

Traditional Treatment Model

Emerging Recovery Model

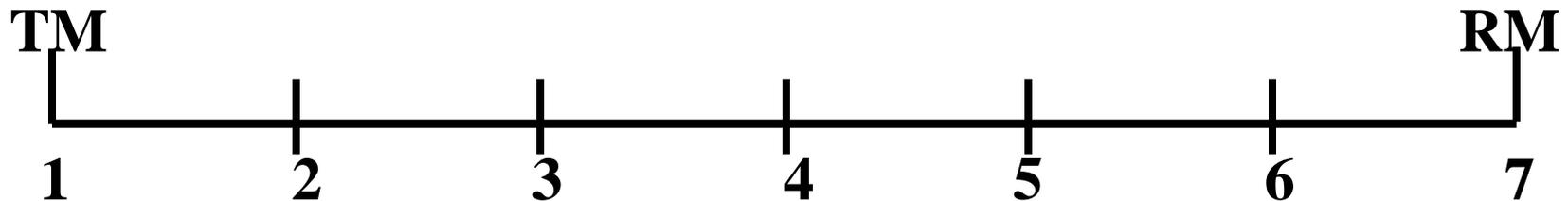
16 major differences in service design and delivery

- Compare and contrast
- Desirability and effectiveness of each model varies across clinical populations and treatment settings

Developed by William White and Michael Boyle for the Behavioral Health Recovery Management project.

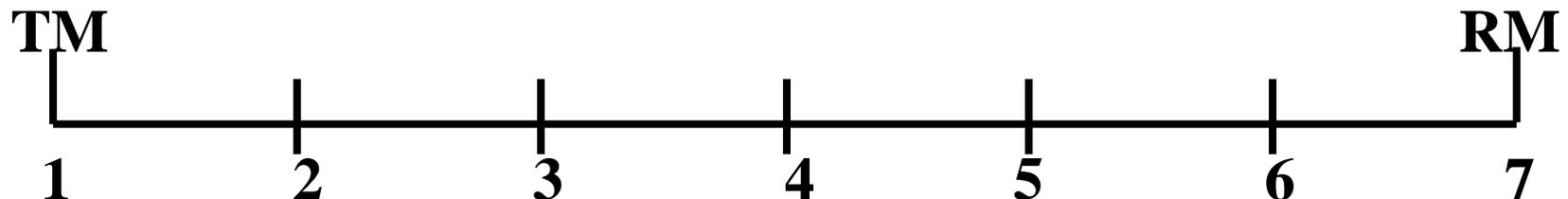
1. Engagement

- Traditional Model: High threshold, crisis intervention, isolated outreach, high extrusion
- Recovery Model: Low threshold (welcoming), emphasis on outreach, low extrusion



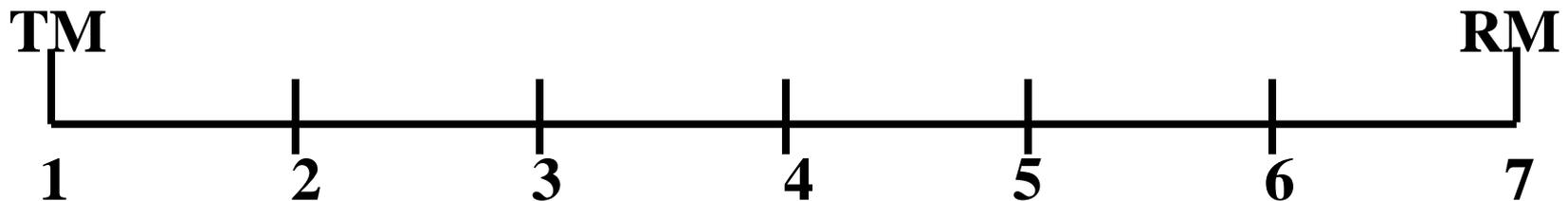
2. View of Motivation

- Traditional Model: Pre-condition for treatment, absence defined as “resistance”, responsibility/blame-- client
- Recovery Model: Seen as outcome of services, emphasis on pre-action stages of change (“recovery priming”, responsibility/blame--service milieu)



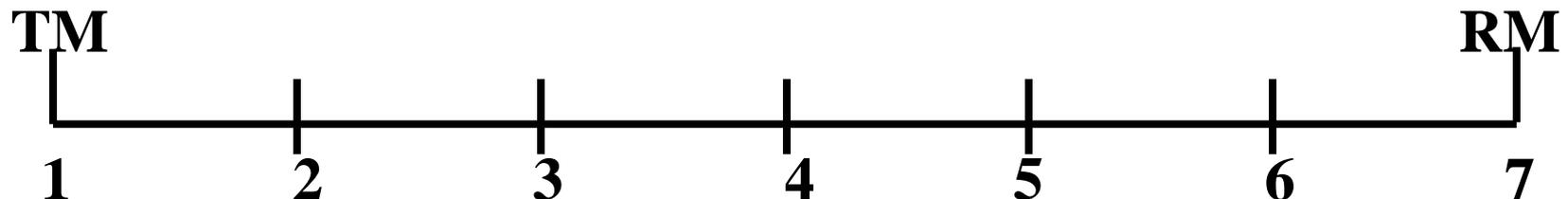
3. Screening/Assessment

- Traditional Model: Categorical, Intake Activity, Deficit-based (problems to treatment plan)
- Recovery Model: Global, Continual (stages of change assumptions), Strength-based (assets to recovery plan); Inclusion of family/kinship network: Consumer defines family.



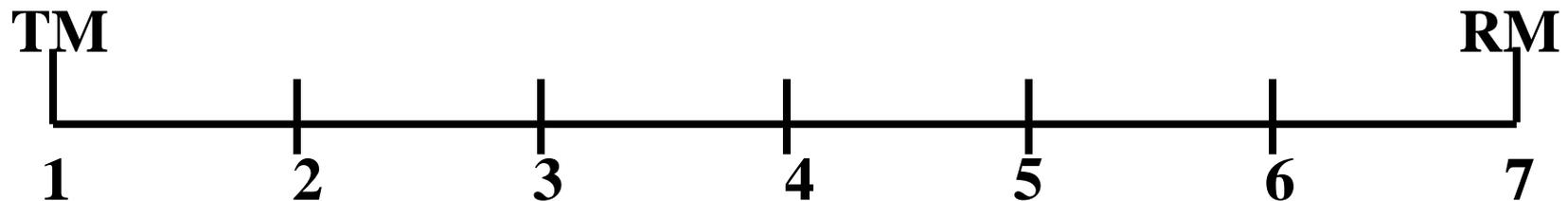
4. Service Goals

- Traditional Model: Professionally defined in treatment plan; Focus on reducing pathology.
- Recovery Model: Consumer-defined in Recovery Plan; Focus on building recovery capital (Borkman, 1998); Recovery vision reflected in mission.



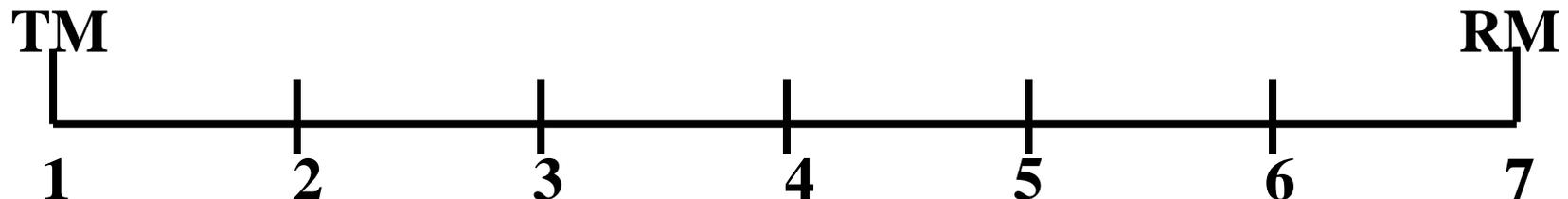
5. Service Timing

- Traditional Model: Focus on crisis/problem resolution; Reactive
- Recovery Model: Focus on post-crisis recovery support activities; Proactive; Commitment to continued availability



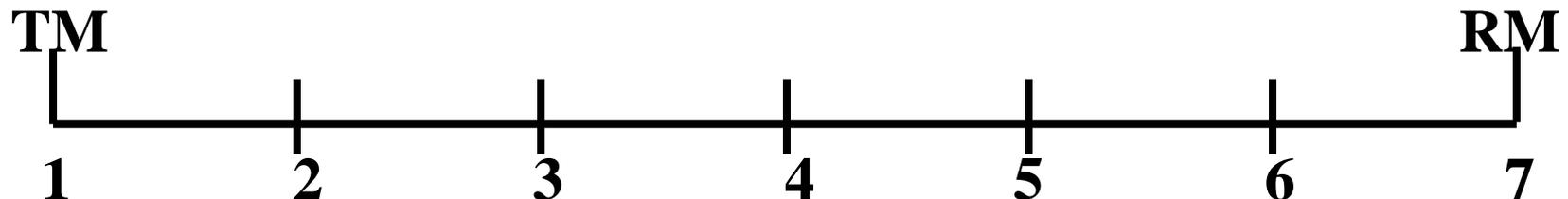
6. Service Emphasis

- Traditional Model: Stabilization
- Recovery Model: Recovery coaching, monitoring with feedback and support, early re-intervention



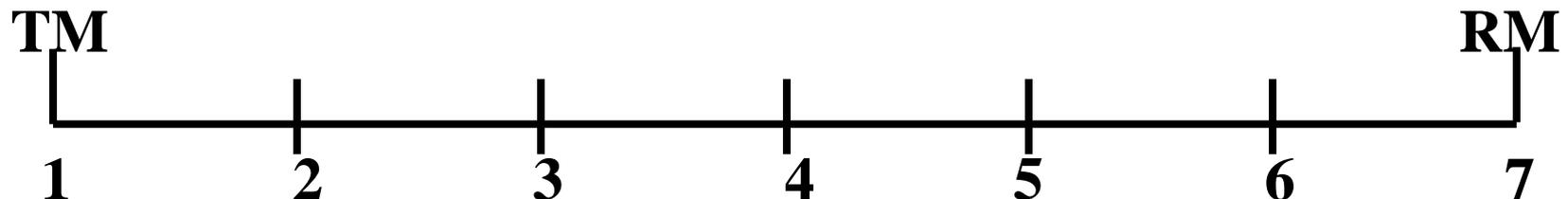
7. Locus of Services

- Traditional Model: Institution-based--"How do we get the client into Tx?"
- Recovery Model: "How do we nest the process of recovery within the client's natural environment?"



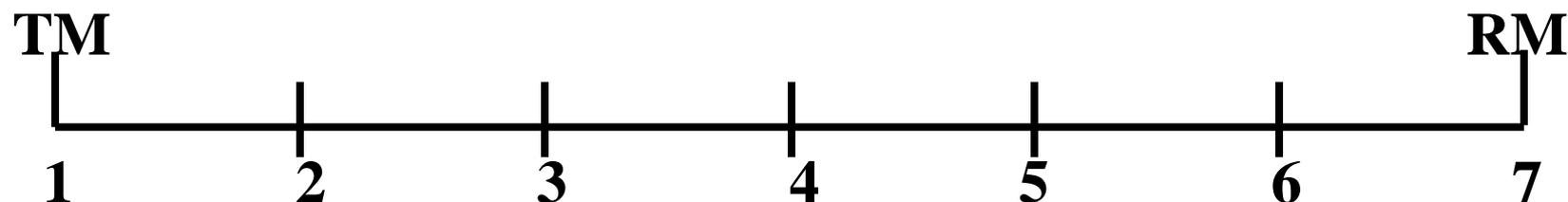
8. Service Technologies

- Traditional Model: Focus on “programs”; Limited individualization; Biomedical stabilization
- Recovery Model: Focus on service and support menus; High degree of individualization; Greater emphasis on physical/social ecology of recovery



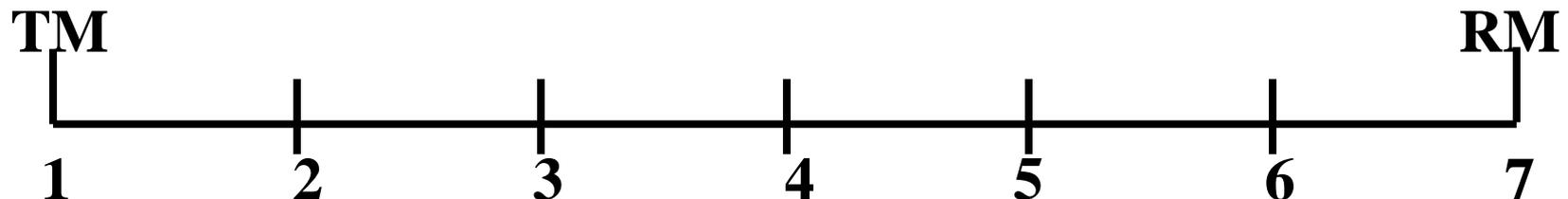
9. Management of Co-morbidity

- Traditional Model: Exclusion, extrusion, recidivism, iatrogenic injury; Experiments with parallel/sequential Tx
- Recovery Model: Concept of “serial recovery”; Integrated model of care, multi-unit/agency, indigenous resource



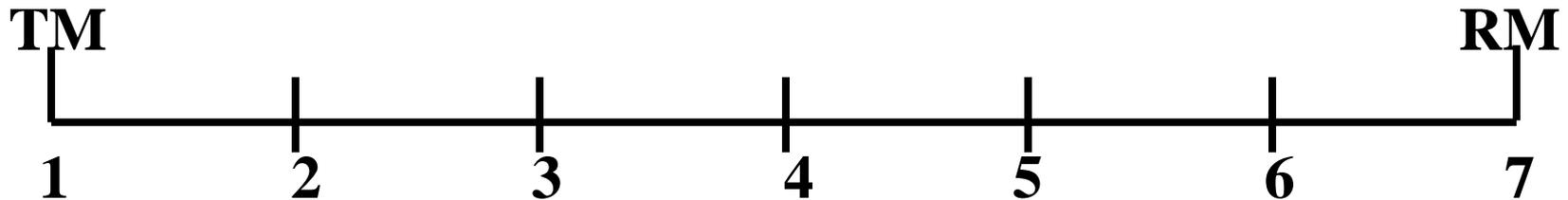
10. Service Roles

- Traditional Model: Specialization of clinical roles, emphasis on academic/technical expertise; Resistance to prosumer movement
- Recovery Model: “Adisciplinary”; Role cross-training; Prosumers in paid and volunteer support roles; Emphasis on mutual aid; Role of primary care physician



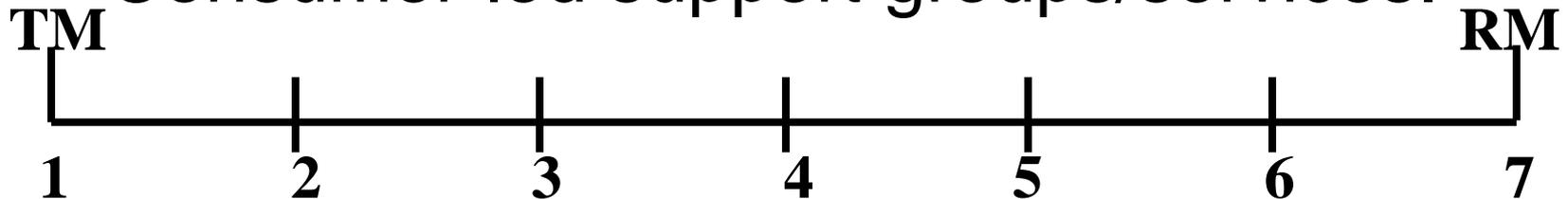
11. Service Relationship

- Traditional Model: (Dominator-Expert Model). Hierarchical, time-limited, transient (staff turnover), and often commercialized.
- Recovery Model: (Partnership-Consultant Model). Less Hierarchical, potentially time-sustained, continuity of contact, less commercialized.



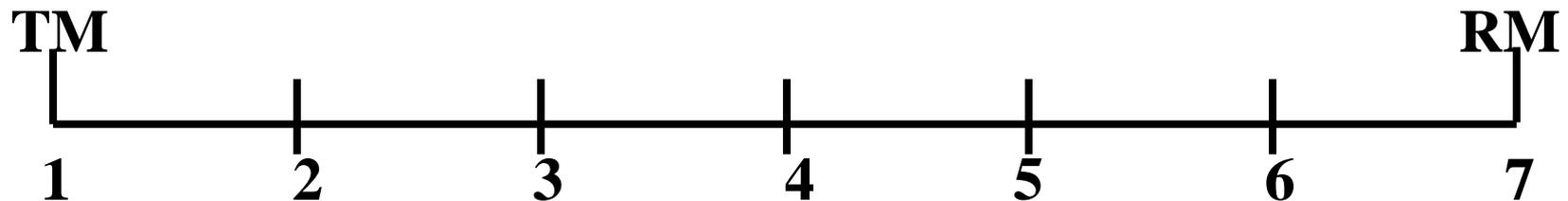
12. Consumer Involvement

- Traditional Model: Passive role-- professionally prescribed; Consumer dependency.
- Recovery Model: Consumer involvement/direction of service policies, goal-setting, delivery, and evaluation. Focus on illness self-management. Consumers as volunteers & employees. Consumer-led support groups/services.



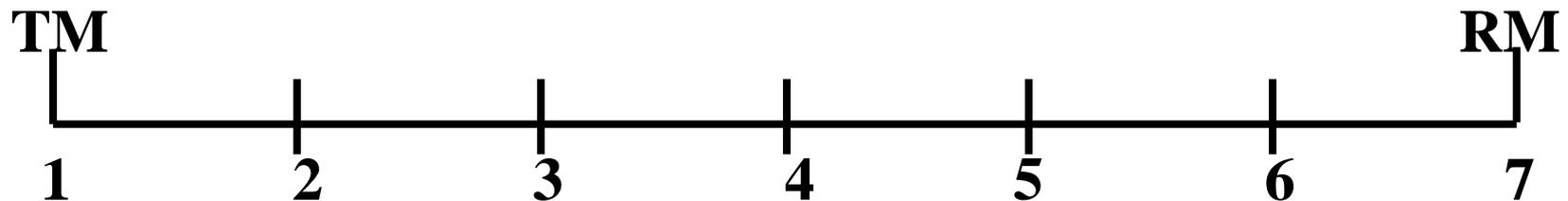
13. Relationship to Community

- Traditional Model: Community defined in terms of other agencies
- Recovery Model: Focus on how to diminish need for professional services; Emphasis on hospitality and supports within the natural community; Emphasis on indigenous supports



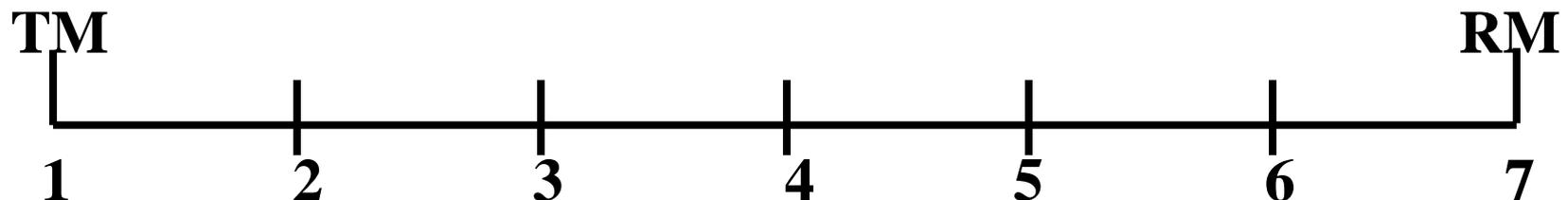
14. View of Aftercare

- Traditional Model: Aftercare as an afterthought (less than 30%) or maintenance for life.
- Recovery Model: Eliminate concept of “aftercare”: all care is continuing care; Emphasis on community resources; Role of guide or recovery coach.



15. Service Evaluation

- Traditional Model: Focus on professional review of short-term outcomes of single episodes of care; Recent emphasis on social cost factors--impact on hospitalizations, arrests, etc.
- Recovery Model: Focus on long term effects of service combinations & sequences on client/family/community; Consumer-defined outcomes & review



16. Advocacy

- Traditional Model: Advocacy often limited to that related to institutional funding; Marketing and PR approach.
- Recovery Model: Emphasis on policy advocacy, community education (stigma) and community resource development; Activist/Community organization approach.

