford Press.

McLellan, A.T., Alterman, A.I., Meztger, D.S., Grissom, G.R., Woody, G.E., Luborsky, L., O'Brien, C.P. (1994). Similarity of outcome predictors across opiate, cocaine, and alcohol treatments: Role of treatment services. *Journal of Consulting and Clinical Psychology, 62*, 1141-1158.

McLellan, A.T., Grissom, G.R., Zanis, D., Randall, M., Brill, P., & O'Brien, C.P. (1997). Problem-services "matching" in addiction treatment: A prospective study in 4 programs. *Archives of General Psychiatry, 54*, 730-735.

McLellan, A. T., Hagan, T. A., Levine, M., Gould, F., Meyers, K., Bencivengo, M., & Durell, J. (1998). Supplemental social services improve outcomes in public addiction treatment. *Addiction, 93*, 1489-1499.

McLellan, A. T., Hagan, T. A., Levine, M., Meyers, K., Gould, F., Bencivengo, M., Durell, J.& Jaffe, J. (1999). Does clinical case management improve outpatient addiction treatment. *Drug and Alcohol Dependence, 55,* 91-103.

Mejita, C. L. & Bokos, P. R. (1997). Improving substance abuse treatment access and retention using a case management approach. *Journal of Drug Issues, 27,* 329-340.

Meyers, R. & Smith, J.E. (1995). *Clinical Guide to Alcohol Treatment: The Community Reinforcement Approach*. NY:Guildord Press.

Milby, J. B., Schumacher, J. E., McNamara, C., Wallace, D. Usdan, S. McGill, T., Michael, M. (2000). Initiating abstinence in cocaine abusing dually diagnosed homeless persons. *Drug and Alcohol Dependence, 60*, 55-67.

Miller, W.R., Wilbourne, P.L., & Hettema, J.E. (2003). What works? A summary of alcohol treatment outcome research. In R.K. Hester & W.R. Miller (Eds.), *Handbook of Alcohol Treatment Approaches* (pp. 13-63). Boston: Pearson Education, Inc.

Miller, W.R. & Rollnick, S. (2002). *Motivational Interviewing (2nd ed.)*. New York: Guilford Press.

Miller, W.R. & Westerberg, V.S. (1996). What predicts relapse? Prospective testing of antecedent models. *Addiction, 91*, S155-S174.

Monti, P., Kadden, R., Rohsenow, D., Conney, N., & Abrams, D. (2002). *Treating Alcohol Dependence: A Coping Skills Training Guide, 2nd Edition*. NY: Guilford Press.

Mueser, K. Bond, G. Drake, R., & Resnick, S. (1998). Models of community care for severe mental illness: A review of research on case management. *Schizophrenia Bulletin, 24*, 37-74.

National Institute on Drug Abuse. (1999). *Principles of drug addiction treatment: A research based guide.* Retrieved on May 15, 2005 from http://www.drugabuse.gov/pdf/podat/podat.pdf

Petry, N. M. (2000). A comprehensive guide to the application of contingency management procedures in clinical settings. *Drug and Alcohol Dependence, 58*, 9-25.

Petry, N.M., Petrakis, I., Trevisan, L., Wiredu, G., Boutros, N.N., Martin, B., & Kosten, T.R. (2001). Contingency management interventions: From research to practice. *The American Journal of Psychiatry, 158* (5), 694 703.

Pringle, J.S., Edmondston, L.A., Holland, C.L., Kirisci, L, Emptage, N.P., Balavage, V.K., Ford, W.E., Etheridge, R.M., Hubbard, R.L., Jungblut, JE., & Herrell, J.M. (2002). The role of wrap around services in retention and outcome in substance abuse treatment: Findings from the wrap around services impact study. *Addictive Disorders and their Treatment, 1*, 109-118.

Prochaska, J., Norcross, J., & DiClemente, C. (1995). *Changing for Good*. New York: HarperCollins Books.

Rapp, C.A. (1998). *The strengths model: Case management with peple suffering from severe and persistent mental illness*. New York: Oxford University Press.

Rapp, R.C., Siegal, H.A., & Fisher, J.H. (1992). A strengths-based model of case management/advocacy: adpating a mental health model to practice work with persons who have substance abuse problems. In Ashery, R.S. (Ed*.). Progress and Issues in Case Management, National Institute of Drug Abuse (NIDA) Research Monograph Series, 127*. Rockville, M.D.:National Institute on Drug Abuse, (pp. 34-53).

Rapp, R.C., Siegal, H.A., Li., L., & Saha, P. (1998). Predicting post primary treatment services and drug use outcome: A multivariate analysis. *American Journal of Drug and Alcohol Abuse, 24*, 603-615.

Rapp. R.C., Siegal, H.A., Fisher, J.H., & Wagner, J.H. (1993). A "strengths-based" . approach to enhance treatment compliance. *Addiction & Recovery, 13* (6), 22-25.

Ries, R.K. and Dyck, D.G. (1997). Representative payee practices of community mental health centers in Washington State. P*sychiatric Services, 48* (6), 811-815.

Rosenheck, R., Morrissey, J., Lam, J., Calloway, M., Stolar, M., Johnsen, M., Randolph, F., Blasinsky, M., & Goldman, H. (2001). Service delivery and community: Social capital, service systems integration, and outcomes among homeless persons with severe mental illness. *Health Services Research, 36*, (4), 691-711.

Schutte, K.K., Nichols, K.A., Brennan, P.L., & Moos, R.H. (2003). A ten-year follow-up of older former problem drinkers: Risk of relapse and implications of successfully sustained remission. *Journal of Studies on Alcohol, 64*, 367-374.

Shaner, A., Tucker, D.E., Roberts, L.J., & Eckman, T. A. (1999). Disability income, cocaine use, and contingency management among patients with cocaine dependence and schizophrenia. In S.T Higgins & K. Silverman (Eds.), *Motivating Behavior Change Among Illicit Drug Abusers* (pp. 95-121).Washington DC: American Psychological Association.

Shwartz, M., Baker, G., Mulvey, K. P. & Plough, A. (1997). Improving publicly funded substance abuse treatment: The value of case management. *American Journal of Public Health, 87,* 1659-1664.

Siegal, H. A., Fisher, J. H., Rapp, R. C., Kelliher, C. W., Wagner, J. H., O'Brien, W. F. & Cole, P. A. (1996). Enhancing substance abuse treatment with case management: Its impact on employment. *Journal of Substance Abuse Treatment, 13,* 93-98.

Siegal, H. A., Li, L. & Rapp, R. C. (2002). Case management as a therapeutic enhancement: Impact on post-treatment criminality. *Journal of Addictive Diseases, 21,* 37-46.

Siegal, H. A., Rapp, R. C., Li, L., Saha, P. & Kirk, K. D. (1997). The role of case management in retaining clients in substance abuse treatment: An exploratory analysis. *Journal of Drug Issues, 27,* 821-831.

Sigmon, S. C., Steingard, S., Badger, G. J., Anthony, S. L., Higgins, S. T. (2000). Contingent reinforcement of marijuana abstinence among individuals with serious mental illness: A feasibility study. *Experimental and Clinical Psychopharmacology, 8*, 509-517.

Simpson, D.D., Joe, G.W., Fletcher, B.W., Hubbard, R.L., & Anglin, M.D. (1999). A national evaluation of treatment outcomes for cocaine dependence. *Archives of General Psychiatry, 56*, 507-514.

Sobell, L.C., Cunningham, J.A., & Sobell, M.B. (1996). Recovery from alcohol problems with and without treatment: Prevalence in two population surveys. *American Journal of Public Health, 87*(7), 966-972.

Sosin, M.R., Bruni, M., & Reidy, M. (1995). Paths and impacts in the progressive independence model: A homelessness and substance abuse intervention in Chicago. *Journal of Addictive Diseases, 14*, 1-20.

State of Connecticut Department of Mental Health and Addiction Services (2005), retrieved on May 18, 2005 from http://www.dmhas.state.ct.us/recovery.htm

State of Oregon (2005), retrieved on May 18, 2005 from http://egov.oregon.gov/DHS/addiction/recovery.shtml

Stein, M.D. & Friedman, P. (2002). Need for medical and psychosocial services among injection drug users: A comparative study of needle exchange and methadone maintenance. *The American Journal on Addictions, 11*, 262-270.

Taxman, F.S. & Bouffard, J. A. (2003). Drug treatment in the community- A case study of system integration issues. *Federal Probation, 67*(2), 4-15.

Unites States Department of Health and Human Services Substance Abuse and Mental Health Services Administration (2005), retrieved on May 18, 2005 from http://rcsp.samhsa.gov/

Vanderplasschen, W., Rapp, R. C., Wolf, J. R. & Broekaert, E. (2004). The development and implementation of case management for substance use disorders in North America and Europe. *Psychiatric Services, 55,* 913-922.

Vaughn-Sarrazin, M. S., Hall, J. A. & Rick, G. S. (2000). Impact of case management on use of health services by rural clients in substance abuse treatment. *Journal of Drug Issues, 30,* 435-463.

Walton, M.A. (2003). Individual and social/environmental predictors of alcohol and drug use 2 years following substance abuse treatment. *Addictive Behaviors, 28*, 627-642.

Walton, M.A., Blow, F.C., Bingham, C.R. & Chermack, S.T. (2003). Individual and social/environmental predictors of alcohol and drug use 2 years following substance abuse treatment, A*ddictive Behavior,* 28 (4), 627-642.

Willenbring, M.L. & Olson, D.H. (1999). A randomized trial of integrated outpatient treatment for medically ill alcoholic men. *Archives of Internal Medicine, 159*, 1946-1952.

Wilson, S.F. (1992). Community support and community integration: New Directions for client outcome research. In Rose, S.M. (Ed.) *Case Management & Social Work Practice*. White Plains, N.Y.: Longman, (pp. 245-257).

APPENDIX A
Form A
Individual Goals and Aspirations: Recovery Plan

Individual's Name _____ Date:_____ Recovery Coach _____

Life Domains	**Individual Goals and Aspirations** What do I want?	**Resources, Strengths, and Skills** What do I have access to or what have I used in the past?	**Barriers and Problems** What barriers or issues do I need to remove or overcome to achieve my goals?
(1) Recovery from substance use or abuse			
(2) Living and financial independence			
(3) Employment and Education			
(4) Relationships and social support			

Life Domains	**Individual's Desires, Aspirations** What do I want?	**Resources, Personal Social** What do I have access to or what have I used in the past?	**Barriers and problems** What barriers or issues do I need to remove or overcome to achieve my goals?
(5) Medical health			
(6) Leisure and recreation			
(7) Independence from legal problems and institutions			
(8) Mental wellness and spirituality			

APPENDIX A, Form B

Specific Steps of the Recovery Plan

Name:_____ Date:_____

Step to be achieved or barrier to be removed	Action Plan (how will the step be achieved and who will help)	Objective and measurable outcome
(1) In the area of recovery from alcohol or other drugs I would like:		
(2) In the area of living and financial independence I would like:		
(3) In the area of employment and education I would like:		

Step to be achieved or barrier to be removed	Action Plan (how will the step be achieved and who will help)	Objective and measurable outcome
(4) In the area of relationships and social support I would like:		
(5) In the area of medical health I would like:		
(6) In the area of leisure and recreation I would like:		

Step to be achieved or barrier to be removed	Action Plan (how will the step be achieved and who will help)	Objective and measurable outcome
(7) In the area of independence from legal problems and institutions I would like		
(8) In the area of mental wellness and spirituality I would like		

APPENDIX B
Recovery Coach Service Documentation Form

Individual's Name:_____
Medical Record #_____

Date of Service:_____ Date of Birth:_____

Program	Procedure Code	Start Time	Length of Event	Location Code	Appointment Contact Code	Face-to-Face
_____	_____	_____	_____	_____	_____	Yes No
_____	_____	_____	_____	_____	_____	Yes No
_____	_____	_____	_____	_____	_____	Yes No
_____	_____	_____	_____	_____	_____	Yes No

Personal Recovery Goal(s) Addressed:_____

_____

What is the person's current cognitive stage of change for recovery management? In other words, what is the person's current level of motivation for managing his or her recovery? (It is okay to estimate)
☐ Precontemplation ☐ Contemplation ☐ Determination ☐ Action ☐ Maintenance ☐ Relapse
☐ Unknown (unfamiliar with consumer)

Recovery domain (s) addressed in this session:
☐ Recovery planning ☐ Physical Wellness ☐ Transportation ☐ Leisure ☐ Stigma
☐ Work ☐ Mental Wellness ☐ Housing ☐ Financial ☐ Childcare
☐ Relationships ☐ Education ☐ Legal issues ☐ Spirituality ☐ Other:_____

Strategies and interventions used to achieve a person's recovery goals (these are optional)
☐ Coaching/case management ☐ Relapse prevention ☐ Early TX re-entry coaching ☐ CRA or CRAFT
☐ Motivational Interviewing ☐ Contingency Management ☐ Skills training:_____
☐ Other (please list):_____

Please provide any narrative information regarding today's contact here. _____

_____

_____

Was a follow-up meeting or contact time been established? Yes No. If Yes, when_____

Please select all specific activities that occurred while working with the individual

Assessment/Engagement

- ☐ 1: Initial assessment for recovery planning
- ☐ 2: Discussion of needs
- ☐ 3: CRA functional analysis
- ☐ 4: Implementing the happiness scale

Personal Recovery Planning

- ☐ 1: Developing a personal recovery plan
- ☐ 2: Reviewing/updating personal recovery plan
- ☐ 3: Organizing Support Networks for Planning
- ☐ 4: Recovery Treatment Meeting/Update with service providers

Housing

- ☐ 1: Communicating with landlords/managers/residential staff
- ☐ 2: Looking for housing sites/exploring housing options
- ☐ 3: Finding emergency housing
- ☐ 4: Obtaining furniture and other household supplies

Resource Capital Development

- ☐ 1: Assisting in obtaining clothing
- ☐ 2: Assisting in obtaining food
- ☐ 3: Assisting in acquiring financial resources/entitlements
- ☐ 4: Assisting with completing forms

Relationships

- ☐ 1: Visiting/telephonic with families/providing education
- ☐ 2: Identifying/engaging recovery supports
- ☐ 3: Calling family members
- ☐ 4: Consulting on parenting
- ☐ 5: Working on partnerships/family/ or friend relationship

Leisure

- ☐ 1: Working on time management
- ☐ 2: Exploring new leisure and fun activities
- ☐ 3: Assistance in connecting to social activities/hobbies
- ☐ 4: Supporting use of or rehearsing social skills
- ☐ 5: Coaching/helping the person in social situations

Physical and Mental Wellness

- ☐ 1: Accompanying person during appointments
- ☐ 2: Assisting the person to maintain appointments
- ☐ 3: Linking to dental
- ☐ 4: Linking to eye care
- ☐ 5: Linking/consultation with primary care
- ☐ 6: Linking to counseling or psychiatric services
- ☐ 7: Provide or link to education or skills training on illnesses
- ☐ 8: Acquiring medication or resources for medication
- ☐ 9: Assisting the individual in managing medications

Legal Issues

- ☐ 1: Support with court personnel
- ☐ 2: Support with probation/parole officers
- ☐ 3: Support with DCFS or DHS
- ☐ 4: Consulting on legal issues (in or out of court)
- ☐ 5: Working with the individual in jail/jail consultation

Work

- ☐ 1: Linking to vocational services
- ☐ 2: Developing a resume
- ☐ 3: Practice interviewing
- ☐ 4: Providing transportation to work (temporary activity)
- ☐ 5: Searching for employment/exploring employment options

Education

- ☐ 1: Linking to educational services
- ☐ 2: Consulting/supporting or exploring educational options
- ☐ 3: Acquiring resources for education
- ☐ 4: Applying for financial assistance

Spirituality

- ☐ 1: Linking to religious-based services
- ☐ 2: Identifying sources of meaning to the person
- ☐ 3: Encouraging/practicing meditation activities

Substance Use Behaviors

- ☐ 1: Linking/re-entry to addiction treatment services
- ☐ 2: Implementing/revising relapse prevention plan or assessing for relapse
- ☐ 3: Communication with treatment providers
- ☐ 4: Provide or link to education or skills training on SUDs
- ☐ 5: Assisting to select sponsor for mutual aid
- ☐ 6: Assisting connection with self-help groups

Transportation

- ☐ 1: Consulting with Secretary of State staff/office
- ☐ 2: Assistance in acquiring a license
- ☐ 3: Consultation with driving lessons/test
- ☐ 4: Assisting/facilitating use of public transportation

Other

- ☐ 1: Please specify _____

_____

Recovery Coach Signature:_____

Recovery Coach ID#:_____

APPENDIX C

Weekly Contingency Management Plan

Individual's Name:_____ Date of Plan:_____

Recovery Coach:_____

Date of next planning meeting to review this plan:_____

The first activity or step is related to my long-term goal of:_____

The first step or activity that I would like to accomplish is:_____

_____

When I accomplish this step or activity I will receive:_____

_____

Confirmation of this step or activity will include:_____

_____

To accomplish this step or activity I will receive assistance from (describe who and what the assistance will be):_____

_____

The second activity or step is related to my long-term goal of:_____

The second step or activity that I would like to accomplish is:_____

_____

When I accomplish this step or activity I will receive:_____

_____

Confirmation of this step or activity will include:_____

_____

To accomplish this step or activity I will receive assistance from (describe who and what the assistance will be):_____

_____

APPENDIX D

Functional Analysis for Using Behaviors

(Meyers, 2003)

External Triggers	Internal Triggers	Using Behavior	Short-Term – Good things (rewards)	Long-Term - Not so good things
1. Who are you usually with when you use?	**1. What are you usually thinking about right before you use?**	**1. What do you usually use?**	**1. What do you like about using with (who)?**	**1. What are the negative results of your using in each of these areas:**
				a) Interpersonal:
			2. What do you like about using (where)?	
				b) Physical:
2. Where do you usually use?	**2. What are you usually feeling physically right before you use?**	**2. How much do you usually use?**	**3. What do you like about using (when)?**	
				c) Emotional:
			4. What are the pleasant thoughts you have while using?	
				d) Legal:
3. When do you usually use?	**3. What are you usually feeling emotionally right before you use?**	**3. Over how long a period of time do you usually use?**		**e) Job:**
			5. What are the pleasant physical feelings you have while using?	
				f) Financial:
			6. What are the pleasant emotions you have while using?	
				g) Other:

APPENDIX D, Form B
Functional Analysis

Trigger	Thought and Feelings	Behavior	Positive Consequences	Negative Consequences