ROSC 101
A Framework for Behavioral Health Integration

Presented by:

Lonnetta M. Albright
Executive Director
Great Lakes ATTC

Sara C. Vanderleest
Board Vice President
Recovery Allies West Michigan

Ohio County Boards
September 24, 2014 – Columbus Ohio
Visit us at: www.attcnetwork.org/greatlakes
Any person or organization can make a Paradigm Shift if willing to do the work?

Language is critical for a Shared Vision

There are achievements in Modern Day Treatment, and yet.....

Recovery Management is a philosophical organizing framework for treatment

Treatment as a chronic disease does look different in a ROSC

Peers and/or Coaches are members of the team (not separate from Treatment) at all levels of the organization (Paid and Volunteers).

Comprehensive Continuing Support is part of the plan, from the start

7 Building Blocks of a ROSC

ROSC aligns with Behavioral Health-Primary Care Integration

Everyone can help people initiate and sustain their recovery

Transformational Change is unique in 3 ways

You’re not alone - experiences from across the country

It Takes Time
## COMPARISON OF VALUES
Are We Recovery Oriented or Not?

<table>
<thead>
<tr>
<th>PERSON-CENTERED</th>
<th>CONVENTIONAL</th>
</tr>
</thead>
<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>
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<tr>
<td>Long-term planning for life in the community</td>
<td>Planning for treatment/service episode</td>
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<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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<tr>
<td>PERSON-CENTERED</td>
<td>CONVENTIONAL</td>
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<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>
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<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>
</tr>
<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>
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
The Philadelphia Experience
A Video
What is Recovery?
It depends on who you ask.
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)

Getting involved with things I enjoy (e.g. church, friends, dating, support groups, etc.)

Learning what I have to offer

Seeing myself as a person with strengths

Taking one day at a time

Knowing my illness is only a small part of who I am

Having a sense that my life can get better

Having dreams again

Believing I can manage my life and reach my goals (bravery and hope)

Being able to tackle everyday

Having people I can count on

--Davidson et al.
What is Recovery?
From a Community’s Perspective

- **Discovering** who I am
- **Lifelong effort** to become the best we can be
- **Change**
- **Regaining health** – physical / mental / spiritual / relationships
- **New beginning** – becoming what you want to be
- **Personal** – different for each person
- **Hope**
- **Bravery** – facing a different way of life
- **Repairing** what is broken
- **Re-establishing** oneself from crises
- **Living** life on life’s terms
Definitions, Components and Principles

A Handout
ROSC is not:

- Just about Substance Use Disorders
- A Model
- Primarily focused on the integration of recovery support services
- Dependent on new dollars for development
- A new initiative
- A group of providers that increase their collaboration to improve coordination
- An infusion of evidence-based practices
- An organizational entity, group of people or committee
- A closed network of service and supports

ROSC is:

- Value-driven APPROACH to structuring behavioral health systems and a network of clinical and non-clinical services and supports
- Framework to guide systems transformation
Recovery Oriented systems support person centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness, and recovery from alcohol and drug problems.

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.

CSAT, SAMHSA

William “Bill” White
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
WHAT IF WE REALLY BELIEVED?

What Would Look Different?

What Would We Want to See?
Many Paths to Recovery

- Mutual Support groups
- Other peer support
- Professional treatment
- Nontraditional methods
- Medical interventions
- Medication-assisted treatments
- Family support
- Faith
- Comprehensive Continuing Care
- On your own
- And more!
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
Recovery Language

- Medicated Assisted Recovery
- Substance Use Disorder
- Substance Misuse
- Mental Health Issues
Examining our Current Service System

Primary Focus

Treatment

OUTCOMES

Love
Work
Play

Community
Life

Housing
Faith
Belonging
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
2nd Edition: Just Released

SLAYING THE DRAGON

The History of Addiction Treatment and Recovery in America

Second Edition

William L. White

To order:

888/547-8271

http://www.chestnut.org/LI/Bookstore/productid/1
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.
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
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
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).
Historical Context

- Federal Emphasis and Expectation
  - President’s New Freedom Commission
  - IOM Reports
  - SAMHSA
- Growing body of MH and SUD research
- Expectations of people in recovery
- National Consumer and Recovery Advocacy Movement
- Trailblazing Systems of Care
Recovery-Oriented Systems of Care 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?”
IF WE REALLY BELIEVED…
Our resource allocation wouldn’t look like this:

- **PEER SUPPORT SERVICES**
- **SUPPORT TO THE RECOVERY COMMUNITY**
- **TREATMENT**
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)
8 Key Performance Arenas Linked to Long-term Recovery Outcomes

- Attraction, access & early engagement
- Screening, assessment & placement
- Composition of the service team
- Service relationship
- Service dose, scope & quality
- Locus of service delivery
- Assertive linkage to communities of recovery
- Post-treatment monitoring, support and early re-intervention

NOTE: There are others but these 8 are most critical
1. Attraction, Access & Early Engagement

AC Limitations

- **Unmet Need:** < 10% who need TX. seek treatment or if they do, arrive under coercive influences
- **Low Retention:** > 50% do not successfully complete treatment
- **Revolving Door:** > 60% one or more TX. episodes, 24% 3 or more – 50% readmitted within 1 year

RM Directions

- Assertive community education & outreach
- Assertive waiting list management
- Lowered threshold of engagement; rethinking motivation; institutional outreach
- Changes in administrative discharge policies
“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 an absence of pain; it is an absence of hope.”

Outreach Worker (Quoted in White, Woll, and Webber 2003)
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
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.
HOLISTIC SCREENING AND ASSESSMENT

- Global vs. categorical assessment
- Continual assessments vs. only intake assessment
- **Assessing recovery capital and other strengths**
- Vehicle for building relationship, trust, and rapport
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.
### Key Principles

<table>
<thead>
<tr>
<th>ROSC</th>
<th>BH-PC Integration</th>
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<tbody>
<tr>
<td><strong>Chronic Care Approach</strong></td>
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<tr>
<td>Sustained healing relationships, post-tx monitoring, support and early re-intervention</td>
<td>Ongoing relationship with care provider</td>
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<tr>
<td>Individualized approaches with a focus on dose, scope and quality</td>
<td>Individualized, stepped care</td>
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<tr>
<td>Attraction via assertive outreach/engagement and focus on earlier intervention</td>
<td>Enhanced access via open scheduling, enhanced hours, new mechanisms for communication, universal screening</td>
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<tr>
<td>Holistic Services</td>
<td>Whole person orientation</td>
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<tr>
<td>Community Health and wellness</td>
<td>Public health approach focused on population health outcomes</td>
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# Key Principles

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<tbody>
<tr>
<td>Strengths Based Approaches</td>
<td>Solution focused approaches</td>
</tr>
<tr>
<td>Integration of Recovery support Services</td>
<td>Care Management, “Enabling Services”</td>
</tr>
<tr>
<td>Peer Support (navigating systems, linkage to community resources, coaching, recovery planning, problem solving, etc).</td>
<td>Wellness Programs</td>
</tr>
<tr>
<td>Collaborative service relationships</td>
<td>Collaborative care and shared decision making</td>
</tr>
<tr>
<td>Expanded composition of service teams</td>
<td>Shift from individual practitioner model to team-based approach</td>
</tr>
<tr>
<td>Expanded locus of service delivery, services delivered in natural environments</td>
<td>e.g. Person Centered health homes</td>
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<tr>
<td>Choice, Self direction</td>
<td>Activated patients (Patient education and self management/ self-care</td>
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</table>
BUILDING BLOCK TWO
IMPLICATIONS FOR PEERS AND OTHER RECOVERY SUPPORT SERVICES
What Say You?

How many of you have Coaches or Peers in your organization?

How many of you have them on the payroll?

How many of you use them as Volunteers?

What do they do?

Of those in recovery on your payroll have other jobs they are being paid for?

How long do you believe a person should be in recovery before being eligible to serve in a Coach or Peer capacity?

- 6 months
- 1 year
- 2 years
- Other
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
COMMON CHALLENGES
Peers report feeling isolated
Staff are often distrustful or threatened by peers
Drift towards professionalization or perform in traditional service roles
Difficulty integrating into service teams
Supervision often does not match the unique peer support role
Low or no pay
Lack of career advancement opportunities
Peer support appears in pockets throughout a system rather than integrated throughout
Inadequate training that does not address key issues
Providers receiving minimal guidance from system administrators and not reaching out to peer run organizations for support
Providers do passive referrals to other community-based RSS or are unaware of RSS
Strategic partnerships with community organizations that could provide RSS are not formed and leveraged
How long should a person be in recovery before serving in a peer support role and what about educational requirements?

...rather than being legitimized through traditionally acquired education credentials, peer staff draw their legitimacy from experiential knowledge and experiential expertise. Experiential knowledge is acquired through the process of one’s own recovery... Experiential expertise requires the ability to transform this knowledge into the skill of helping others to achieve and sustain recovery.

Many people have experiential knowledge but not experiential expertise

(White and Sanders, 2006)
Frequent Concerns

1. What about confidentiality?
2. Do peer staff abide by the same ethical standards?
3. Aren’t peer staff too fragile?
4. What happens if someone relapses?
5. How long should a person be in recovery before serving in a peer support role?
6. Will peer staff and volunteers take our jobs?
7. Will peer staff be held to a different standard?
8. I’m in recovery and I’m also in a professional role, doesn’t that count?
Lessons Learned

Preparation of all Staff – "Create a Transitional Space and embrace resistance" (Michael A. Diamond)

- Cannot be successfully implemented in a vacuum, staff need an understanding of recovery and recovery-oriented services
- Clear job descriptions are needed prior to hiring
- Supervisors need to have a clear understanding of roles and be advocates of peer support roles
- Peer providers need access to peer support both within and outside of their organization
- More than one peer provider should be hired in a setting
- Hiring needs to rely more heavily on selection vs. training
- Need to build in evaluation protocols
- Focus on building a CULTURE of peer support throughout the organization and system
- Provide clear guidelines and best practice recommendations for peer and recovery support services

Source: Innovation and Diffusion of Technology: A Human Process, Michael A. Diamond
Peer Workforce

Valued as equal partners in the system

Continuing Education

Career path
Recovery Coaching and Peer Support

- Ethics and Boundaries
- Working within a clinical environment and how not to become mini clinicians
- Differences and similarities between Mental Health and Substance Use Peers
- Finding their voice and the system making sure that voice is valued
- The Value of Peer run organizations
- What to do in case of relapse?
Mental Health: Certified Peer Support Specialist

- 40 Hour Training with additional 2 day on Michigan Specific
- To be trained you must: Be working at least 10 hours a week as a peer and have community mental health lived experience
- You get two college credits for passing the exam
- CPSS can pull down Medicaid dollars
- Many continuing education choices
Substance Use: Recovery Coaches

- You do not have to be a working RC to go to the training
- As of yet can not pull down Medicaid dollars
- 40 hour training with no test
- Continuing education is offered thru independent agencies such as Recovery Allies of West Michigan that does offer CEUs
• Universal Precautions
• Peers know how to find non Trauma Informed environments within the workplace because of their unique filter, due to their own experience
• Empowering
• Peers developing and training the system in Trauma Informed Care
Stigma

• 25 Million people in recovery in the United States today
• What if we all stood together?
• With Peers in the workforce we start to fight that stigma
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.
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.
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
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.
25-35% of clients who complete addiction treatment will be re-admitted to treatment within one year, 50% within 2-5 years (Hubbard, et al, 1989; Simpson, et al, 2002).

An Acute Revolving Door: Of those admitted to the U.S. public treatment system in 2003, 64% were re-entering treatment--23% accessing treatment the 2nd time, 22% for the 3rd or 4th, and 19% for 5 or more times (OAS/SAMHSA, 2005).
### CONTINUING SUPPORT AND COMMUNITY INTEGRATION

<table>
<thead>
<tr>
<th>Addiction/Chronic Illness</th>
<th>Compliance Rate</th>
<th>Relapse Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>30-50</td>
<td>50</td>
</tr>
<tr>
<td>Opioid</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>
</tr>
<tr>
<td>Insulin Dependent Diabetes</td>
<td></td>
<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>
</tbody>
</table>


But only 1 in 5 (McKay, 2001) to 1 in 10 (OAS, SAMHSA, 2005) adult clients receive such care (McKay, 2001) and only 36% of adolescents receive any continuing care (Godley, et al, 2001).
8. RM Model: Assertive Approaches to Continuing Care

- Comprehensive Continuing Support Plan
- Post-treatment monitoring & support (recovery checkups)
- Stage-appropriate recovery education & coaching
- Assertive/continued linkage to recovery resources
- Early re-intervention & re-linkage to TX and recovery support resources
- Recovery community building
So Why Are You Here today?

What Outcome Are You Seeking?
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?
Culturally Responsive Services
Strategies for Culturally Responsive Services

- Awareness of differences in worldview
- Culturally competent assessment procedures
- Diverse staff at all levels of the organization
- Linguistic competence
- Focus on empowerment with historically disenfranchised communities
- Recognition of the increased importance of natural supports and family in collective cultures
- Culture specific services
BUILDING BLOCK FIVE:
IMPLICATIONS FOR COMMUNITY MEMBERS AND OTHER ALLIES
Recovery is not simply about personal health, but the health and well being of the entire community... "This isn’t about me. I’m doing this for my children and my community. I have to build up my community because I need to know that if something happens to me, there will be resources and people in the community who can step in and take care of my girls."

AMIR participant, New Haven CT
The Need for a Community Approach

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 - Stone Circle of Ubuntu
www.UbuntuParty.org.za
What Can Community Members Do?

- Recognize that you and your community do have resources and strengths
- Look for opportunities to build relationships and partner
- Share resources and information
- Influence legislators
- Combat stigma and discrimination
- What skills, talents, information can you share?
- Support the development of peer run organizations
- Start an annual recovery walk

Examples:
- Small businesses
- Faith-based recovery – ministries
- Transportation support
- Continue the dialogue
- Mental Health first aid trainings for first responders
Remember that there is hope for recovery and recovery is real.
Provide support and hold hope for/with other families that are going through a tough time
Share your story!
Get involved with advocacy
Volunteer at peer run organizations and treatment facilities to provide support to family members
Help to identify local community resources that can help others initiate and sustain their recovery and help to build a network of allies
Address NIMBY barriers to community integration
What Can People In Recovery Do?

- Tell your Story!!! Use it to fight stigma and discrimination.
- Join an advocacy organization to stay informed e.g. Faces and Voices of Recovery, National Association for Mental Illness, Mental Health Association
- Engage in training to become a recovery coach or mental health peer specialist
- Reach out to the media
- Support other people in early recovery
- Join or start a recovery rally
- Seek ways to give back to your community
- Start or support a recovery community organization in your area
Back to our original question...

WHAT IF WE REALLY BELIEVED?

What Would Look Different?

What Would We Want to See?
RECOVERY AND RESILIENCE ORIENTED SYSTEM OF CARE
What is Transformational Change?

Additive
Adding peer and community based recovery supports to the existing treatment system

Selective
Practice and Administrative alignment in selected parts of the system

Transformational
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.
ATTC Network Model of Technology Transfer in the Innovation Process
You are not Alone

National Examples
Michigan's Definition of ROSC:

Michigan's recovery-oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life enhancing recovery and wellness for individuals, families and communities.

Recovery Oriented System of Care Transformation Steering Committee

http://www.michigan.gov/mdch/0,4612,7-132-2941_4871_4877-113480--00.html


“Many of the early publications on addiction recovery management (Arm) and recovery oriented systems of care (ROSC) focused on work underway in the State of Connecticut and the City of Philadelphia. Recently that work has expanded in states and cities across the country, adapting itself to widely diverse cultural settings and economic and political constraints. One such area of concentrated development is the State of Michigan. In June of 2014, I had the opportunity to interview several people about the work underway in this state”.  ---William White

ROSC in Michigan: An Interview with Deborah Hollis, Director Office of Recovery Oriented Systems of Care

ROSC in Western Michigan:  An Interview with Mark Witte and Kevin McLaughlin

Recovery-focused Addiction Medicine: An Interview with Dr. Corey Waller
Seeking to align system transformation concepts, practice and context.

- **10 Core Values** guided the development of transformation principles and strategies, and will continue to guide the implementation process.
- **4 Domains** in which the strategies will be carried out.
- **7 Goals** are concrete, action-oriented goals that organize and focus the strategies.
“It will take years to transform addiction treatment from an exclusively Acute Care model of intervention to a Recovery Management model of sustained recovery support.

The future of addiction treatment and recovery will hinge on how well we are able to achieve the task.”

--William White
At the 2011 ATTC ROSC Training of Facilitators
**Recommended Resources**

**Monographs**
- Recovery Management
- Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices
- Practice Guidelines for Resilience and Recovery Oriented Treatment

**Interviews**
- Dr. Ijeoma Achara, ROSC Transformation
- Dr. Calvin Trent, ROSC in Detroit
- Grand Rapids – 3 interviews
  - [http://www.williamwhitepapers.com/leadership_interviews/recovery_management_interviews/](http://www.williamwhitepapers.com/leadership_interviews/recovery_management_interviews/)

**Websites:**
- [www.attcnetwork.org/greatlakes](http://www.attcnetwork.org/greatlakes)
- [http://beta.samhsa.gov/brss-tacs](http://beta.samhsa.gov/brss-tacs)
Questions?

Contact:
Lonnetta Albright
lalbrigh@uic.edu
www.facebook.com/LonnettaAlbrightCoach