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Recovery Management Implementation in Indiana: An Interview with Linda Grove-Paul, Vice President of Recovery and Innovation Services, Centerstone of Indiana

Introduction

Much has been written on addiction recovery management (ARM) and recovery-oriented systems of care (ROSC) in recent years, but there is much to be learned about how ARM and ROSC principles are implemented on the front lines of organizations providing addiction treatment and recovery support services. Across the country, visionary professionals and people in recovery are collaborating to forge new service models to support long-term personal and family recovery. In the following interview, Linda Grove-Paul discusses how such ARM and ROSC principles are being used to guide the transformation of services provided by Centerstone of Indiana. Please join us in this most interesting discussion.

Background

Bill White: Linda, could we begin by sharing your background of working in the addictions field?

Linda Grove-Paul: I grew up in a warm and loving family that experienced more than its share of loss. As I was growing up, I had no sense of what alcoholism was, but I did know alcohol as a haunting presence within our family. I lost my only brother when he was just 28. He was a juvenile diabetic and alcoholic. At the time, the diagnosis of juvenile diabetes was a death sentence. My brother was diagnosed at age 4. Although he would not die right away, the road ahead of him and my family was one of pain and suffering. My parents had little-to-no support system. Even so, I had so many of what we, in the field of recovery management, like to call "protective factors." My dad and mother were always there for my brother and me. I had absolute unconditional love, which laid a foundation for security and stability.

While I could not have had better parents, my father battled "the demons of alcohol" all his adult life. He was able to keep the disease at bay enough to not impact his job, his legal situation, our financial situation, or family vacations. He suffered in silence with his trauma, loss, depression, guilt, and shame. As far as I know, he had no help to speak of and no one intervened on his behalf.

My brother and I both went to college. My brother was an amazing writer, but he began to play “Russian Roulette” with his drinking as a diabetic. While he knew the toll drinking exacted on his health, he did not know how to stop. He faced many losses as a result of his diabetes, including his eye sight. He had no real support system with which to cope with these losses until he became part of a 12-step community (which I only found out about after his death).

By this time, I was also well on my way to developing a problem with alcohol. I did not know that I had an issue, but even in my high school and college years, I had brushes with the legal system. I certainly would have been a candidate for a treatment program. When my brother died, I was 24 and pregnant with my daughter. This was the first time I had ever really thought about alcoholism or the impact it had on our family. Honestly, it wasn't until later that I put the pieces together. I thought alcohol was just a normal way of coping.

At this point, I didn't have plans to go into addiction work, but I was very much committed to working in social justice and mental health. Through my involvement with the HIV community, I pursued a master's degree in social work (MSW). I took a full time job following graduate school with the Center for Behavioral Health in Bloomington, IN, which later became Centerstone, because I needed benefits for my family. My husband had a significant chronic illness and could no longer work. We had six young children and the financial and related struggles were immense. In my first 6 years of employment, I would come to work facing eviction, disconnection of utilities, bankruptcy, terrible creditors, and so forth as a result. Like many I work with, I know what it is like to live life on the brink and the burning desire and frankly desperaion to do the very best you can to provide for your family.

My first job with the Center was with a day treatment program for those who are just getting clean and sober. When I interviewed and shared some of my background about my family I was told that I had come to this program for a reason. While I had no interest in working in the addictions field at the time, I thought they were just those touchy feely social work types; I had no idea how right they were! Two distinctions really struck me about the people I was working with. The first was that these individuals were totally desperate, alone, disenfranchised, traumatized, and despairing. The other was that they were also so very responsive and resilient. I worked Thursday through Monday, doing group, individual, and family counseling with hundreds of individuals. I found that they were so grateful for my kindness, compassion, and respect. In return, they showed me that with some skills, support, resources, respect, and hope, they could accomplish anything. We learned from one another and that was really just the beginning of my journey.

Bill White: Provide an overview of Centerstone for our readers.

Linda Grove-Paul: Centerstone's mission is to prevent and cure mental illness and addiction. Its services go beyond diagnosis and treatment. The focus is on enabling people to rebound from adversity, build on their strengths, and achieve their life goals. Centerstone's programs are guided by the principles of recovery and resilience. What this means is that services are tailored around individual needs and choices. By providing increased access to services, proactively innovating, and continually improving services, Centerstone works to reflect the changing landscape of behavioral healthcare. The emphasis is on the importance of hope in the life of every individual. We understand that every individual wants to live a purposeful and meaningful life.

In Indiana, Centerstone offers a wide range of mental health and addiction services to more than 24,000 people of all ages each year through 60 facilities located within 17 counties. Formed through the merger of Center for Behavioral Health, Quinco Behavioral Health Systems, and Dunn Mental Health Center in Indiana with Centerstone in Tennessee, Centerstone has now served Indiana residents for more than five decades. Centerstone is accredited by The Commission on Accreditation of Rehabilitation Facilities (CARF).

Additionally, Centerstone Research Institute (CRI) partners with a range of institutions, including Vanderbilt University, Texas Southwestern, Columbia, and Duke University, as well as pharmaceutical companies and behavioral health organizations to uncover new treatments and shorten the cycle between innovative science and compassionate service. CRI continuously conducts an average of 40 concurrent studies with a focus on grants that will bring the best possible treatment to Centerstone clinicians. Of particular focus is research to help close the gap of increased mortality rates of people who are chronically addicted and seriously and persistently mentally ill, who die almost 25 years earlier than the rest of the U.S. population as a whole. This discrepancy is not only alarming, but a travesty. *CRI seeks to bridge the gap between science and service*, so the 33 million Americans seeking help for behavioral health disorders receive the most effective care without delay. Research shows an alarming 13–17 year delay between significant treatment breakthroughs and the standard use of those treatments in clinical settings. This means that an addicted person diagnosed with substance dependence may have to suffer for 15 years before receiving a life-saving treatment already known today. This link between research and practice makes Centerstone particularly unique as a community-based behavioral healthcare provider.

Recovery Management & Recovery Oriented System of Care (ROSC) Implementation

Bill White: How did addiction recovery management and recovery-oriented systems of care come to be a core philosophy at Centerstone?

Linda Grove-Paul: Well, in general, Centerstone clients with addictions tend to be poor and uninsured. Most are involved in the revolving door of the criminal justice system. Many have been hospitalized, are jobless, have lost custody of their children, have lost their families, and have lost most of their social support resources. They may have lost almost everything by the time we see them. As a result, the majority of available resources end up being spent on the most severe cases of the disorder. Because of this, non-profit programs often risk running "in the red" since the need for treatment exceeds organizations' capacity to provide. As you know, only 1 in 10 of the individuals who need addictions treatment actually receives it, and the needs consumers bring are very complex. They often have very serious mental health, social, economic, physical, and disenfranchisement issues. With minimal resources, we are unable to make a significant impact in their often despairing lives. We see literally 1000s of individuals, children, and families who are devastated by the disease of addiction and its consequences. The communities we serve also often see this population as the greatest burden to their community. Also we know that the resources we have available to us (state, federal) for funding have been decreasing and are likely to continue to do so. Finally, the individuals we serve need housing, employment, childcare, healthcare, spiritual connection, a formal and informal support system in addition to their mental health and behavioral health needs.

To meet these needs, care has traditionally been delivered through separate service silos, each of which is served by a different provider with a different objective. The system itself is daunting to navigate. This fragmented approach to total service delivery leads to complex, uncoordinated, and therefore less effective overall treatment.

It was clear that we were only a part of the solution and that we had a real opportunity with the philosophy of recovery management and the vision of the ROSC approach to build a broader safety net for our communities, particularly for the 18 rural Indiana counties we serve.

To get help developing that safety net, I approached the Great Lakes Addiction Technology Transfer Center (GLATTC). At the time, we were in a state of crisis because 80-85% of the individuals we see at Centerstone in Indiana are uninsured, and recent Medicaid cuts posed a very real threat to our service programs. I cannot overestimate the feeling of fear and desperation I had at that time. I participated in a GLATTC leadership training program as a mentor and was introduced to some of your writing, Bill. I began to read everything I could get my hands on. GLATTC also offered a phone consultation with Dr. Achara. After our first conversation, she arranged three other telephone calls for me to talk with providers who are doing recovery management and recovery-oriented systems of care (ROSC) in Michigan, Illinois, and Connecticut. These hour-long calls and my reading got me started, and I began to come up with a plan for some next steps.

The major decision was that the primary focus for addiction treatment would involve recovery management and an ROSC. Recovery management has now become primary to how we deliver care to individuals with serious mental illness as well as addiction. Ultimately, we at Centerstone believe people can, and do, recover. We recognize recovery management and ROSC as catalysts that will advance this goal. Also key is building "partnerships" with consumers as a "way of being," rather than a collection of techniques. We create a genuine environment built on mutual respect that fosters recovery, that emphasizes helping individuals navigate those silos and in fact, creating a community of "silo busters" with our volunteers, mentors, coaches, staff, and community partners. Because we saw success with recovery management and ROSC within addiction, we have since moved these philosophies into other areas of behavioral health as well.

Bill White: How did the original vision of recovery-focused care develop within Centerstone?

Linda Grove-Paul: Like so many providers of addiction treatment, every year we are being asked to do more with less. Safety-net sources of funding, such as block grants, were the primary way we paid for care, but needs were outstripping those resources. It was clear that more people were "falling through the cracks."

If you consider this scenario from the point of view of a person coming to us for treatment: You just got out of jail today. You are being told by your parole officer that you have to go for a treatment evaluation. You are on house arrest. You don't yet have a job. You have a felony conviction on your record, making it that much more difficult to get a job. Now you have been assessed and told you have to go to an intensive outpatient treatment program three times a week. You are told you should go to 12-step meetings and put treatment first. This is a very typical scenario. So, if you are put into this situation you are likely thinking, "How am I going to do this? Get a job. Pay my fees for treatment. And, oh, by the way, you also have Hepatitis C and need medical attention." Often individuals in this situation also need Medicaid assistance to pay for their health care. Often they also need Section 8 or other assistance for housing. Frequently, the person has a child who is involved in the Department of Child Services, and so on.

We, as clinicians, seriously expect a person in this situation to be paying attention to us. Yet from day-one upon their release from prison, the way we "help" him/her is to advise the person on where to go or who to see. We give them more hoops to jump through. Just thinking about it all would make me want to quit.

I wanted to rethink how we work with people. I realized we needed to get staff out of the clinic and into the community. We ask consumers to navigate a system that is far too complex.

One of the first things we needed to do in order to become recovery management focused was to physically move staff from clinic locations to the community. We also had to start to make a business case for redesigning services. We had to show how the RM and ROSC approach would make better use of the resources we have available and how we could make changes without incurring additional expense. Because no one else in our state was doing this, we knew we would need to pilot a potential model of care that was more targeted, with better outcomes, and with greater emphasis on community partnerships.

So, with the help of the phone conversations through GLATTC and brainstorms about the current approach, we began to develop a broader framework for our system. We identified a four quadrant model (see Figure 1 below), which compares recovery capital need with treatment need. Using this model, individuals are placed in the appropriate clinic according to their reserves of recovery capital and their need of treatment. With this scenario, each assessment determines the person's treatment need in addition to recovery capital need. An individual who has low treatment need and low recovery capital gets services focusing more on building recovery capital, less on formal treatment. An individual with high treatment need and high recovery capital gets more treatment and less emphasis on building recovery capital.

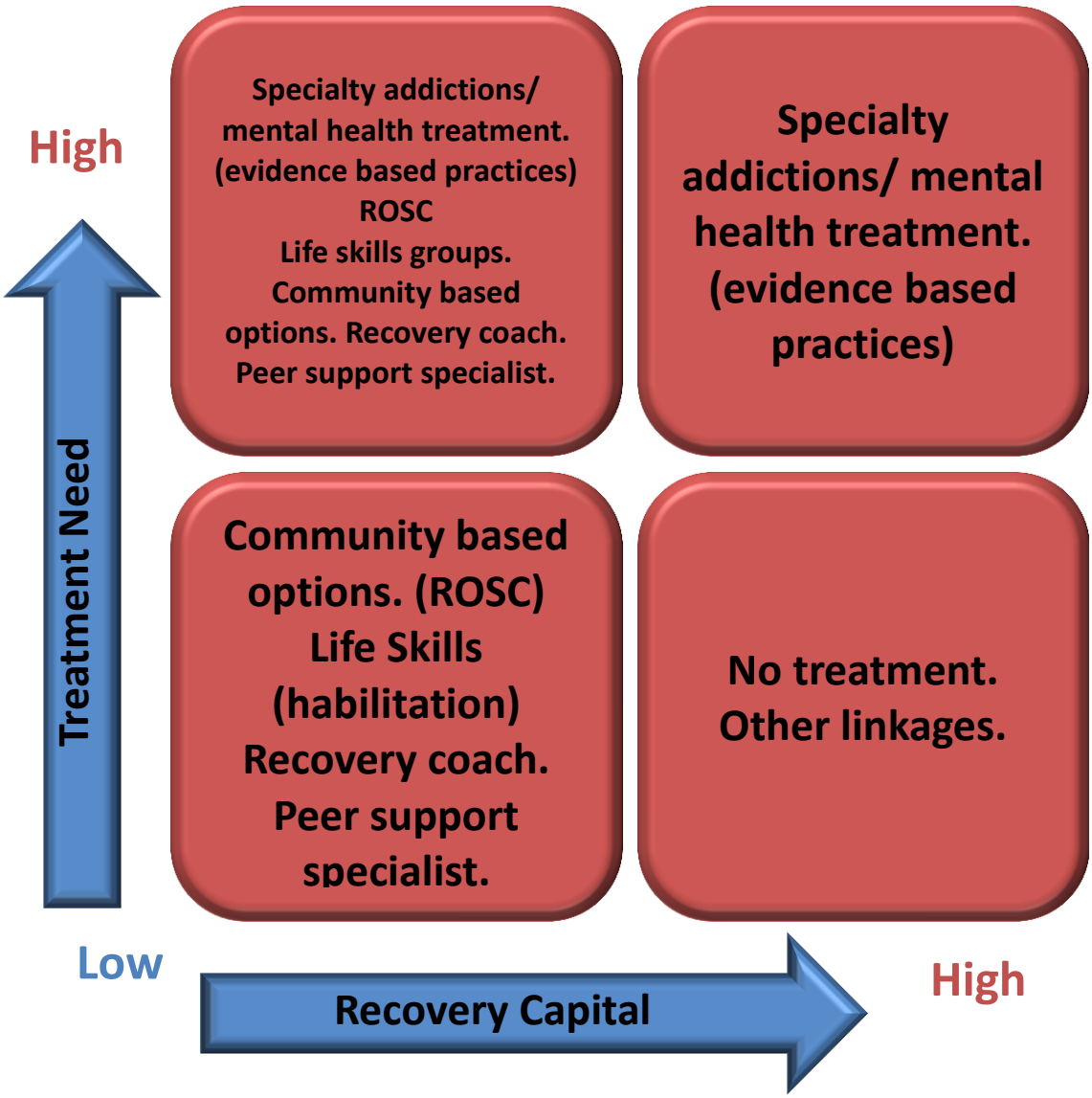

Figure 1

Identifying and diverting clients with higher recovery capital need to an ROSC model makes tremendous financial sense. By doing this, in essence Centerstone developed a triage model aimed at assessing and addressing client need in a more comprehensive fashion.

Most Centerstone clients are received through walk-in clinics. They are often court system referrals who have complex needs and would not be efficiently or effectively served by formal treatment first. So, by first placing emphasis on building a person's recovery capital, we build supports that allow for more effective treatment efforts. Conducting formal treatment without reinforcing a person's recovery capital at least concurrently undermines the intervention.

Using this model, the emphasis is placed on empowering clients to navigate their world in a self-sufficient manner. We help the person recognize the recovery capital they already have and build more recovery capital by equipping them with the information, tools, resources, life skills, and supports necessary for long-term recovery, such as the means to find a job or

meaningful work, housing, and other community resources. Not only does this model provide a more efficient use of resources allocated to recovery, it also changes how they enter and interact with these recovery systems.

Bill White: What were the major obstacles you encountered in trying to implement this vision?

Linda Grove-Paul: The first major obstacle was revising the philosophy of care. Not only did we implement a change in service delivery, down to the details of how notes are written and treatment plans developed, but we also changed the overall philosophy of care toward greater recovery orientation. We also had to take ourselves out of our own siloes. We had to work to integrate the entire community into one system of care. Additionally, we faced funding issues. The old model still received the majority of resources. Providing care the old way was incentivized by the traditional payment models. We had to obtain support from all levels within Centerstone. We had to have buy-in from clinicians to company leadership. We had to have support from key community stakeholders like the criminal justice system, the department of child services, the local healthcare system, and the 12-step community.

Fortunately, clients presented less of a challenge with buy-in—largely because this change in service provision is congruent with their reality. As you've stated in your writing, recovery management and ROSC is a real paradigm shift. Using this approach is a move away from the clinician as the expert to the client driving their own care. While we want services to be client driven, we haven't always been able to easily operate within payer requirements and other constraints, at least initially.The treatment planning process is very much insurance driven, so it is hard to ensure that you truly have a client-driven care plan that also includes all of the other information we are required to collect. We had to develop a recovery plan for the client outside of, or in addition to, the "treatment plan." This is a major change, and loss of control, for professionals who previously have driven the recovery process for the client.

In convincing partners to work with us on this community-based, client-driven philosophy, we had to ask them to take a leap of faith. Once we moved some recovery services into the community, it became easy for clinic partners to revert back to old philosophies and bad habits. Because of this, we've had to work with community partners constantly. But clients ultimately sell us on what works. They loved the recovery coaching element and the empowerment of having their own recovery plan. What we learned as we worked through a lot of these obstacles with team work, communication, integration and support, is that recovery management and ROSC is not a substitute for treatment. It is, instead, a complement to clinical care. It is a constant reminder that integration is the key to effective programming. Through recovery management and ROSC, we are learning that treatment can be delivered more efficiently, so we are able to serve more people with the same resources.

Bill White: What are some of the major program components that were added as a result of this shift in service philosophy?

Linda Grove-Paul: The most essential program component added to addiction services as a result of this shift has been recovery coaching. The goal of recovery coaching is to help people with substance use disorders (SUD) expand their recovery during and after treatment, which helps to prevent relapse. Recovery coaches work with people at all stages of readiness to change. Centerstone's recovery coaches use non-confrontational techniques to help build recovery capital. They help people develop or repair social support relationships. They ensure clients

obtain safe housing. They assist with setting and achieving employment goals. They assist with setting and achieving educational goals and financial goals. Recovery coaches also work with clients to build internal recovery capital by teaching coping skills, such as how to manage stress, anxiety, and depression.

At Centerstone, recovery coaches use evidenced-based techniques, including motivational interviewing, to reinforce treatment concepts and apply them within the community. Recovery coaches help remove barriers to recovery and coordinate services with other providers, so clients can carry out their plan for treatment. Typically, a recovery coach meets with an individual on a weekly basis. This might be over the phone, in person, or in a group. Recovery coaches provide follow-up and continued support, even for those who are stable in their recovery. Coaches work in a highly personalized way to help the individual meet his or her needs. For the most part, recovery coaches are located in the community and are rarely at their desks. Recovery coaches are trained as health navigators, as well, to ensure that all of the health needs of the individual are addressed. A major innovation in services involves the use of, and integration into service, online recovery tools. With these tools, coaches and clients are able to communicate, "check-in", plan, and assess the recovery process in real time.

Recovery Coaches are now embedded throughout our system, working with people of all ages within all of our teams. We have coaches that work with our severely mentally ill, children, residential services, with one of our FQHC partners, and within our clinics. For example, we have integrated coaching into adolescent treatment to assist in the reinforcement of the skills learned in counseling sessions. The coach, in this example, may have been in a session where the client discussed fun alternatives to substance use. The coach will also work with the adolescent outside of group to reinforce the new, healthy habit. Using this approach of reinforcement has been very successful.

Another essential component of the shift to recovery management is the use of volunteers. Many support groups are offered through volunteers at recovery engagement centers. Life skills training groups, focusing specific, targeted skills to meet recovery capital needs, such as sober living skills, early recovery health and wellness, family and healthy relationships, and employment skills are provided with the assistance of volunteers. Many services are offered because of support from volunteers and mentors rather than staff. This model of peer supports helps us quickly work with people in the beginning of their recovery journey and then transition them to other supports.

Bill White: What changes in service practice occurred as a result of moving toward a recovery management model of care?

Linda Grove-Paul: The overall goal for recovery management is to shift from formal intensive services to sustained recovery in the community. This means that our overall philosophy is to organize ourselves, our services, and our community to help clients immediately transition from intensive institutional, paid, formal supports, to natural, long-term, community-based support. If we are to be successful with our limited resources, our high demand, and the great need of our clientele and our communities, this is the only way we will be successful.

With this community-based, client-driven recovery management model of care, Centerstone's focus is on meeting the client where they are when they walk through our door. That means whether it's been one day's worth of sobriety or three years, we provide continued support and early re-engagement in a non-stigmatizing setting. Services integrate a holistic

approach to care. In tending to both the mind and the body, we make sure we work with each person to develop an individualized, strengths-based recovery plan that involves family and other allies. Centerstone offers a comprehensive menu of services across the lifespan. Clients can access them whenever they need.

Additionally, we have anchored our system of care in the community through developing mutually beneficial collaborations with other organizations and groups. With more community involvement comes more community ownership. Because of this emphasis on community, we now have over 100 volunteers actively engaged in the program. Having so many volunteers and community participants allows us to serve more people, provide more support groups, and make programming that much more robust. In fact, becoming a volunteer is a major milestone for many people in recovery. Also by investing in the community, clients are empowered, volunteers are empowered, and coaches are empowered. It is really a "train the trainer" kind of model. If you have a solid infrastructure with good support, then all you need to do is give your staff, clients, and volunteers the tools and support within a framework and then get out of their way.

Bill White: How would you describe the response of staff to the changes that have been implemented?

Linda Grove-Paul: This shift in thinking has been a real work in progress. Philosophically, people in behavioral health care tend to believe that we are already embracing client-driven care and recovery management in philosophy and in practice. So, in theory, the staff response has been that they are 100% behind the change. But the reality is that when it comes down to truly handing over care to the consumer, it becomes much more difficult. In large part, this is because of the way our systems have been created. Barriers are created due to funding, training, and accreditation. Whereas the current system tends to honor the traditional method of practice in which a hierarchical model is used and the clinician is the expert, recovery management principles make us move toward a flatter model of equality. In the new model, the consumer is the expert and driver of his or her own care. Implementing this shift can and has been difficult, but getting staff buy-in is absolutely critical to success.

One of the very first things we did when we introduced this concept was to put forward a questionnaire for staff to complete with consumers. Questions were asked about what was working well and what wasn't working well. The answers we found were really eye-opening. As it turned out, consumers did not feel as empowered as clinicians thought they were. Clients didn't feel they had a lot of say in their own recovery or treatment plan. By tapping into exactly how consumers felt, rather than just sending messages from organization leadership or literature, we were able to allow staff to hear their feedback, buy-in to the process, and fully commit to implementing recovery management and ROSC philosophies in practice.

Another tool that we have used is the integration of key metrics and continuous quality measurement of both staff and consumers to ensure that we are moving in the direction that we have committed. One of the ways that we have done that initially with adult severely mentally ill clients is through utilizing the Recovery Tools from the Mental Health Center of Denver. The two tools that we are using are the RMI (Recovery Marker Inventory) and the CMI (Consumer Marker Inventory). RMI is the clinician's rating of the consumer on eight objective factors associated with recovery. In other words, when a person is moving forward in his/her recovery, these factors tend to be affected and the clinician can see how the consumer is progressing. The

consumer also completes a CMI to record their perception of recovery. These tools help to facilitate a critical conversation that creates a partnership. As we have moved forward with these kinds of tools, the client is truly the driver, and the clinicians are so very excited about their work. Clients have never been more empowered, thus recovery management is really transforming our culture.

Bill White: What has been the response of the individuals and families you serve to the changes in program philosophy and services?

Linda Grove-Paul: We really wanted to get consumers on board and advise us in the process. When we asked consumers and their families to participate, they were really excited, flattered, and honestly, I think, flabbergasted because traditionally we hadn't sought their opinion. As I mentioned, conventional wisdom is that "we" are the experts and "they" are the consumers – but really, "they" are the experts of themselves and the services they seek.

The idea is that these are their services. What we found is that families are very open with their responses and appreciative of our interest in them. The change began to snowball from there. Of course, there has been a vast array of opinions about how this change should take place. We continue to make change internally to address issues of bureaucracy. But for the community-based piece to truly be successful, we need consumers to help start a recovery engagement center and then take control and run it. The response we've seen as a result has been absolutely amazing. Since we made sure consumers felt ownership from the very beginning, we're now able to build consumer councils and other consumer opportunities that inform different service areas within the organization.

Bill White: Could you describe the Recovery Engagement Center?

Linda Grove-Paul: A recovery engagement center, known as REC, is a low barrier community center for someone who is seeking recovery. It is intended to be a walk-in center, in the community, that is warm, welcoming and non-threatening. An individual who needs to find resources, help, or just a cup of coffee can drop in and feel welcome. The goal of a REC is to be a hub for recovery and to serve as a clearing house for recovery resources for the community. This is a place where faith-based providers can have events, 12-step meetings can occur, treatment referrals can be made, and so forth. The point of the REC is that a consumer is met by a warm and welcoming person who gives him or her hope that recovery is possible right now. We have the resources available today to assist them to take the next step. It is a collective effort built through collaboration with community members. The goal is to create a clearinghouse of information, support, and resources for individuals coping with addiction and substance abuse issues.

A REC is volunteer-driven. It is a place where people can connect with others and get care and resources to enhance recovery and prevent relapse. It is low barrier, meaning you can come in without an appointment and it feels safe and hopefully, like home. Also, there is no expectation of a period of sobriety so you are not turned away if you only have a day clean. Honestly, this was a big stumbling block initially because this was a big change. But with the amazing volunteers and mentors we have on site and the respect that is given to the consumers by the volunteers, mentors and staff, we have found that our consumers do not abuse. If you give respect, you get respect.

Unlike many other engagement centers and recovery management endeavors that serve a more urban population, such as in Philadelphia and Connecticut, we had to adapt to fit our small towns and rural environments. That has shaped the way we have structured our start up, such as how we use recovery coaches as the backbone of our REC. They have been integral to the startup of all three RECs. The idea is that we need to help put the infrastructure in place, bring the stake holders together, and provide support up front. The coaches not only bring in the community (as they are the community navigators,) but they bring in the consumer/leaders and volunteers.

Centerstone communities have three REC locations right now: Bloomington, Richmond, and Bedford. So far, more than 5,000 people come in and out of REC locations for service every year. Each REC is different, depending on community need and volunteer participation. A REC is really about volunteers and ownership.

Bill White: Describe the E-ROSC in more detail.

Linda Grove-Paul: The electronic recovery engagement center (E-ROSC) was developed to address the needs of underserved individuals with SUD in south central Indiana. While a local recovery engagement center can be a hub for individuals in a larger community, the rural nature of so much of south central Indiana still left a large population of people who have transportation issues and other barriers to treatment. Equally, many people who could benefit from treatment are reluctant to walk through the front door of a Recovery Engagement Center. It's that same old stigma we face every day. At the same time, our staff was operating near capacity, knowing that we were falling short of meeting demand. Seeing the challenges and unmet need, Centerstone applied for and was awarded a SAMHSA grant to develop and implement a web-based, recovery-oriented system of care.

Working with White Pine Systems, we developed a website and virtual recovery engagement center that we call the "Electronic Recovery Oriented System of Care" or "E-ROSC". The E-ROSC is an electronic extension of our successful in person ROSC program. E-ROSC offers a way to engage rural participants with a recovery coach and track their progress while connecting them to community resources and others in recovery. The targeted population of E-ROSC is adults, aged 18 and over, who have SUD, reside in identified rural underserved counties, and have recently been released from incarceration. These populations were selected primarily because of identified need and direct request of resource partners in county criminal justice. Other specific identified issues among this population included transportation needs, failure to engage in traditional treatment, physical barriers to participation in treatment and community support, and the stigma of seeking treatment.

E-ROSC uses recovery management and recovery-oriented system of care approaches along with technological enhancements to create and maintain services and relationships that eliminate barriers and silos. E-ROSC provides the appropriate level of formal treatment, while working to build a sustainable network of community support. E-ROSC participants are guided by a recovery coach. The recovery coach helps participants develop an individualized recovery plan, including targeted formal addiction and mental health treatment as well as community support services outside the scope of traditional "treatment." Just as in a physical ROSC environment, the approach creates wraparound teams of support.

E-ROSC capitalizes on technology to increase treatment access and helps individuals track information about their care. E-ROSC tools also aid in achieving recovery goals by

assisting in the sharing of information instantly between recovery coach and other care providers. Additionally, Centerstone ROSC staff have seen the power and potential of more robust health information technology in reaching vulnerable individuals. They have found that members of the focus population are ready to be engaged. E-ROSC can also give special attention to focused cultural needs of a population, such as the drug use trends of a particular racial or ethnic group, the criminal activity amplified by socioeconomic distress, or criminal activity influenced by substance abuse, trauma, or mental illness.

The website, v-recover.com, provides three major elements. The first is public access to a virtual recovery engagement center that includes a volunteer and staff discussion board, a resources page, an events calendar, and pages providing general information on recovery engagement centers and the ROSC service model. The second element is a private site, which requires a specific login and password and contains individualized participant recovery tools. Tools in the private site include a recovery capital scale assessment (which is a tremendous tool that you developed); a personalized, self-determined recovery plan completed with a recovery coach; and Telephonic Monitoring and Adaptive Counseling (TMAC)—an evidence-based approach that our coaches are utilizing with our clients to track a person's progress towards recovery through weekly updates and scores. The third element is a personal health record that allows people to manage and share all of their personal health information. This personal health record helps people coordinate all of their care, both behavioral and physical, through one system. As with all other elements of this ROSC orientation, the process and goals are client driven so buy-in at each level comes more naturally. Additionally, the technological advancements allow for increased coordination between community supports and observable progressions toward client defined goals.

Education and outreach throughout targeted communities continues to be a primary focus for E-ROSC. We continue to explore new collaborative relationships with community agencies and other civic-oriented organizations and caregivers. Part of the reason for this is that the development of cultural capital, even within a service delivery model that focuses on the individual, also should facilitate an inclusive and respectful approach and include the voices of consumers, their families, and their communities.

Bill White: Describe the recovery support assessment and recovery planning process.

Linda Grove-Paul: Since the overall goal for recovery management is to shift from formal intensive services to sustained recovery in the community, clients need to be much more involved in the process. Clients, therefore, determine their own recovery and life goals with the assistance of a recovery coach. Electronic clinical tools are used to assist in tracking progress toward achieving them. The neat thing about using online technology in this way is that it is a low-barrier approach that not only offers an access point for formal treatment options, but also more comprehensive and community specific support services. It also allows clients to determine their own service menu choices. This focus on empowering the individual is integrated throughout and spans multiple service delivery silos. It also enhances access to behavioral health treatment among individuals living in underserved rural areas.

In the recovery tools component of E-ROSC, people can answer their weekly questionnaires, which are then scored by the recovery coaches. In fact, the E-ROSC system calculates most scores automatically, so all the recovery coach has to do is review or edit them. These are then used along with a completed recovery capital scale to form a personalized

recovery plan. Conducted on a weekly basis, either in-person or over the phone until the client transitions to less intensive services, the TMAC questionnaire provides clients and recovery coaches important insights on progress toward recovery goals. Also included are assessed risk factors and protective factors against relapse. Self-assessment data comes from different life domains such as: career/education; leisure/recreation; independence from legal problems and institutions; financial independence; drug/alcohol recovery; relationships/social support; medical health; and mental wellness/spirituality/self-efficacy. Data collected triggers a flag for domains that are of strong risk or protective factors to help clients and coaches work together to prioritize recovery objectives. E-ROSC's online recovery plan also provides an area to record drug of choice, data on abstinence, as well as usage, and high-risk behavior.

By using the recovery capital scale and TMAC to formulate a recovery plan, coaches empower clients to problem-solve using a strength-based approach. Through the process of creating their own recovery plan, clients must think through and document the actions necessary to achieve their goals. Both clients and coaches work as partners, update the plan continually, and track progress toward achieving goals. One example of how this works is that clients can indicate when they have completed certain action steps. This translates into a visual progress report, which is also available on the client's personal dashboard when he or she logs into the private portion of the site. So, the recovery plan is an evolving document. It tracks goals accomplished as well as ongoing struggles. It allows the client and recovery coach to adjust treatment and use various case management strategies as needs evolve, goals are accomplished, and life circumstances change.

Ultimately the E-ROSC platform is intended to provide our structural foundation for the expansion of comprehensive services available to our clients electronically. We are continuing to add services, like an employment module for offenders through a Department of Labor grant we received, for example, that will link to this, to continue to add value to our consumers and provide critical data to our payors.

Bill White: How do volunteers fit into the system of care that is evolving?

Linda Grove-Paul: Volunteers are an integral aspect of ROSC. Becoming a volunteer, particularly in the E-ROSC system, is a major milestone for folks in recovery. They view it as a real accomplishment and honor to receive this responsibility, authority, and expectation. They assist in advocacy, awareness, and interaction. At Centerstone, a REC divides tasks into core areas but also utilizes a tier system to facilitate a progressive volunteer experience. Volunteers in more intensive areas must have a minimum of six months or more of sobriety. Those who have not met this minimum can still assist the community through other tasks such as facility cleaning, grounds keeping, or inventory coordination. Top tier volunteers operate within the same standards, procedures, policies, and boundaries as coaches and mentors. All are focused on providing a recovery-friendly environment.

With respect to E-ROSC, volunteers write posts for the community blog, maintain the REC's public calendar, and even monitor the "Talk to us now" feature, where people who need someone to talk to can chat privately with a volunteer online. Each of these needs appropriate training, and contribute value for the individual, for the REC, and for the community.

Volunteers also work to support the center based upon their strengths and areas of interest. Through a professional, recovery-oriented approach, volunteers are able to provide individualized support for an array of needs. But essentially, volunteers are self-sufficient,

providing a variety of options for people who need services at REC. Volunteers, of course, are not limited to the services we have at specific locations. We have individuals who want to volunteer for IT, marketing, re-entry, job placement, gardening, community speaking, and fundraising. You name it and, frankly, if they have an interest in it and we can accommodate them, then we will. The reality is that most of the services we offer at our various locations are shaped by the volunteers we have and the interests and passions of the volunteers and clients at the various locations.

A recovery-oriented system of care stresses the inclusion of recovering individuals in service provision, placing emphasis on their experiences and knowledge. At Centerstone, this is achieved through peer-based services designed to extend treatment efforts toward long-term interventions. By utilizing people who themselves are recovering from the same identified condition, recovery mentors interact with ROSC program participants as peer supports and role models. These volunteers have demonstrated the ability to maintain recovery for at least three years, and their personal recovery must continue to take priority. Recovery mentors cannot be on probation, parole or in drug court or have committed a criminal offense within the past three years. Recovery mentors have been trained and have passed a volunteer orientation course as well as a series of tests on confidentiality, safety, and ethics. Recovery mentors have also completed 90 days of on-the-job training. These are just a few examples of some of the volunteers though. I want to be clear from the outset that our volunteers at REC are not necessarily connected with Centerstone, just like many of the folks who regularly use our services. From the beginning, we have made it clear that there is a place for everyone regardless of their involvement with Centerstone. We know that we are not the be all, end all for recovery. We just want to create a safe place for recovery to begin and connections to be made, know we don't have all of the answers.

This use of mentors and volunteers provides two beneficial elements for ROSC participants. First, from their initial day of intervention, consumers are immediately connected to persons of recovery. This creates a connection point to pro-social community supports. It is a solid option for persons with low treatment need and high recovery capital need (see Figure 1). This style of service also allows consumers an atmosphere where they can relate and feel understood. Moreover, peer-based services provide hope in a tangible form and a model for successful recovery. Consumers see an eventual opportunity to go from being in need to supporting others in need. This fuels purpose-driven actions and places consumers into a role of providing. It is an added protective factor that not only gives purpose, but increases confidence and pride.

Bill White: You have recently begun integrating RM principles into your children and adolescent services. What have you learned to date through this process?

Linda Grove-Paul: Operating within the evidence-based curriculum of the Adolescent Community Reinforcement Approach (ACRA), recovery coaches are now also involved with children and adolescent services to reinforce treatment by applying these same concepts within the community. Much like adult recovery coaches, adolescent coaches help remove barriers for recovery and help coordinate services with Centerstone. They also help decrease risk factors and build recovery capital.

Centerstone has also made a commitment to youth throughout their entire recovery process, not just a 3-day or six-week period. Recovery coaches are placed with Department of Child and Family Services (DCFS) families who have gone through traditional addiction services, such as an IOP, but have not been successful. Tension is sometimes encountered with DCFS because addiction policies can be inflexible. For example, if a parent misses three groups, or has a drug test come back "dirty," it is considered a treatment failure. If a parent fails treatment, they are moved down the line of losing custody of their children. Still, DCFS is reluctant to remove a child, even if a parent isn't completely "clean." So, the challenge is to get a recovery coach involved with the family so we can reduce the overall potential harm of the situation.

Overall, we are integrating the use of coaches throughout various departments, from addictions to SMI. A coach can best represent a child's team. The same is true with adolescents. By using coaches, we are really reinforcing the matrix model and doing a lot of skills building. With recovery coaches, we can spend more time on building skills and imparting more productive alternatives instead of just telling them not to use.

Closing Reflections

Bill White: How do you envision the future of this transformation process? What areas do you see as the most fertile for future development?

Linda Grove-Paul: I can see lots of opportunities using recovery management and recovery-oriented systems of care models. In particular, I think these models offer great potential solutions for what we, in the mental health profession, call "safety net populations." At Centerstone, our whole platform is based on your Recovery-Oriented System of Care model. I really believe you have identified a philosophy and approach that works well. The way Centerstone has brought communities together has been cheap, replicable, and doable in any region. If people have this same vision, instead of moving in so many different directions, we can all move together toward the same goal. That is very empowering to the community as a whole.

Where we need to go next is to develop a way to demonstrate the value of this approach and this scale. It is especially important to demonstrate this value to payers and entities like SAMHSA. What we still have to create is uniformity in how data is collected, outcomes are presented, and reimbursements are made. With formalized, uniform metrics and outcomes, we can show that we are reaching "safety net populations" and improving the delivery of behavioral healthcare, thus creating real, sustainable community solutions. We are doing this in partnership with CRI's Center for Clinical Excellence. Ultimately, I hope that this work will eventually transform some of the horribly fragmented aspects of current care and result in removal of unacceptable barriers to recovery in our culture today. By sharing the powerful recovery stories of our clients, while also demonstrating the cost-effectiveness of our approach, we can communicate a critical message of <u>hope</u> to healthcare policymakers, providers, payers and, most importantly, the people in our communities who desperately need access to these lifesaving services.

Bill White: As you look back over this recovery-focused transformation process at Centerstone, what do you feel best about?

Linda Grove-Paul: When I think about the community that has been created through this recovery-focused transformation process, I feel like we have accomplished something great. I think about the "Pay-it-Forward" aspect. So many consumers have become volunteers and certified peer mentors, recovery coaches, staff members. A person gets out of jail today and can go to a REC, see a volunteer, and not only get the help they need today, but become a volunteer himself or herself. He or she can start feeling good about giving back right then and there. What really could have been a disaster, dismantling of services, further siloing, became an opportunity for us to become integral members of our community.

This approach has created so many services and activities that touch people in need. A community has been created with a whole new level of hope and opportunity. It didn't really exist before. And I feel so much more connected to my community than I ever have been. I know this work will continue to develop and grow and reach more people throughout the communities we serve. The author of The Road Less Traveled, psychiatrist Scott Peck, MD, once wrote "In community lies the salvation of the world." And when you focus your work on the powerful impact that true community can have, the sky is the limit for what we can achieve in making all of our lives better and reaching our true potential as individuals, regardless of what we have been through. I am just so touched by this amazing community. I am truly honored to be a part of it.

Bill White: Linda, thank you for taking the time to share your experience about the application of recovery management principles on the front lines of addiction treatment and recovery support. For additional information related to this discussion, see **www.v-recover.com**

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