THE CONCEPT OF RECOVERY: PRACTICAL RECOVERY MANAGEMENT APPLICATIONS FOR INTEGRATING ADDICTION & MENTAL HEALTH SERVICES AND SYSTEMS

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“It’s not just a matter of kicking this off today, tomorrow or the next day; it’s the sustainability of this work that’s going to be most important”

~ John Bryant, Assistant Secretary, Substance Abuse and Mental Health, Florida Department of Children and Families

Sponsored by the Florida Alcohol & Drug Abuse Association and the State of Florida, Department of Children and Families
Welcome

__________ Regional ROSC Lead & ROQI

Image: Social Venture Partners
LEARNING OBJECTIVES
By the end of the workshop participants will:

• Create a foundational framework around Purpose and “knowing their why” ~Simon Sinek; Collaboration; and A system of care that builds on strengths, opportunities, aspirations and results.

• Understand ROSC; its goals, principles and values.

• Increase and/or expand their awareness and understanding of Florida’s statewide and local ROSC Transformation efforts.

• Understand the distinction between disease management and recovery management.

• Explore implications and dispel myths regarding how Behavioral Health Services look in a ROSC – parallels, common elements and changes in service practice.

• Identify and discuss 9 organizing principles for integration and 7 characteristics of recovery-oriented care for Mental Illness and Addiction.

• Learn about local and national Outcomes & Process Evaluation tools and data.

• Create a practical action plan and next steps for ongoing Provider & Workforce Development.

• Be exposed to and use strength-based approaches and language while experiencing a variety of Recovery Management activities, tasks and tools that they can adopt and transfer to others in their organizations and communities.
Sometimes we overestimate the event, and underestimate the Process!
introduce yourself
Know Your Why, Michael Jr
A Video
FLORIDA’S ROSC TRANSFORMATION

Wesley Evans, Statewide Coordinator of Integration and Recovery Services
Substance Abuse Mental Health Program Office
Florida Department of Children and Families

Image: DCF Communications Office
WHY ROSC IN FLORIDA
FLORIDA’S EMERGING SHARED VISION

ROSC Summit participants identified five priorities – applies to children/youth SOC

1. Collaborative service relationships
2. Cross-system partnerships
3. Community integration
4. Community health and wellness
5. Peer-based recovery support
The bill addresses Florida’s system for the delivery of behavioral health services

Recovery is mentioned 14 times

• Beginning in 2017, each managing entity is required to develop and submit a plan to the department describing the strategies for enhancing services and addressing three to five priority needs in the service area. The plans must be developed with input from consumers and their families, local governments, local law enforcement agencies, and other stakeholders.

• ‘Services provided to persons in this state (shall) use the coordination-of-care principles, characteristics of recovery-oriented services and include social support services, such as housing support, life skills and vocational training, and employment assistance to live successfully in their community.’
BIG PICTURE
PRIORITY OF EFFORT FY 18-19

Priority: Access to Recovery Oriented Systems of Care for Adults and Children

Goal: Enhance the system of care to shift from an acute care model to a recovery based model of care

Objective: Implement System of Care and Recovery oriented best practices throughout the system of care
BIG PICTURE – POE KEY ACTIVITIES

• Implement Enhanced Standards
• Adapt Oversite Mechanisms
• Incorporate Enhanced Standards in System Planning
• Develop Enhanced Standards for Managing Entity Administrators
BIG PICTURE – POE MILESTONES

• Implement effective outreach, engagement, and retention strategies
• Monitor and improve care coordination activities through quarterly reports and reviews
• Develop a roadmap for a community based service array that comprehensively addresses the needs of those we serve
• Promote community and stakeholder integration
• Develop a recovery oriented workforce and provider network
BIG PICTURE

HOW IT’S DONE

Everything is viewed through the lens of and aligned with recovery oriented values, principles and care

Cultural and values based change drives relationships, practice, policy and fiscal changes at all levels

Goal: Transformation from a system of acute care management to one focused on recovery and wellness
FLORIDA’S ROSC SYSTEMS TRANSFORMATION

Common Priority Areas of Focus

1. Voice and choice – family driven youth guided care
2. Cultural and linguistic competent
3. Trauma informed care
4. Adequate and accessible array of services and supports – that meet the needs of those served
5. Meaningful outcomes for the people we serve
STATEWIDE ACTION PLAN

Promote Collaborative Service Relationships

• Support Community Stakeholders to create regional ROSC-focused coalitions

✓ Recovery-Oriented Quality Improvement Specialist to coordinate with their respective Managing Entities, and key stakeholders

✓ Recurring Technical Assistance Calls with ME and SAMH Change Agents
STATEWIDE PROMOTE COMMUNITY INTEGRATION ACTION PLAN

Provide More Opportunities for Individuals and Families to Give Feedback into the System:

✓ Utilize current community peer council groups facilitated by Managing Entities and independent networks;

✓ Promote utilization of feedback provided to ME’s and contracted providers to inform system improvements through development of peer networks; and

✓ Utilize information gathered to inform the creation of practice guidelines for service priority areas identified during ROSC summit activities.
LOCAL ROSC TRANSFORMATION

_________________________ Regional ROSC Lead & ROQI

1. Updates
2. Strengths
3. Opportunities
4. What’s Next Take Away
WHAT IS ROSC?

ROSC is:

• Value-driven APPROACH to structuring behavioral health systems and a network of services and supports
• Framework to guide systems transformation

ROSC is not:

• 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
• A closed network of services and supports
Recovery-oriented systems of care (ROSC) are networks of formal and informal systems; clinical and non-clinical services and supports developed and mobilized to sustain long-term community-based recovery for individuals and families.

The system in ROSC is not a treatment agency but a macro level organization of a community, a state or a nation.
PRIMARY GOALS OF A ROSC

1. Prevent the development of behavioral health conditions
2. Intervene earlier in the progression of illnesses
3. Reduce the harm caused by behavioral health conditions
4. Help individuals and families to sustain their wellness
5. Promote good quality of life, community health and wellness for all
7 BUILDING BLOCKS OF A ROSC

1. Aligning Treatment with a Recovery-Oriented System of Care
2. Fully Integrating Peers and Other Recovery Support Services
3. Supporting the Development of a Mobilized Activated Recovery Community
4. Integrating Recovery-Oriented Performance Improvement and Evaluation
5. Developing a Shared Vision and Strengthening Cross-System Collaborations
6. Focus on Prevention and Early Intervention through Promotion of Population and Community Health
7. Fiscal Policy, Regulatory and Administrative Alignment
WHY ROSC?
Unmet need and failure to attract

Among adults reporting a behavioral health condition, more than half report onset in childhood or adolescence

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

Less than 10% of those who need SUD treatment seek treatment

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

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
WHY ROSC?

ROAD TO RECOVERY

Image: www.careofsem.com
FACTORS THAT INFLUENCE HEALTH STATUS

Why Are Some People Healthy and Others Not? The Determinants of Health of Populations, *a 1994 book by* Evans, Barer, and Marmor

IHI, Institute for Healthcare Improvement: *What Are We Talking About When We Talk About Population Health, Health Affairs*, April 6, 2015
These account for 70% of healthcare outcomes.
INTERFACE BETWEEN MENTAL HEALTH RECOVERY & THE ADDICTION RECOVERY MOVEMENT

• Both fields recognize the high prevalence of co-occurring disorders
• Research consistently shows that to receive effective care they must integrate
• When the focus is on the nature of the illness or on the treatments required, historical differences outweigh commonalities
• Concentrating on the processes of recovery, healing and the community’s inclusion will achieve true integration
• In both mental illness and addiction – recovery is a personal and individualized process for growth for which are multiple pathways

PARADIGM FOR HIGH PERFORMING SYSTEMS AND ORGANIZATIONS IS EXPANDING

**FROM:** HOW CAN WE GET POPULATIONS HEALTH?

- How do we best protect children?
- How do we transition Criminal Justice involved people into communities, reduce recidivism, and ensure community safety?

**TO:** HOW DO WE HELP PEOPLE TO GET WELL AND STAY WELL?

- How do we not only prevent abuse, but also promote health and wellness?
- How do we help children, families and all individuals to thrive, develop meaningful lives, and sustain their wellness?

How do we make this shift?
Health is a state of COMPLETE physical, mental and social well-being and not merely the absence of disease or infirmity.

*World Health Organization*
ROSC AS A CONCEPTUAL FRAMEWORK & ROAD MAP

**S O C I A L  S U P P O R T**
- Veterans
- Healthcare
- Trauma-informed Services
- Treatment and Medication Support
- Justice Systems (Adult & Juvenile)

**P e e r  S u p p o r t**
- Administration
- Recovery Community
- Judiciary and Justice System

**H o u s i n g  I m p r o v e m e n t s**
- NAMI
- Faith-based Support
- Life skills training

**O r g a n i z a t i o n s**
- Schools
- Employment Opportunities
- AA and NA

**A C A D E M I C  I N S T I T U T I O N S ,  R E S E A R C H**
- Physical Health
- Healthy Relationships
- Child Welfare

**F a m i l y  E d u c a t i o n &  S u p p o r t**
EXAMPLES: FLORIDA ROSC SUCCESS

- Big Bend Community Based Care (BBCBC):
  - Community Learning Sessions have occurred in all three circuits
  - Decrease in the number of mental health and substance use individuals at the Bay County Jail
- Lutheran Services Florida (LSF):
  - Providers established partnerships with the NE FL PEER Network
  - Training and developing Peer Support Capacity
EXAMPLES: FLORIDA ROSC SUCCESS

• Central Florida Cares Health System (CFCHS):
  • Engagement and buy-in from contracted providers has increased by 50%
  • Integrated the SAPT items into Survey Monkey to collect and analyzing survey results.

• Central Florida Behavioral Health Network (CFBHN):
  • Providers implementing the Self Assessment Planning Tool (SAPT) and developed a timeframe to which they would complete each phase of SAPT implementation.
  • Strategic planning committee developed a ROSC presentation to educate local communities and providers on transforming our system of care.
EXAMPLES: FLORIDA ROSC SUCCESSES

- Southeast Florida Behavioral Health Network (SEFBHN):
  - Adopting recovery-oriented concepts for CQI process
  - Internal development of ROSC workshops to model recovery-oriented concepts

- Broward Behavioral Health Coalition (BBHC):
  - SFWN and BBHC recently filmed interviews for Peer integration video
  - Expanding use of peer-based services in care coordination

- South Florida Behavioral Health Network (SFBHN):
  - Peers on the Move Project; to promote community re-integration, from SFSH to Miami-Dade community
  - Targets TA for network providers on integration of Peers services and Peer service roles.
“Recovery Management” (RM) is a philosophical framework for organizing addiction treatment and recovery support services across the stages of pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality of life enhancement for individuals and families affected by severe substance use disorders.
RECOVERY MANAGEMENT & STAGES OF RECOVERY

1. Pre-recovery identification and engagement (recovery priming)
2. Recovery initiation and stabilization
3. Transition to successful recovery maintenance
4. Enhancement of quality of personal/family life in long-term recovery
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. Integrating Recovery-Oriented Performance Improvement and Evaluation
5. Developing a Shared Vision and Strengthening Cross-System Collaborations
6. Focus on Prevention and Early Intervention through Promotion of Population and Community Health
7. Fiscal Policy, Regulatory and Administrative Alignment
RECOVERY CONCEPT FINDS COMMON GROUND IN MENTAL HEALTH AND ADDICTION

Hopscotch Model of Dual Recovery

—Davidson, et al., 2008, p. 235

A Handout
RECOVERY IN MENTAL HEALTH AND ADDICTION

• Larry Davidson, Ph.D. and William L. White, M.A.
• Recovery to Practice: Resource Center for Mental Health Professionals
INTEGRATED SERVICE TEAMS
WHETHER LIVING WITH MENTAL ILLNESS, ADDICTION OR BOTH

- **People in Recovery** need to have HOPE
- **People in Recovery** want to manage or eliminate their symptoms
- **People in Recovery** want to increase their capacity to participate in valued social roles and relationships
- **People in Recovery** want to embrace purpose and meaning in their lives
- **People in Recovery** want to make worthwhile contributions to their communities

Recovery-oriented care recognizes that each person must be either the agent of and/or central participant in his or her own recovery journey.
BENEFITS OF INTEGRATION AND A SHARED VISION

• Historical differences provide opportunities for synergistic growth for both
• Developing integrated recovery-oriented practices and systems create guiding principles:
  • Recovery looks different for different people
  • Adoption of a longitudinal perspective
  • Develop a framework that matches where people are with appropriate interventions & supports
  • Focus on person-environment and natural supports
  • Recovery is non-linear, a process and a continuum not an outcome
  • Importance of family, peer support and spirituality in supporting the recovery process
8 KEY PERFORMANCE ARENAS LINKED TO LONG-TERM RECOVERY OUTCOMES

NOTE: There are others but these 8 are most critical
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

1. ATTRACTION, ACCESS & EARLY ENGAGEMENT

Acute Care (AC) Limitations

• 10% & 25% data; late stage and under coercion; waiting list drop-out data; attrition data (more than 50% will not complete)

Recovery Management (RM) Directions

• Assertive community education & outreach
• Assertive waiting list management
• Lowered threshold of engagement; rethinking motivation; institutional outreach
• Changes in administrative discharge policies
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.
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 roles** 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.
4. SERVICE RELATIONSHIP

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

**RM:** 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?

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
by our silence we let others define us

How will anyone know about recovery from addiction if we don’t tell them? Will we continue to allow stigma, shame and misunderstanding to destroy our friends, our families, and our communities? How will anyone know?

Be an Agent of Change!
Join the Missouri Recovery Network and support the Face and Voice of Recovery!
Toll-free 877-669-2280 www.morecovery.org

Missouri Recovery Network
8. POST-TREATMENT MONITORING, SUPPORT AND, IF NEEDED, EARLY RE-INTERVENTION

• 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.

8. POST-TREATMENT MONITORING, SUPPORT AND, IF NEEDED, EARLY RE-INTERVENTION

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).

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**

- Post-treatment monitoring & support (recovery checkups)
- Stage-appropriate recovery education & peer support
- Assertive/continued linkage to recovery resources
- Early re-intervention & re-linkage to treatment and recovery support peers and resources
- Recovery community building
IMPLICATIONS FOR BEHAVIORAL HEALTH SERVICES
7 BUILDING BLOCKS OF A ROSC

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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)
Meeting People Where They Are

- No Administrative Discharges for Set-Backs
- No “come back when you are clean”
- Looking for Opportunities to assertively connect people to resources
STRATEGIES TO PROMOTE: ASSERTIVE OUTREACH AND ENGAGEMENT

- Pre-treatment Peer Support Groups
- Going into jails and prisons before release
- Offer peer mentors as soon as contact is initiated
- For urban settings, develop a welcome/recovery support center
- Focus on care coordination
- Tele-health particularly in rural settings
- Build strong linkages between levels of care
- Use charismatic & engaging staff in reception areas
- Connect with people before initial appointments
- Screening and early intervention in health facilities
- Establish relationships with natural supports to promote early identification
ASSERTIVE OUTREACH AND ENGAGEMENT STATUS CHECK

Does Your Organization Have...

• Lengthy and repeated assessment processes?
• Long wait times prior to treatment access with minimal interim contact?
• Multiple appointments prior to beginning treatment?
• Administrative discharges for symptoms of substance use disorders?
• Discharge after 30 days of no-shows or 3 missed appointments?
• High rates of no show or treatment incompletion?
• Limited outreach following missed appointments?
BENEFITS OF ASSERTIVE OUTREACH AND ENGAGEMENT

The Financial Impact of Small Changes

- **CO-MHAR (Supporting Growth & Purpose Through Community, Philadelphia, PA)** – Reduced wait times, reduce no shows, increase admissions = savings of $172,320.00

- **JEVS (Jewish Employment & Vocational Service, Philadelphia, PA)** – Increase Retention = Additional income of $249,000.00

- **Minsec Holdings, Inc, (Wallingford, PA)** – Increased admissions = $266,000.00 additional income

- **Sobriety Through Outpatient** = Re-engaged
  15% of assessment no shows = Additional income of $209,000.00
1. Assessment is broader in scope. Focuses on multiple life domains.

2. Assessment expands beyond the challenges of the past and the here and now, and focuses also on the desired future state.

3. Assessment is truly an ongoing process.

4. Focus on strengths and recovery capital is viewed as equally important to focusing on challenges.
SERVICE 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 some things in your life that you hope you can do and change in the future?
• 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?
ASSESSING RECOVERY CAPITAL

WHAT’S THE RELEVANCE?

Image: Achara Consulting
VALUES AND GUIDING PRINCIPLES
A SNAPSHOT

- Person-Centered
- Holistic Approaches
- Family and other Ally Involvement
- Individualized and Comprehensive
- Anchored in the Community
- Continuity of Care
- Partnership-Consultant Relationships
- Strengths-based
- Culturally Responsive
- Commitment to Peer Recovery Support Services
- Inclusion of those with lived experience and their families
PERSON-CENTERED PLANS: WHAT ARE THE MAIN DIFFERENCES?

Focus of Traditional Plans

• What needs to happen in treatment
• Reflect mainly what the provider thinks needs to happen
• Not individualized
• Strengths listed but not used
• Not connected to life goals and what is important to the person
## Important **TO** the Person

**PERSONAL PERSPECTIVE**

- Meaningful relationships
- A home/place of my own
- Valued roles/purpose
- Independence/Self-determination
  - Cultural/personal preferences may impact
- Faith/spirituality
- A job/career
- Family expectations

## Important **FOR** the Person

**PROFESSIONAL PERSPECTIVE**

- Basic health and safety
  - Reduction of clinical symptoms
  - Maslow’s basic needs
  - Harm reduction
  - Management of risk issues
- Legal obligations and mandates
- Community Safety
BENEFITS OF A PERSON CENTERED APPROACH?
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
PRE-PLANNING EDUCATION AND PREPARATION (TONDORA) - WHAT MIGHT THIS LOOK LIKE?

• Peers working with people prior to initial assessment/and or planning meeting
• Providing people/families with info describing the goals of the process and their participation
• Having peer led workgroups to assist people with identifying interests/goals
• Supporting people in identifying their Circle of Support
INDIVIDUALIZED SERVICES

A Menu of Options Promotes

- Relevance
- Choice
- Ownership

Image: Achara Consulting
Relationships

- Professionals support people in making their own choices
- Risk taking is supported even when failure is an option
- Doing with, rather than for or to
WHAT DOES IT MEAN FOR SUPPORTS TO BE COMMUNITY-BASED?

Community Integration

Image: Achara Consulting
COMMUNITY INTEGRATION: WHAT DO YOU SEE IN THIS PICTURE?

“The central concern shifts from How do we get the client into treatment? To How do we nest the process of recovery within the person's natural environment.”
PROMOTING COMMUNITY WELLNESS
8 DOMAINS OF COMMUNITY INCLUSION

- Housing
- Employment
- Friends
- Education
- Health and Wellness
- Religion and Spirituality
- Family
- Intimacy
SCREENINGS EMBEDDED IN NATURAL COMMUNITY

Screenings:
Get a Check UP from the Neck Up
• Philadelphia Dept of Behavioral Health and Intellectual Disabilities

Image: Achara Consulting
CONTINUING SUPPORT VS. DISCHARGE PLANNING

- It takes 4 to 5 years for the risk of relapse to drop below 15%

- The most critical period of vulnerability is the first 90 days following a tx episode

- Continuing support should be nested in the person’s natural environment


Image: Achara and Albright
MULTI-MEDIA
(FACE TO FACE, TECHNOLOGY-BASED, MAIL)

APPROACHES TO CONTINUING SUPPORT

- Recovery check-ups
- Linkages to Recovery Community Organizations
- Home visits
- Peer Support groups
- Assertive linkage to mutual aid societies
- Participation in peer leadership councils
- Recovery centers
- Recovery Residences

- Clinic based individual and group sessions
- Mail
- Internet and phone-based RSS
- Assertive Linkages to natural supports
- Embedded within natural settings (e.g. faith communities, barber shops, shelters)
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INTEGRATING PEER SUPPORT SERVICES

OUTCOMES - INCREASED

• Hope
• Active roles in treatment
• Health literacy
• Overall satisfaction with services
• Connection to community
• Ability to cope with stress
• Quality of life
• Practical outcomes: housing, employment, finances

Image: M. Velazquez
FLORIDA'S ACTION PLAN
INCREASE PEER-BASED RECOVERY SUPPORT SERVICES

Provide additional support to providers on integration of peer support services through alignment with ROSC values

✓ Cultivate deeper clarity for conceptual alignment of recovery-oriented practices through the utilization of SAPT

✓ Recovery-oriented Quality Improvement Specialists to provide TA to community behavioral health providers on the utilization of the SAPT

✓ Peer Support Coalition to coordinate with ME and regional SAMH to conduct TA site visits with MAT providers; develop strategic action plans for successful integration of peer-based services
Outcomes for Cohort of Members with a *Minimum of Two Inpatient Admissions in 30 days upon Enrollment in Magellan Complete Care’s Internal Peer Support Program


Image: Dana Foglesong
(PSCFL)

FLORIDA’S STATEWIDE PEER NETWORK

The Peer Support Coalition of Florida, Inc. (PSCFL) is a peer-run nonprofit organization led by peers in recovery who are dedicated to advancing peer support in Florida.

At PSCFL, we are passionate about peer support because as peers we have the opportunity to role model recovery and offer hope and a sense of belonging within the community to those seeking recovery for themselves. Through self-help and mutual support, peer support facilitates personal growth, wellness promotion, and recovery while honoring one’s strengths, needs, and personal choices. We strive to provide services that continue to advance peer support in Florida, which includes strengthening and supporting peer workforce development, promoting the full integration of peer and recovery-oriented services, and collaborating for social and system transformation.

PSCFL provides:

- Peer and Recovery Education
- Technical Assistance (Certified Recovery Peer Specialist, peer networks, employers).
- Certified Recovery Peer Specialist (CRPS) Employment Opportunities
- Advocacy Opportunities
- Resources
- And Much More!
SAMHSA 2018 STATEWIDE NETWORK
Building Bridges & Connecting Communities

Operating Strategy

• Aligned with DCF’s six regions
• Designed to engage collaboratively with Managing Entities, Providers, & Peers
• Development of 6 regional networks
• Development of peer leadership and advocacy skills

Regional Network & Outreach Coordinators (RNOC)

• Northwest & Northeast – Denise L. Barber
• Central & Suncoast – Cheryl Molyneaux
• Southeast & Southern – Kimberly Comer
Time for lunch
Gallery Walk
Focus on engagement, tolerance, respect, personal and system strengths, partnership, honesty (transparency), and commitment to continuity of support.
ACTIVITY
Integration Brainstorming
NEXT STEPS
FLORIDA’S BIG PICTURE

WE’RE ON OUR WAY

- State Opioid Response (SOR)
- Provider Self-Assessment Planning Tool (SAPT)
- State Treatment Facilities

SOC - System of Care
OCW - Office of Child Welfare

- Children’s SOC grants
- Statewide training and implementation of wraparound
- Care Coordination
- OCW Parent and Child Service Array PoE
- SAMH POE – Recovery Oriented System of Care
- Statewide, regional and local ROSC efforts
STATEWIDE SUPPORT
TRAINING AND TECHNICAL ASSISTANCE

DCF/FADAA Webinars:

- Removing the Stigma: Changing the Public Outlook on Substance Use and Recovery
- Customer Service Strategies for Substance Abuse Treatment Engagement and Retention to include Warm Welcomes & Warm Handoffs
- "Moving Case Management to Wraparound"
- Voice and Choice - Family Driven Youth Guided Care
- Introduction to Harm Reduction and Assessment
- Recovery Planning and Sustainability
- Using Community Outreach Strategies to Increase Engagement

Access information through the FADAA website for archived webinars and to register for upcoming trainings.
Workshops:

• 6 Regional Recovery Management Workshops: Practical Applications of ROSC

• 3 Agency Supports for Quality Peer Recovery Services Workshops

• Quality Assurance and Transformational Support Activities for Recovery-Oriented Systems of Care for ME QA Visits
| **NEXT STEPS**<br>**PLANNING & IMPLEMENTATION**<br>**FOR PROVIDERS** |
|---|---|
| Identify | Identify agency priorities and establish a manageable number of goals. |
| Focus on | Focus on areas of strength and opportunities for growth. |
| Integrate | Integrate recovery-oriented services planning with Continuous Quality Improvement (CQI) activities. |
| Establish | Establish person-centered decision making as a high priority. |
| Repeat | Repeat the SAPT self-assessment and RSA to modify plans every 12 months. |
| Use | Use the RSA and the SAPT at the same 12 month intervals to provide corresponding outcome information. |
AVAILABLE TOOLS & RESOURCES
SEE YOUR LOCAL ROSC LEAD

- Recovery Capital Scale
- Strengths Assessment (In handouts)
- Self-care Assessments (In handouts)
- SOAR (In handouts)
- Change & Implementation Strategies
- Technical Assistance (TA): What do you need?
CLOSING

The personal/professional destinies of some of you in this room are linked to leadership in this emerging movement.

For some of you, your whole lives have prepared you for this unique moment in the field’s history. We invite you to join us.
COMMITMENT

How can you, how will you get more involved?
REFERENCES AND CITATIONS


• White, William L., 1947 – Slaying the Dragon: The History of Addiction Treatment and Recovery in America, 2nd ED 1998 (Slide 27)

• Why Are Some People Healthy and Others Not? The Determinants of Health of Populations, a 1994 book by Evans, Barer, and Marmor (Slides 30 & 31)

• IHI, Institute for Healthcare Improvement: What Are We Talking About When We Talk About Population Health, Health Affairs, April 6, 2015 (Slides 30 & 31)


• Tondora, Janis; Miller, Rebecca; Davidson, Larry. The Top Ten Concerns about Person-Centered Care Planning in Mental Health Systems. International Journal of Person Centered Medicine, [S.l.], v. 2, n. 3, p. 410-420, sep. 2012. ISSN 2043 7749. (Slide 76)


• Source: Magellan claims data for HealthChoices members receiving fee-for-service CPS services between January 1, 2012 and September 30, 2015. (Slide 90)
RESOURCES

Monographs – Published by Great Lakes ATTC in partnership with William White:

- Recovery Management
- Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices
- Practice Guidelines for Resilience and Recovery Oriented Treatment, Philadelphia Department of Behavioral Health and Intellectual Disability Services

Articles & Books

- Recovery concept finds common ground in mental health and addiction, Co-occurrences Newsletter of the Minnesota Co-Occurring State Incentive Grant Project
- Recovery in Mental Health & Addiction, Davidson and White, Recovery to Practice Issue No. 14

Websites:

- www.acharaconsulting.com
- www.attcnetwork.org/
- http://www.yale.edu/PRCH/documents/toolkit.draft.4.16.10.pdf
- http://www.facesandvoicesofrecovery.org/
- www.williamwhitepapers.org
Thank you!
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