

RECOVERY

*The official newsletter of the
Fletcher Group Rural Center Of Excellence*



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WORDS MAKE A DIFFERENCE

by Founder and Chief Medical Officer Dr. Ernie Fletcher

“If you want to care for something, call it a flower,” says White Bison Founder Don Coyhis. “If you want to kill it, call it a weed.”

It was not that long ago that waiting for pain to trigger change was the norm. “They just need to hit rock bottom,” people said, “then they’ll change.”

But words make a difference and terms like “Recovery Capital” helped us see that the problem wasn’t insufficient pain. It was insufficient hope, connectedness, and help.

A four-page Newsletter can’t address all the ways our understanding and treatment of Substance Use Disorders has changed. But examining the role of Recovery Capital, including its powerful influence on our own “Recovery Ecosystem” model, may help remind us how big a change we’ve made and the incredible distance we’ve come to make sure those in need are not alone.



HOW TO DEFINE IT

It was 1999 when Robert Granfield and William Cloud, colleagues of pioneering recovery advocate William White, defined Recovery Capital as “the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery.”

To many, coinage of the term was little more than an academic footnote, but it marked a major turning point. The pathology-based, one-size-fits-all model that mechanically assessed, admitted, treated and discharged patients, as though an SUD was a momentary crisis, not a lifelong journey, was revealed for what it was: naïve, archaic, unfeeling and ineffective.

Taking its place was a more personal and holistic model. Because it shared with other chronic disorders, such as diabetes, asthma, and hypertension, the same goals of functional improvement and quality of life, it confirmed the long-standing suspicion that stigma and incrimination had always been counter-productive and needlessly, even cruelly, punitive.

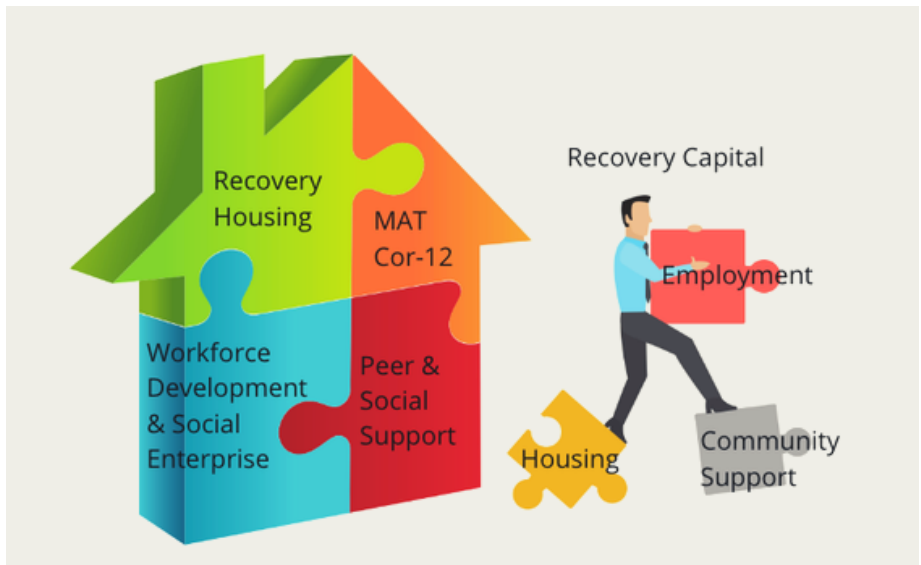
But defining “Recovery Capital” wasn’t easy. White and Cloud knew what it wasn’t: “Therapeutic processes in addiction treatment must encompass more than a strictly clinical intervention.” But what it was seemed to expand the more you talked about it: “Recovery Capital is conceptually linked to natural recovery, solution-focused recovery therapy, strengths-based case management, recovery management, resilience and protective factors, and the ideas of hardiness, wellness, and global health.”

The benefits grew, too: “Dramatic improvements in all areas,” said Alexandre Laudet, included “healthier/better financial and family life, higher civic engagement, dramatic decreases in public health and safety risks, and significant increases in employment and work.”

Pathologists look for what’s subtracted: drug use, criminal activity, threats to public safety, financial problems, emotional distress. But Recovery Capital focuses on what’s added: increased coping and communication skills, improved relationships, new rules and rituals, safe housing, meaningful employment, and a sense of purpose where none existed before.

You know things have changed when concepts that were once ground-breaking become ubiquitous. No one today doubts, for example, that “recovery is a dynamic process,” that there are “various pathways to recovery,” or that “recovery is a journey, not an event.” Stigma and incrimination, too, are easier to dismiss when those in recovery share the same goals we all have—to live a better life.

Change takes courage, whether it’s overturning an antiquated way of thinking or confronting our own weaknesses. The term “Recovery Capital” may lack poetic grace, but its power to bring forth the better angels of our nature cannot be denied. Its impact can be seen everyday in the resources made available to those in recovery as well as the far more enlightened, human, and loving manner in which we work on their behalf.



HOW TO QUANTIFY IT

Quantifying Recovery Capital is no easier than defining it. The inherent flaws of self-reporting are further complicated by the fact that Recovery Capital is always a “moving target,” varying widely not only from person to person but within the same person from one moment to another.

The First Try

Robert Granfield and William Cloud devised the first tool for measuring Recovery Capital in 1999. Still used today, the “Recovery Capital Scale” asks the patient to rate on a five-step scale their satisfaction with 34 different “recovery resources,” ranging from food, clothes, job and living environment to health, insurance, spirituality and sense of purpose. Its goal is to identify deficits that can then be addressed in a customized action plan.

REC-CAP

Years later came REC-CAP. Billed by creator David Best as “a bridge from treatment to self-directed recovery,” it assesses at quarterly intervals the respondent’s level of commitment, recovery strengths, barriers, group involvement, activities, and unmet needs. By identifying “intervention opportunities” and “recovery pathways,” REC-CAP brings into focus the stepwise incremental changes in Recovery Capital needed at each stage of recovery. One insight revealed by REC-CAP is that the barriers to quality of life and well-being seldom disappear altogether.

ARC

ARC stands for “Assessment of Recovery Capital.” Created by Teodora Groshkova, David Best, and William White, ARC is a much simpler tool designed to produce a quick “snapshot” of an individual’s strengths, barriers, and needs.

SABRS

The “Strengths and Barriers Recovery Scale” is also referred to as “The Life In Recovery Survey.” Used around the world, it highlights the changes that occur as an individual transitions through the three major stages of recovery—early, sustained, and stable. It can be completed and discussed in an interview format or completed by the client and discussed later.

All such tools share a common goal—to provide an evidence-based profile of Recovery Capital that can help guide the patient’s future steps in the journey to recovery.

A Work In Progress

Whether in recovery or not, we are all “moving targets,” all “self-reporting,” and all involved in negotiating our way through a multitude of relationships and a world that seems to change almost daily. No wonder, then, that the quantification of Recovery Capital remains a work in progress.

That being said, its promise remains as bright as ever. An “evidence-based scientific approach” may sound impersonal, but it’s driven by the most human of hopes—that the best is still yet to come.



HOW TO BUILD IT

The concept of Recovery Capital lies at heart of the Fletcher Group’s “Recovery Ecosystem” model. An outgrowth of the Recovery Kentucky program launched by Dr. Ernie Fletcher when governor, the model provides a safe, nurturing home where residents can receive a full Continuum of Care as well as all the resources needed to begin and maintain recovery. Residents can stay up to two years and are welcome back should they return to use.

As a result, there's no more bouncing from one service or facility to another or crashing with friends who may be using. Instead, those in recovery live and work together in a peer-monitored and peer-supported setting that promotes accountability, self-initiative, learning, and sharing—the same qualities and skills they'll need outside.

Recovery Capital is thus created “in-house” by residents who share an intimate knowledge of the streets, the trauma, and the denial that have held them back. This “Social Recovery” approach generates Recovery Capital in a manner that’s both more effective and more economical than a clinical or medical model. There’s no place to hide and yet everything needed to succeed is within reach.

Called “a model that works” by the U.S. Department of Health and Human Services, Fletcher Group Recovery Ecosystems have much in common with what the Native American Wellbriety movement calls “The Healing Forest” where the health of individual, family and society are inextricably linked.

To enlist the help of local stakeholders, the Fletcher Group employs highly trained Outreach and Engagement Specialists. While they're at work, Subject Matter Experts build partnerships with state, local and national agencies as well as criminal justice departments, faith-based entities

and progressive employers to gather together the services and funding to construct and staff debt-free residences that can accommodate a hundred or more men or women. From start to finish, it’s a team effort contributed to by everyone from developer and financier to in-house counselor and residents working in the kitchen or laundry.

Experience Matters

Many of those who worked with Fletcher when he launched the Recovery Kentucky program over 20 years ago still work with him and have seen for themselves how, in the words of Cloud and Granfield, “Increases in recovery capital can spark turning points that help end addiction, initiate recovery, elevate coping abilities, and enhance quality of life in long-term recovery.”

Funded by a grant from HRSA, a new entity—the Fletcher Group Rural Center of Excellence—is now working to extend the “Recovery Ecosystem” model to thousands of rural Americans who, without it, might have little hope of accessing the Recovery Capital that we now know is so critical to abstinence and long-term recovery.