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## **Toward Recovery Community Mobilization and Recovery Support: An Interview with Cathy Nugent**

William L. White

### **Introduction**

In 2001, recovery advocates from more than 30 states assembled in St. Paul, Minnesota, to lay the foundation for a new recovery advocacy movement that subsequently spurred the dramatic expansion of new recovery support institutions and recovery support services throughout the United States and beyond. The St. Paul Recovery Summit might never have occurred without the support the Center for Substance Abuse Treatment (CSAT) had earlier provided to grassroots recovery community organizations through a program then known as the Recovery Community Support Program (RCSP). One of the key individuals in the design and evolution of the RCSP was Cathy Nugent, whose keen wisdom and gentle manner endeared her to the diverse recovery advocates who shared her vision. In August of 2013, I had the opportunity to interview Cathy about her life, her leadership of the RCSP program, and how that experience has informed her subsequent work within the Substance Abuse and Mental Health Services Administration (SAMHSA). Please join us in this engaging conversation.

### **Early Career**

**Bill White:** Cathy, let me begin by just asking you how your early professional experiences prepared you for the work you would later do at CSAT?

**Cathy Nugent:** My early preparation was as a clinician, an educator, and a change agent. I was trained and certified as a group psychotherapist and psychodramatist, and I worked in a psychiatric hospital for ten years. So, that was the beginning of the clinical part, although I later was licensed as a mental health counselor. I received my first masters' degree in applied behavioral science, which is an interdisciplinary course of study that looks at how to implement planned change at different system levels. So, that was the educator and change agent preparation. The clinical work at the hospital laid the groundwork for me to understand that professional clinical treatment alone was not enough to get people onto a trajectory of long-term recovery, reintegration into the community, and a full and satisfying life. I saw the need for recovery support services even then, and I also saw that community-based services were woefully inadequate. In addition, my training as an applied behavioral scientist heightened my awareness of the need to bring together people with concern for an issue or a problem and apply systems thinking and facilitation skills to enable them to come up with ideas and solutions most relevant to their needs, strengths, and preferences.

**Bill White:** You also were involved with other projects at CSAT before your involvement with RCSP. How did that earlier work inform your later CSAT work?

**Cathy Nugent:** I had a very interesting and fulfilling project with the Center for Substance Abuse Prevention (CSAP) working with the National Resource Center for Women. The Center focused on substance abuse prevention and treatment, mental health, and maternal and child healthcare for women. The project examined the intersection of issues such as domestic violence, sexual abuse, and women's substance use and mental health problems.

With the National Resource Center, I managed the community team training institute (CTTI). The CTTI brought together stakeholders from the women's community to look at intersecting issues and develop community solutions to address them. Community teams of representatives from domestic violence, criminal justice, prevention, mental health, maternal health, and other areas participated in cross-disciplinary training focused on action plans for facilitating key areas of change in their home communities. Working with that project laid the groundwork for how I would later think about working with the RCSP Program.

### **The RCSP Program**

**Bill White:** And how did the opportunity to work with CSAT's RCSP come up?

**Cathy Nugent:** I actually left the government briefly to work on my doctorate, and about a year later, I decided to come back to SAMHSA. My reentry was in a position as a State Project Officer for the block grant in CSAT. I was in that position for about three months when the Request for Applications for the RCSP program was released. CSAT needed a Project Officer to work with the RCSP. It sounded like a really exciting opportunity, and because of my training and previous experience, I was fortunate enough to be chosen for the role.

**Bill White:** How did the idea for the RCSP develop within CSAT?

**Cathy Nugent:** The idea actually began before I came to CSAT. A few self-identified staff members in recovery and their allies saw the possibilities of an organized recovery community. CSAT leadership was quite receptive and hosted an early focus group to explore the idea with leaders, such as Linda Kaplan, who at the time was with NAADAC, and June Gertig, a self-identified family member who would later play an important role as Project Director for the RCSP Technical Assistance Project. CSAT said to these people, "We want to do something to bring people in recovery together and we want you to help us decide what that would look like." Out of that focus group came the idea for the recovery community support program.

RCSP was modeled, to some degree, on the mental health community support program that SAMHSA had been supporting for some time. SAMHSA had a long history of giving support to mental health consumers/survivors in local communities to come together to work on common concerns, but the agency hadn't focused on the addiction recovery community before RCSP. I think there was a perfect storm or confluence of influences at that time that helped launch RCSP. We're talking about the mid-1990s. There was awareness of efforts by people like Harold Hughes to organize SOAR and other recovery mobilization efforts. SAMHSA was poised and ready to step in and help.

**Bill White:** What was the original long-term vision of the RCSP?

**Cathy Nugent:** I appreciated that there would be power in numbers by organizing the recovery community and was open to whatever vision might emerge from the leaders in the recovery community. In my mind, the idea was that we would bring together the different communities of recovery and provide an opportunity for them to forge a long-term vision of expanding support for recovery in the U.S. My approach was always that the people coming together, our grantees and others, were really the experts who had wonderful, creative ideas. I saw my role as a project officer to facilitate the emergence of those ideas and bring to bear whatever resources SAMHSA could offer to move those ideas and the larger vision forward.

**Bill White:** What are your recollections about those first RCSP grantees and the first RCSP meetings?

**Cathy Nugent:** I look back on them with a sense of great appreciation and awe. Everyone there was an innovator. There was a tremendous amount of enthusiasm and energy, as well as a real sense that what we were doing was historic and unprecedented. We all wanted the opportunity to make a positive mark and hoped RCSP would have a long life. Those early meetings were filled with tremendous excitement and creativity.

The early meetings provided opportunities for different communities to share and express their culture. This was an important part of the community-building process: that individuals and groups shared what was most important to them – their values, heritage, and beliefs. There was also lots of time for networking, thought-provoking community discussion, problem-solving in small groups, and time for project development and planning. We did the typical kinds of sessions on how to manage a federal grant because, for many of the grantees, this was the first time that they had had a grant. We offered lots of technical assistance and support because, above all, we wanted these organizations to be successful.

We had some wonderful consultants and facilitators who worked with us. Using their knowledge and skill, they helped us shape the RCSP vision. There were also powerful leaders and facilitators within the recovery community who emerged – people like Tom Hill, Patty McCarthy Metcalf, Phil Valentine, Joe Powell, Andrea Johnson, Bev Haberle, Barbara Warren, and many others. They soon emerged as leaders and technical assistance providers to others.

**Bill White:** The thing that is most striking to me when I think of the early RCSP days was the incredible cultural diversity of the grantees. How was that diversity achieved? And how conscious was that effort?

**Cathy Nugent:** Well, it was very conscious. One of the things that we knew even in those early days was the importance of culture in achieving and sustaining recovery. We also wanted to honor the idea that there are many pathways to recovery and that all of those pathways were valid. So we wrote into the early RFAs that we were seeking geographical and cultural diversity.

At that time, SAMHSA still had the resources that allowed us to go out on the road when we had RFAs out. We would go to maybe three places around the country and invite potential applicants to come in and to discuss how to write a grant application and do things like the budget and the evaluation section. Then we had break-out sessions that were specifically about the program component of the RFA, where we could really go into detail about the kinds of ideas that would be promising to include in an application. We did a great deal of outreach to

communities of color and encouraged them to come to those meetings so that they would have the benefit of that technical assistance.

We also provided a great deal of telephone TA in the pre-application period and application period. I remember having very lengthy and sometimes very exciting and interesting conversations with potential grantees. Many had never thought of applying for a federal grant and were surprised and excited to know that SAMHSA would consider funding an innovative, culturally specific intervention. For example, White Bison was one of our early grantees. It is very gratifying to know that RCSP gave Don Coyhis a start on the Wellbriety Movement and the many other exemplary programs and initiatives White Bison has developed. Another of our early grantees was the Asian Recovery Center in Seattle, Washington. They did a beautiful job fashioning a family-centered approach to recovery that was more congruent with the cultural values of their community than an approach focused primarily on the individual. An exciting part of the RCSP was the grantees sharing their cultures and their pathways to recovery with each other. It was a wonderful opportunity to raise awareness and promote a sense of oneness across very diverse communities. I also think it's fair to say that RCSP flourished in part because of the culturally specific models that emerged in those early years.

**Bill White:** What do you think were some of the most important accomplishments of the RCSP during that early period when it was focused primarily on recovery community mobilization and advocacy?

**Cathy Nugent:** I think just bringing together the recovery communities and laying the seeds for what would later become a large organized network of recovery community organizations across the country was a major accomplishment. Faces and Voices emerged a little later, but I recall some of the key players from those early days, including a group called The Alliance that was headed up by Jeff Blodgett that later convened that historic meeting in Minnesota where Faces and Voices of Recovery was initiated. We invited Jeff to speak with our grantees, and many of the early RCSP grantees were involved in shaping that national movement. And, Bill, you will remember that we invited you to come and speak with us many times. You were then and have continued to be a major thought leader in the recovery movement. Your presentations and discussions with the grantees and with me were always insightful and helpful. One of the achievements of the RCSP was to link the amazing group of grantees with innovative thinkers like you, Jeff, Stacia Murphy (from NCADD), and others. We really did have hopes at that time of an emerging national movement.

**Bill White:** I remember a period with all of these rising local grassroots efforts with virtually no connecting tissue between them. RCSP served as that first connecting tissue.

**Cathy Nugent:** I think you said that really well, Bill. And that is what I see as the major accomplishment of those early years. RCSP built the capacity of those small grassroots efforts and formed connections that allowed them to come together and experience themselves as a network.

**Bill White:** How was the RCSP received within CSAT and SAMHSA?

**Cathy Nugent:** Very positively. There was tremendous support for the program. The program started just about the time that Dr. H. Westley Clark came as the CSAT Director. I remember Dr. Clark came to the first RCSP meeting along with then SAMHSA administrator Dr. Nelba Chavez. Dr. Clark clearly understood what the program was about and was very supportive from day one. We also enjoyed great support from Rick Sampson, who was the Director of the Division where the RCSP was housed and from Ivette Torres, who headed up Recovery Month. Other CSAT and SAMHSA leaders were also interested in what the grantees were doing and frequently met with them at grantee gatherings.

**Bill White:** Do you see RCSP as the beginning of the increased recovery orientation within CSAT?

**Cathy Nugent:** Yes, I do. The peer movement's strong emphasis on recovery had a major influence on CSAT.

I remember the first recovery community grantee meeting. In preparation, June Gertig and I were talking, and June came up with this metaphor of treatment as a big table and with all these chairs pulled up to the table—recovery being one of the chairs. But halfway through the first grantee meeting, we realized that June's metaphor was incorrect: The table was recovery, and treatment was one of the chairs at the table. My work with the grantees precipitated a dramatic shift in my thinking, and CSAT began to undergo a similar change. We all became aware that our focus needed to be on recovery as the larger construct, with treatment being an important route to recovery, but not the only one. The peer movement's emphasis on recovery and wellness also influenced a shift toward strengths-based and holistic services, in contrast to fragmented and deficit-based approaches. These changes in orientation and approach have continued to be important in CSAT and SAMHSA.

## **2002 Change in RCSP Focus**

**Bill White:** I want to take you to the year 2002. The focus of RCSP shifted from recovery community mobilization and advocacy to a focus on the development of recovery support services. Could you describe the background behind this shift?

**Cathy Nugent:** Sure. The RCSP focused on organizing the recovery community to have a voice in policies, programs, and services for people with addictive disorders. Sometimes community members were unclear about the purpose or value of such an effort. We sometimes heard, "Mobilizing for what purpose?" from the recovery community. Efforts to influence service delivery toward a recovery orientation appealed to some people, but to others, that idea seemed vague and abstract. Moreover, many people coming to RCSP events wanted and needed recovery-related services themselves. They wanted help with things like finding recovery housing, getting a job, working on their legal problems, finding a way to get a criminal record expunged, or having a place to come and be with other people in an alcohol- and drug-free environment where there were opportunities for social engagement and recovery support.

There were no programs in CSAT providing these types of services at the time. As we saw this greater need for recovery support services, we changed the focus of the grant program. We also increased the funding level from about \$100,000 each to up to \$275,000 because we

knew the grantees would need more funding to provide recovery support services. We made the shift, and the RCSP became the Recovery Community Services Program.

**Bill White:** How well were the existing RCSP grantees able to make that transition?

**Cathy Nugent:** We held a series of meetings to do that, and we definitely called it a shift in focus. We invited the grantees to help us think about how we could best accomplish this shift and what some of the issues would be. It was a more difficult transition for some than others, but I think most embraced the idea that they were going to be able to provide direct services in their communities and have the opportunity to develop creative ways of meeting the holistic needs of the people they were engaging.

**Bill White:** This year will mark the 15<sup>th</sup> year of RCSP. When you look back, what do you feel are the most important accomplishments of the RCSP over this extended time span?

**Cathy Nugent:** I think RCSP brought some very important innovations for the field. One is the emergence of recovery and wellness centers in the addiction recovery field. Some of the grantees developed physical spaces – recovery centers – where people could come in and participate in a broad range of recovery support activities, including all kinds of peer-led meetings, twelve-step groups, peer-led relapse prevention groups, and computer banks where people could develop a resume following a resume-writing class. Some of these centers had a clothing closet where people could actually get a nice-looking suit that they might wear for a job interview. There might be health and wellness activities, like yoga and meditation. These centers were set up to meet the full range of needs for people in recovery in their communities. They also served as safe alcohol- and drug-free spaces where people could develop a culture of recovery and give and receive support from people who were part of that culture.

We organized the services around four categories: 1) emotional support, and that included things like peer coaching or peer mentoring one-on-one or in groups, 2) informational support such as educational groups or linking people up to resources that they needed but they didn't know about, 3) instrumental support, which would be actually helping people do concrete things like getting clothes or arranging transportation for outpatient treatment or recovery meetings, and 4) affiliational support, which would help people make that transition from the culture of addiction to affiliational support within the culture of recovery. I think the development of recovery centers and the organization of recovery supports around those four categories of social support were very important contributions of the Recovery Community Services Program.

**Bill White:** What lessons did you learn through this process about how to effectively work with recovery community organizations?

**Cathy Nugent:** I think there was a really strong affirmation for me in the stance I naturally assumed: coming in as a person who felt I wasn't the expert, who didn't have the answers, but who had a sense of excitement and appreciation of the skills, talent, and wisdom of the community that was coming together. I think that was a really important lesson—to provide the process skills to bring people together in a way that will facilitate their having the opportunity to

bring forth their ideas and their wisdom. The people that we're working with are those who have the answers to their needs and they know best how to bring their strengths and resources to bear.

**Bill White:** There's one event I'd like you to reflect back on, and that is the 2005 National Recovery Summit. Looking back today, what was the significance of that event?

**Cathy Nugent:** We had brought together our grantees a number of times, and this was an opportunity to bring together a larger group of national leaders in the recovery field and some other federal agencies. We had representatives from NIDA and NIAAA there. The idea was to bring together a group that would help us come to consensus on a definition of recovery, on a set of principles of recovery, and elements of a recovery-oriented system of care. I think bringing together people to think through these issues and arrive at general consensus was of great importance to the field. The work from the Summit gave us a vision, definition, and operational principles that were concrete and had buy-in. This work was then disseminated across the nation and used to help guide policy, programs, and services.

**Bill White:** To me, that summit was a key policy transition point. I'm thinking back to your metaphor with June Gertig about the table and the chairs and the federal policy awakening that the table is recovery rather than treatment. I think a major leap towards recovery management and recovery-oriented systems of care emerged out of that conference.

**Cathy Nugent:** I agree. This was a real turning point in federal policy, with CSAT coming out and saying, "We're promoting recovery and we see that there are many pathways to recovery, treatment being one of them. We certainly understand the critical importance of treatment, but we also know that recovery is the larger construct and treatment is a part of it."

### **The ATTC Network**

**Bill White:** How did your work with the RCSP inform your later work with the Addiction Technology Transfer Center network?

**Cathy Nugent:** Well, when the opportunity for the position of ATTC Project Officer emerged, I was very excited because I thought it fit well with my earlier preparation and training in applied behavioral science. I also saw that the ATTC system was a national infrastructure influencing the way state administrators and treatment providers thought about treatment and recovery.

The RCSP was a way to mobilize the recovery community and understand their vision. The National Summit put forth a recovery definition and set of principles and elements of a recovery-oriented system of care. And the ATTC network became a vehicle to disseminate the recovery orientation nationally through training, technical assistance, materials, and other resources. Through the ATTCs, I saw an opportunity to infuse the recovery vision and principles into state systems and to help addiction treatment providers better understand this new vision of recovery.

**Bill White:** At that time, there was a lot of interest in shifting addiction treatment from acute models to recovery management models and in developing recovery-oriented systems of care, but most of this was emanating from the advocacy and research communities and a few pockets

of clinical innovation. The real shift at the state and provider levels seems to me to have come from the influence of the ATTCs. Would you agree?

**Cathy Nugent:** Yes. An important role of the ATTCs was to take research and translate it so that it was understandable to providers. The ATTCs played a significant role in helping to shift the national treatment perspective towards a recovery orientation. For example, the ATTCs developed a number of key monographs, several of which you authored. Mike Flaherty wrote one that I think is very important on the research undergirding many of the recovery concepts. Several other ATTC Directors had been advocates for recovery for some time, so they were ready, willing, and able to help advance the ball. The ATTCs developed a “training of facilitators” approach that was very instrumental in helping state leaders understand what a recovery-oriented system of care would look like and how to implement it. The ATTCs became a national dissemination effort to help make the shift from the traditional acute treatment model to a long-term recovery management and recovery-oriented systems of care approach.

### **Center for Mental Health Services**

**Bill White:** In 2011, you began work as a Senior Public Health Analyst at SAMHSA’s Center for Mental Health Services. How did your interest in recovery support resource development continue in that role?

**Cathy Nugent:** In my work at CMHS, I am staff lead for the Recovery Support Strategic Initiative, which is one of the eight initiatives of focus in SAMHSA. Paolo del Vecchio is the current lead. Kathryn Power was the lead previously, and I’ve worked with both to help infuse the recovery orientation into all programs and initiatives across SAMHSA. This is a progression of the work that I had been doing in CSAT and a logical next step for me. I was always interested in mental health because that was my early training. In addition to my administrative work at SAMHSA, I have maintained a strong interest in clinical work, and I am still a practicing licensed clinical professional counselor and Board-certified psychodramatist. My current position provides an opportunity to explore how the recovery movements from mental health and substance use disorders might be able to work together in the emerging landscape of health reform with its greater emphasis on a unified behavioral health recovery community and integration with primary health care.

**Bill White:** Do you see any potential pitfalls in these service integration initiatives that we will need to carefully manage?

**Cathy Nugent:** I do. Although there are definite commonalities between the mental health and addiction recovery movements, there are some distinct differences. It is really important to honor those differences – as a practical as well as a philosophical matter. I’ll give an example. In our development of recovery centers, it is critically important for people in addiction recovery that those centers and that the people who come there be alcohol- and drug-free. For most people in recovery, abstinence is the cornerstone. So, recovery spaces need to be sober/abstinent spaces. For some people with mental health conditions (who don’t also have substance use disorders), the use of alcohol may be okay. But it wouldn’t be a good idea to have a recovery center for people with substance use disorders where there was not an abstinence-based culture.



There are differences too in the services that are provided. For example, many people with mental health conditions might benefit from supported employment where there's a job coach who goes to the job with the person, helping to pave the way in the workplace and negotiating accommodations for the individual. People in recovery from addictions often need different kinds of vocational support services. More often than needing special accommodations on the job, they need help overcoming legal barriers to employment. For example, in some states, you can't even get a barbers' license if you have a prior conviction for possession of an illegal substance. So the kinds of services that are needed may be very different, and it's really important to make sure every individual gets the specific services that best serve his or her long-term recovery.

**Bill White:** With all of this new service integration activity, it occurs to me that this move toward a focus on more holistic, global health has been a persistent theme within your career.

**Cathy Nugent:** It has. I see the whole health model as the wave of the future. The fragmented, siloed approach simply doesn't work for most people. We need to find ways to provide integrated services in accessible settings so that people can easily get the full range of clinical and recovery support services they want and need. At the same time that we find improved coordination and integration of services, it is important that we don't create a homogenized behavioral health recovery community that no longer recognizes and honors the differences between the mental health and addiction recovery movements. And it is equally important to encourage people from the two movements to reach their hands across the aisle and find ways they can work together to build a stronger whole health delivery system that will serve the needs of everyone.

### **Career Retrospective**

**Bill White:** You played such an incredibly important role in the development of recovery community organizations and the development of peer recovery support services in the US. When you look back over this work, what do you feel best about?

**Cathy Nugent:** That's a really excellent question, Bill, especially at this late stage in my career. I would say, first of all, that I just feel very grateful and honored to have witnessed and participated in this work over the past fifteen or so years. I'm excited about the continued growth in the recovery movement and so gratified to have played a part in that development. I guess I feel best about having had the wisdom to approach the task with humility. I think I provided the space for people to come together and let the vision and values of the community emerge. I trusted that everyone was coming from a place of integrity and that everything would work out. And it did work out beautifully.

**Bill White:** What do you see as the future of recovery support services in the United States and, in particular, the relationship between recovery community organizations and professionally directed addiction treatment?

**Cathy Nugent:** I think the peer workforce is going to continue to grow in the future. It certainly is moving toward a stage of "professionalization." There's a movement for developing national

practice guidelines. Even back in the days of the early RCSP, we worked on codes of ethics, but there is a need to further elaborate the values, principles, and guidelines for the delivery of peer recovery support services and to assure their quality. Under the contract that I currently manage called Bringing Recovery Supports to Scale Technical Assistance Center Strategy or BRSS TACS for short, we're now developing a set of core competencies for peer support. This work is very important. But, at the same time the peer provider role is being codified and upgraded, I hope these services and the people who provide them will remain true to their roots as grassroots advocates and supporters. I wouldn't want to see them become "assistant counselors" or merely extensions of the treatment arm. There is a concern in the recovery movements that this could happen and a strong acknowledgment that we need to retain the authentic "peer-ness" of the role.

That said, I think there can be a great relationship between professionally directed treatment centers and autonomous recovery community centers as well as the use of peer providers in professionally directed treatments – as long as those agencies understand and honor what peers can bring to the workforce. I think we will see treatment organizations building cultures to accept peers and use them in appropriate ways, and I think there will be increased opportunities for more freestanding peer recovery community centers. I think both directions will enhance access to care and the quality of such care and support.

**Bill White:** Cathy, thank you for taking this time to reflect on your career and thank you also for all you've done and continue to do in shaping the future of addiction recovery.

**Cathy Nugent:** Thank you, Bill. I really appreciate this. It has been a wonderful opportunity for me to reflect back over a long period of time and pull together for myself some thoughts about what it has all meant.

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### **Recommended Reading:**

Kaplan, L., Nugent, C., Baker, M., & Clark, H. (2010). Mobilizing the addiction recovery community: The Center for Substance Abuse Treatment's Recovery Community Services Program. *Alcoholism Treatment Quarterly*, 28(3), 244-255.

### **Related Interviews:**

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