Recovery Oriented System of Care

Sponsored by
Great Lakes Addiction Technology Transfer Center
(GLATTC)
Presented By: Cherie A. Hunter

ATTC Network Map 2012 – 2017
The ATTC Network 2007-2012

(MAP NOT TO SCALE)
Evaluation Procedure

Consent  Post  Follow up

ROSC: A PARADIGM SHIFT

Recovery-Oriented Systems of Care (ROSC) shifts the question from:

“How do we get the client into treatment?”

to

“How do we support the process of recovery within the person’s life and environment?”
What is Recovery?
It depends on who you ask.

What is Recovery?

Recovery from alcohol and drug problems is a process of change through which an individual achieves improved health, wellness, and quality of life. (SAMHSA 2009)

Recovery from Mental Disorders and/or Substance Use Disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. (SAMHSA’s working Definition, 2012)

What does a Recovery-oriented Provider Look Like?

Recovery Management

A philosophy for organizing treatment and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery

(William White)

What is a ROSC:

Recovery-oriented systems of care (ROSC) are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by severe substance use disorders. The system in ROSC is not a treatment agency, but a macro level organization of a community, a state or a nation.

William “Bill” White
WHAT IS A ROSC?

A ROSC IS NOT:
- A model or an initiative
- Primarily focused on the integration of recovery support services
- Dependent on new dollars for development
- A group of providers that increase their collaboration to improve coordination
- An infusion of evidence-based practices

A ROSC IS:
- Is a value-driven APPROACH to structuring behavioral health systems and a network of services and supports
- Bridges labels, taxonomies and philosophies
- Focuses on returning people to “Life in the Community”
- Is comprehensive and holistic
- Focuses on essentials (jobs, housing, child and family)
- Is a framework to guide systems change
7 Building blocks of a ROSC

1. Aligning Treatment with a Recovery-Oriented System of Care
2. Fully Integrating Peer and Other Recovery Support Services
3. Supporting the Development of a Mobilized Activated Recovery Community
4. Recovery-oriented Performance Improvement and Evaluation
5. Providing Individualized, Evidence-based, Services (Appropriate to Trauma, Culture, Gender etc.)
6. Focus on Prevention and Early Intervention through Promotion of Population and Community Health
7. Fiscal Policy, Regulatory and Administrative Alignment

VALUES UNDERLYING A ROSC

- Person-centered
- Self-directed
- Strength-based
- Participation of family members, caregivers, significant others, friends, community
VALUES UNDERLYING A ROSC

- Individualized, comprehensive services and supports
- Community-based services and supports

COMPARISON OF VALUES
Are We Recovery Oriented or Not?

<table>
<thead>
<tr>
<th>PERSON-CENTERED</th>
<th>CONVENTIONAL</th>
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<tbody>
<tr>
<td>Collaborative</td>
<td>Provider-driven, compliance is valued</td>
</tr>
<tr>
<td>Preferences, life goals, choices define scope of services</td>
<td>Deficits, disabilities, and illness drive focus of services</td>
</tr>
<tr>
<td>Quality of life</td>
<td>Maintenance, Safety, stabilization, symptom reduction</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Dependence</td>
</tr>
<tr>
<td>Community-based</td>
<td>Facility-based</td>
</tr>
<tr>
<td>Long-term planning for life in the community</td>
<td>Planning for treatment/service episode</td>
</tr>
<tr>
<td>Self-determination is a fundamental civil right</td>
<td>Self determination follows peoples demonstration that they are equipped with certain skills, or clinically stable</td>
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</table>
COMPARISON OF VALUES
Are We Recovery Oriented or Not? Cont’d

<table>
<thead>
<tr>
<th>PERSON-CENTERED</th>
<th>CONVENTIONAL</th>
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</thead>
<tbody>
<tr>
<td>High expectations</td>
<td>Low expectations</td>
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<tr>
<td>People choose from a flexible menu of services including natural and professional supports</td>
<td>Professional services only are selected for the person</td>
</tr>
<tr>
<td>Promotes trial and error growth in the context of responsible risk-taking</td>
<td>Paternalistic approach avoids risk taking</td>
</tr>
<tr>
<td>Focuses on building positive sense of self, competence and confidence</td>
<td>Can be punitive, shaming</td>
</tr>
<tr>
<td>Evolving, living plan adjusts over time</td>
<td>Static plan</td>
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<tr>
<td>Encourages inclusion of family members/and/or natural supports</td>
<td>Typically engages only the person receiving services</td>
</tr>
<tr>
<td>Process</td>
<td>Product</td>
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</table>

DO THESE VALUES LEAD TO OUTCOMES?

Example: Western New York Care Coordination Program (Janice Tondora, Yale Program on Recovery and Community Health)

Outcomes Achieved:
• 68% Increase in competitive employment
• 43% decrease in ER visits
• 44% decrease in inpatient days
• 56% decrease in self-harm
• 51% decrease in harm to others
• 11% decrease in arrests

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WHY ARE WE SHIFTING?

“My clients don’t hit bottom; they live on the bottom. If we wait for them to hit bottom, they will die. The obstacle to their engagement in treatment is not the absence of pain, but the absence of HOPE

White and Woll
In 2011, 20.6 million people aged 12 or older met the criteria for substance use disorders

- Did not feel they needed treatment: 95.3%
- Felt they needed treatment – Did not make an effort: 3.3%
- Felt they needed treatment – Did make an effort: 1.5%

19.3 million people needed but did not receive treatment for illicit drug or alcohol use (NSDUH, 2011)

Health Care Reform / Affordable Care Act

Effective January 1, 2014

32 million people currently uninsured may have access to insurance through either Medicaid expansion or Health Insurance Exchanges. Of the 32 million people, 11 million will have a mental health or substance use condition
Michigan and the ACA

- 89.5K adults ages 18-64 with substance use disorders will have coverage for substance use treatment under Medicaid expansion
- 88K adults ages 18-64 with substance use disorders will have coverage for substance use treatment within the Health Insurance Exchange
- This represents a two-fold increase in the estimated prevalence within the existing eligible Medicaid population (currently 89K).

ROSC: A PARADIGM SHIFT

Recovery-Oriented Systems of Care (ROSC) shifts the question from:

“How do we get the client into treatment?”

to

“How do we support the process of recovery within the person’s life and environment?”
Examining our Current Service System

Achievements of Modern Treatment Include (To name a few):

- Replicable, community-based treatment modalities

- Federal, state, local, private partnership to fund addiction treatment and ancillary support industries, e.g., research, training, etc.

- Accessibility: From less than 50 to more than 13,000 U.S. specialty treatment programs
Achievements of Modern Treatment, continued

• Professionalization of addiction medicine & addiction counseling
• Systems of early intervention, EAP, SAP, SBIRT
• Screening/assessment/diagnostic tools
• Continuum of care
• Millions of lives touched and transformed

Background Source: Slaying the Dragon

Limitations of Acute Care Approach to Addiction Treatment

• Modern treatment has focused on an acute care model of addiction treatment;

• The AC Model can achieve: biopsychosocial stabilization more effectively, more safely for more people than has ever been achieved in history and YES;

• “Treatment Works”, BUT Recovery initiation does not assure recovery maintenance especially for people with high problem severity / low recovery capital.
Limitations of Acute Care Approach to Addiction Treatment

- Discovery that addiction shares many characteristics with other chronic medical disorders (McLellan, et al, 2000)

- Growing interest in: How would we treat addiction if we really believed that addiction was a chronic disorder?”, e.g., how models of “disease management” in primary health care might be adapted to long-term management of addiction

<table>
<thead>
<tr>
<th>Addiction/Chronic Illness</th>
<th>Compliance Rate (%)</th>
<th>Relapse Rate (%)</th>
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<tbody>
<tr>
<td>Alcohol</td>
<td>30-50</td>
<td>50</td>
</tr>
<tr>
<td>Opiate</td>
<td>30-50</td>
<td>40</td>
</tr>
<tr>
<td>Cocaine</td>
<td>30-50</td>
<td>45</td>
</tr>
<tr>
<td>Nicotine</td>
<td>30-50</td>
<td>70</td>
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<tr>
<td>Insulin Dependent Diabetes</td>
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<td></td>
</tr>
<tr>
<td>Medication</td>
<td>&lt;50</td>
<td>30-50</td>
</tr>
<tr>
<td>Diet and Foot Care</td>
<td>&lt;50</td>
<td>30-50</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td>&lt;30</td>
<td>50-60</td>
</tr>
<tr>
<td>Diet</td>
<td>&lt;30</td>
<td>50-60</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td>&lt;30</td>
<td>60-80</td>
</tr>
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# Impetus for Change

1. Cultural and political awakening of individuals/families in recovery  
   * Growth/diversification of mutual aid  
   * New recovery advocacy movement  
   * New recovery support institutions

Resources: *Let’s Go Make Some History*  
[www.facesandvoicesofrecovery.org](http://www.facesandvoicesofrecovery.org)

## Impetus for Change

2. Frustration of frontline addiction professionals  
3. Addiction science, particularly research on addiction/recovery careers, treatment outcome studies & treatment systems performance data  
4. Addiction treatment payors  
5. Need to counter growing cultural pessimism about treatment, e.g., effects of celebrity rehab recycling
Among adults reporting a behavioral health condition, more than half report onset in childhood or adolescence.

Average delays in help seeking for mental health challenges is more than a decade (National Comorbidity Study).

Differences Between MH and Addiction Recovery

- The challenge of language: “Chronic Illness”
- Differences in the type, frequency and duration of ongoing support?
- Substances are powerfully reinforcing
- Peers historically had a role in addiction recovery, leads to the need for role clarification between a recovery coach, counselor and a sponsor
- In SMI recovery may involve ongoing management of symptoms
- Different Concepts of Recovery?

Lonnetta Albright & David Njabulo Whitters
Similarities between MH and Addiction Recovery

- The ultimate goal of recovery transformation is the same: a meaningful, fulfilled life in the community
- Both entail moving beyond a focus on symptom reduction and redefining oneself
- Family and community contexts can provide environments to promote wellness
- Both involve overcoming stigma
- Underlying principles are the same
- The process of systems transformation is the SAME PROCESS...
- The same types of services, supports and opportunities promote wellness in everyone

Challenges Facing Addiction Treatment Systems

- Unmet Need: > 20 million Americans need treatment, < 10% seek or access it, and many arrive under coercive influences
- Low Pre-Treatment Initiation Rates
- Low Retention: > 50% fail to complete treatment
- Inadequate Service Dose: most receive less than NIDA's recommended 90 day minimum dosage
- Lack of Continuing Care: only 1 in 5 receive post-discharge recovery plan
- Recovery Outcomes: 50% return to using within 1 year with 80% returning within the first 90 days
- Revolving Door: > 60% have one or more treatment episodes, 24% 3 or more, 50% readmitted within 1 year

Lonnetta Albright & David Njabulo Whitters
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Challenges Facing Mental Health Treatment Systems

- **Unmet Need 2001**: less than one half of adults with SMI receive treatment (SAMHSA)
- **Low Retention**: a quarter of individuals have contact with the public systems for 8 days or less (Bray et al., 2004)
- **Low Dose of Tx**: Insufficient doses of medication and short length of treatment have all been associated with poorer outcomes (DHHS, 1999, Young et al., 2001)
- **High Recidivism**: in higher levels of care, often leading to policies that limit access to care
- **Extremely High Burden of Disability**: When compared with all other diseases (such as cancer and heart disease), mental illness ranks first in terms of causing disability in the United States, Canada, and Western Europe, according to a study by the World Health Organization (WHO, 2001).

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Implications for Child Welfare

- Assertive Linkages
- Assessment of Recovery Capi
- Mobilization of Natural Suppo
- Relevance of Recovery Planni
- Graduated Sanctions
- The Power of Peer Support
- Others?

Lonnetta Albright & David Njabulo
Implications for Prevention Services

The Federal Perspective:
“Prevention Prepared Communities”

Community Systems Perspective

- Rather than addressing a single problem, prevention efforts simultaneously considers a wide ranging set of problems
- Rather than focusing on individuals at risk, studies the entire community
- Employs interventions that alter the social, cultural, economic and physical environment rather than only individual behavior

Lonnetta Albright & David Njabulo Whiters

Conceptual Integration of Prevention in a ROSC

- People and their families exist on a continuum of health and wellness
- More holistic recovery planning will reveal opportunities for increased prevention services within a ROSC
- A ROSC expands the focus beyond individual health to community health, this entails promoting wellness for all
- Rather than diminishing the role of prevention services, developing a ROSC moves prevention into the mainstream

Lonnetta Albright & David Njabulo Whiters
What if we really believed?

**What Would Look Different?**

**What Would We Want to See?**

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**Why Transformational Change?**

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>Additive</td>
<td>Adding peer and community based recovery supports to the existing treatment system</td>
</tr>
<tr>
<td>Selective</td>
<td>Practice and Administrative alignment in selected parts of the system</td>
</tr>
<tr>
<td>Transformational</td>
<td>Cultural, values based change drives practice, community, policy and fiscal changes in all parts and levels of the system. Everything is viewed through the lens of and aligned with recovery oriented care.</td>
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**Non-traditional Methods**

“Recovery support and its pathways are not always within your recovery community. It is healthy to find PASSION; sometimes that passion or pathway is gardening, sculpting, running, or boxing etc.”

If everything you do in recovery is in the recovery community, it does two things:

- It excludes an entire world of possibilities from the recovering person
- It promotes stigma when we stay within our own communities and do not venture out

---Sara Vanderleest
### 8 Key Performance Arenas Linked to Long-term Recovery Outcomes

1. Attraction, access & early engagement  
2. Screening, assessment & placement  
3. Composition of the service team  
4. Service relationship  
5. Service dose, scope & quality  
6. Locus of service delivery  
7. Assertive linkage to communities of recovery  
8. Post-treatment monitoring, support and early re-intervention

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### STRATEGIES TO PROMOTE  
**ASSERTIVE OUTREACH AND ENGAGEMENT**

- Pre-treatment Peer Support Groups  
- **Offer peer mentors as soon as contact is initiated**  
- For urban settings, develop a welcome/recovery support center  
- **Tele-health particularly in rural settings**  
- Build strong linkages between levels of care through peer-based recovery support services  
- **Use the most charismatic & engaging staff at reception**  
- Connect with people before initial appointments via phone  
- **Screening and early intervention in health care facilities**  
- Establish relationships with natural supports to promote early identification
### 2. Screening, Assessment & Placement

**AC assessment** is categorical, pathology-focused, professionally-driven, an intake function & focused on individual; placement based on problem severity.

**RM assessment** is global, strengths-based, client focused (rapid transition to recovery plans), continual and encompasses the individual, family and recovery environment; recovery capital factored into placement decisions.

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### CLINICAL ASSESSMENTS

**CHANGING OUR QUESTIONS: EXAMPLES**

- Can you tell me a bit about your hopes or dreams for the future?
- What kind of dreams did you have before you started having problems with alcohol or drug use, depression, etc.?
- What are you good at?
- What are you most proud of?
- What are some things in your life that you hope you can do and change in the future?
- How satisfied are you with the quality of your friendships and relationships?
- If you went to bed and a miracle happened while you were sleeping, what would be different when you woke up? How would you know things were different?
- What would your ideal job be?
  - Leads to Recovery Plans vs. Treatment Plans
3. Composition of the Service Team

AC model uses disease rhetoric but few medical personnel; recovery rhetoric but decreasing involvement of recovering people.

RM expands role of medical (including primary care physicians) and other allied professionals, recovering people (P-BRSS) and culturally indigenous healers. Also emphasizes reinvestment in volunteer and alumni programs.

The Creation of Peer Culture
Peers, Coaches and Recovery Supports are not separate from Treatment but rather a Part of the Treatment Service Continuum

- Recovering persons on agency boards
- Developing / empowering informal peer leadership
- Openly recruiting recovering persons as staff
- Paid “peer specialists” to provide formalized support
- Creating a sense of a community where recovering persons helping recovering persons is highly valued
- Infusing peer self help throughout the service continuum
- Understanding the unique learning advantages of peer delivered services
Examples of Peer Support

Treatment Efforts
- Recovery coaches and peer specialists
- Recovery Resource Centers
- Facilitating linkages
- Leadership Councils
- Recovery Check-ups and early re-engagement
- Companionship / modeling of recovery lifestyles
- PIR led groups
- Peers in primary care settings

Prevention Efforts
- Peer-based prevention service for youth (e.g. community leadership councils)
- Peer-based prevention services devoted to parents (e.g. train the trainers for parent wellness coaches)
- Involving youth in assessment and planning efforts for environmental strategies

4. Service relationship

Acute Care: Dominator model; emphasis on professional authority; great power discrepancy; role of client is one of compliance.

Recovery Management: Sustained recovery partnership (long-term consultation) model; emphasis on prolonged continuity of contact; client as co-leader; philosophy of choice; greater use of personal/professional self; contrasting ethical guidelines.
5. Service Dose, Scope & Quality

**AC model** has become ever briefer, narrower via reimbursable services & continues to incorporate methods lacking scientific support.

**RM model** emphasis on importance of dose (NIDA principles—90 days), role of ancillary services and weeding out practices that are not linked to recovery outcomes or that may produce inadvertent injury.

6. Locus of Service Delivery

**AC model** locus is the institution: How do we get the individual into treatment—get them from their world to our world?
* Problem of transfer of learning

**RM model** emphasizes the ecology of long-term recovery: “How do we nest recovery in the natural environment of this individual or create an alternative recovery-conducive environment?”
* Healing forest metaphor (Coyhis)
* Concept of “community recovery”
7. Assertive linkage to communities of recovery

**AC Model:** Passive linkage, low affiliation and high early attrition, single pathway model of recovery

**RM model:** Assertive linkage, multiple pathway model of recovery, linkage beyond recovery mutual aid groups; active relationship with local service committees, involved in recovery community resource development

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The Need for a Community Approach

**UBUNTU**

An anthropologist proposed a game to the kids in an African tribe. He put a basket of fruit near a tree and told the kids that the first one to find the fruits would win them all. When he told them to run they all took each others hands and ran together, then sat together, enjoying their fruits. When he asked them why they ran like that as one could've taken all the fruits for one's self, they said: "UBUNTU, how can one of us be happy if all the other ones are sad?"

Ubuntu Planet - Stage Circle of Ubuntu
www/ubuntuparty.org.za
8. Post-treatment Monitoring, Support and, if needed, Early Re-intervention - Continued

- 50-80-90 rule: More than 50% of clients discharged from TX will return to some use in the next year—80% of those will do so in first 90 days after discharge.
- 15-25 rule: The stability point of recovery (risk of future lifetime relapse drops below 15%) isn’t reached until 4-5 years for alcohol dependence; 25% of opioid dependent persons who achieve five years of abstinence will later resume narcotic addiction.

IF WE REALLY BELIEVED, Our resource allocation wouldn’t look like this:

- PEER SUPPORT SERVICES
- TREATMENT
- SUPPORT TO THE RECOVERY COMMUNITY
**Recovery and Resilience Oriented System of Care**

*In the model, clinical care is viewed as one of many resources needed for successful integration into the community.*

OUTCOMES FOR THE INDIVIDUAL

- Abstinence
- Education
- Employment
- Reduced criminal justice involvement
- Stability in housing
- Improved health
- Social connectedness
- Quality of life
OUTCOMES FOR THE SYSTEM

- Increased access/capacity
- Proper placement and quality of care
- Retention
- Perception of care
- Cost-effectiveness
- Use of evidence-based practices

Message of Hope

“Addiction is visible everywhere in this culture, but the transformative power of recovery is hidden behind closed doors. It is time we all become recovery carriers.

It is time we helped our community, our nation, and our world recover...Recovery is contagious. Get close to it. Stay close to it. Catch it. Keep catching it. Pass it on.”

William White, Author and Recovery Advocate – www.williamwhitepapers.com
“Though no one can go back and make a brand new start, Anyone can start from now and make a brand new ending.”

So Why Are You Here today?    What Outcome Are You Seeking?
What Say You?

- What excites you about shifting to a ROSC framework?
- What does it look like in our organization?
- What concerns do you have?
- Why is this shift necessary?
- What would help you become more recovery oriented?
- What outcome(s) are you seeking?
- How are you integrating Peers and Recovery Coaches into your workforce alongside your clinical team members; with your board, at all levels of the organization?
- How are you navigating the shift?
- What's getting in your way – obstacles, barriers?
- What do you need to make the shift?
- What if there's no new money?

Questions/Answers
<table>
<thead>
<tr>
<th>ROSC Facilitator</th>
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<tbody>
<tr>
<td>Cherie A. Hunter, Executive Director</td>
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<tr>
<td>Hunter Communications Group, Inc.</td>
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<td><a href="mailto:Hunterca7@comcast.net">Hunterca7@comcast.net</a></td>
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