Prevention and Recovery - The Cornerstones of Success

The evolution of a science

…where prevention and recovery strengthen treatment !

Michael T. Flaherty, Ph.D.
Clinical Psychologist
Founder – Institute for Research, Education and Training in the Addictions (IRETA)
Pittsburgh, Pennsylvania
&
Ted N. Strader
Executive Director
Council on Prevention and Education: Substances
Louisville, Kentucky

December 6, 2012
Webinar
SAMHSA/Great Lakes ATTC

Gratitude

SAMHSA Region 5

Great Lakes ATTC – ATTC Network

National Prevention Network

NASADAD

SAMHSA/CSAP

Institute for Research, Education and Training in the Addictions

Council on Prevention & Education:Substances

Core Questions ...

How does our emerging science of prevention, intervention, treatment and recovery now inform or define best practice in each?

How do we bring this continuum together in our daily practice, i.e. how do we integrate care?

Why Prevention is the Cornerstone of Treatment

Why Prevention is a critical important component in addressing SU and SUD and recovery.

Why Prevention's value is MUCH greater to our society than currently estimated.

How we can implement and show this to all stakeholders, i.e. within a recovery perspective, prevention matters most!

Why Recovery is a Cornerstone of Treatment

We will ask ourselves why we do what we do with each person, family and in our community?

What is the purpose of your work?

In addressing the illness are we focusing enough on providing the tools to attain and sustain remission and wellness?

Why Recovery is a Cornerstone of Treatment

- Recovery from Mental Health and Substance Use Disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their potential - delineated over four dimensions: Health, Home, Purpose and Community (SAMHSA 2012).

- What achieves wellness from an illness is one of the greatest insights into how to prevent the illness in the first place, and how to treat it pro-actively in each person , e.g. diabetes, hypertension, depression, HIV/AIDS.

- Recovery is a component science on to itself for addressing SU, SUD and addiction with the capacity to strengthen each part of the continuum in practice, e.g. Beck et al (CT-R), 2012.

Our Prevention work here will include reviews of:

Proposed 2014-2015 SAMHSA Block Grant Application

National Prevention Strategy

SAMHSA Strategic Prevention Network – Partnerships for Success II

SAMHSA Strategic Prevention Framework

Patient Protection & Affordable Care Act 2010

NIDA Prevention Principles

Our Recovery work here will include reviews of:

- SAMHSA's work and evolving definitions of recovery
- SAMHSA Recovery-Oriented Systems of Care (ROSC) Resource Guide (2011)
- The Role of recovery Support Services in Recovery-Oriented Systems of Care (2008)
- Numerous ATTC Published Monographs documenting the birth and evolution of recovery focused care, contributions of William White and over 100 peer reviewed articles on recovery, et al.

Our Treatment work here will include reviews of:

SAMHSA CSAT Principles of Recovery

Elements of a Recovery-Oriented System of Care

ROSC as the extension of proven and best practice (e.g. CBT, MET, MSR)

An outline for a refined “medical model” based on our above analysis.

We will most importantly:

- ... refine and integrate our understanding of the illness we seek to prevent based on current best science and lived experience thereby making our work more relevant, adoptable, scientific, accountable and effective via the an evolved *medical model .*

(ask: what to do when evolution moves beyond proven science? How can communities embrace our work?)

We will most importantly:

Let the illness and how we prevent and attain and sustain individual, family and community wellness and recovery from it educate us.

This is simultaneously: Person Centered Care Family/Community Centered Prevention

The Evolving *Paradigm* of Treatment of Addiction

The history of the addictions field has been one of evolving paradigms (organizing constructs, evolving core technologies, and evolving definitions of the field's niche in the larger culture whose needs it must serve.

- William White, Recovery Management, GLATTC, 2006

Evolution of Models that Underlie our Approaches to Addiction Today

- Moral Model
- Temperance Model
- Spiritual Model
- Education Model
- Characterological/Personality Model
- Conditioning Model
- Socio-Cultural Model
- Social Learning Model

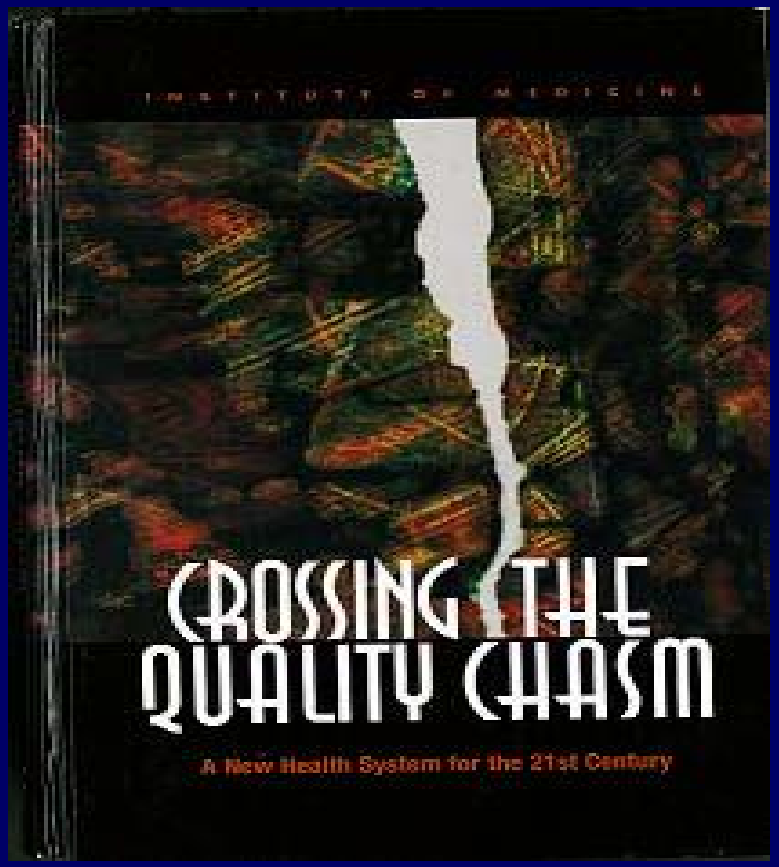
Evolution of Models that Underlie our Approaches to Addiction
(Continued)

- Cognitive Model
- Biological Model
- Psychological Model
- Disease Model
- Systems Model
- Public Health Model
- Bio-Psycho-Social (Spiritual) Model

The Pathology Paradigm

ALL focused on the pathology and ALL from an understanding of the illness to be acute in nature – like a broken arm, cold, flu, pneumonia, etc.

A paradigm begins to shift … by accident (2001)



Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, D.C.: National Academy Press.

IOM -2001

- "The American health care delivery is in need of fundamental change." (p.1)
- Too often patients do not receive the care that meets their needs and is based on best scientific knowledge."(p.1)
- "Health care today harms too frequently and routinely fails to deliver its potential benefits." (p.1)

IOM - 2001

- Care should be patient or *person centered* and encompass qualities of compassion, empathy, and responsiveness to the needs, values and expressed preferences of the individual patient; care should be integrated and involve family and friends, etc. (pp.48-51)

- Health care for chronic conditions is very different that care for acute episodic illnesses...carefully designed, evidence based care processes, supported by automated clinical information and decision support systems, offer the greatest promise of achieving the best outcomes from care for chronic conditions.

IOM – 2001 … the accident

- Criteria for defining priority conditions: prevalence, burden of illness, cost, variability in practice, and potential to improve outcomes or reduce costs.(p.103)
- This would rank cancer, diabetes, emphysema, high cholesterol, HIV.AIDS, hypertension, ischemic heart disease, stroke, arthritis, asthma, gall bladder disease, stomach ulcers, and back problems of any kind as the leading chronic illnesses to be addressed .(p.103)
- No SU or SUD or Addiction!

Drug Dependence, a Chronic Medical Illness: Implications for Prevention, Treatment, Insurance, and Outcomes Evaluation

McLellan, Lewis, O'Brien, Kleber

JAMA, 4 October 2000

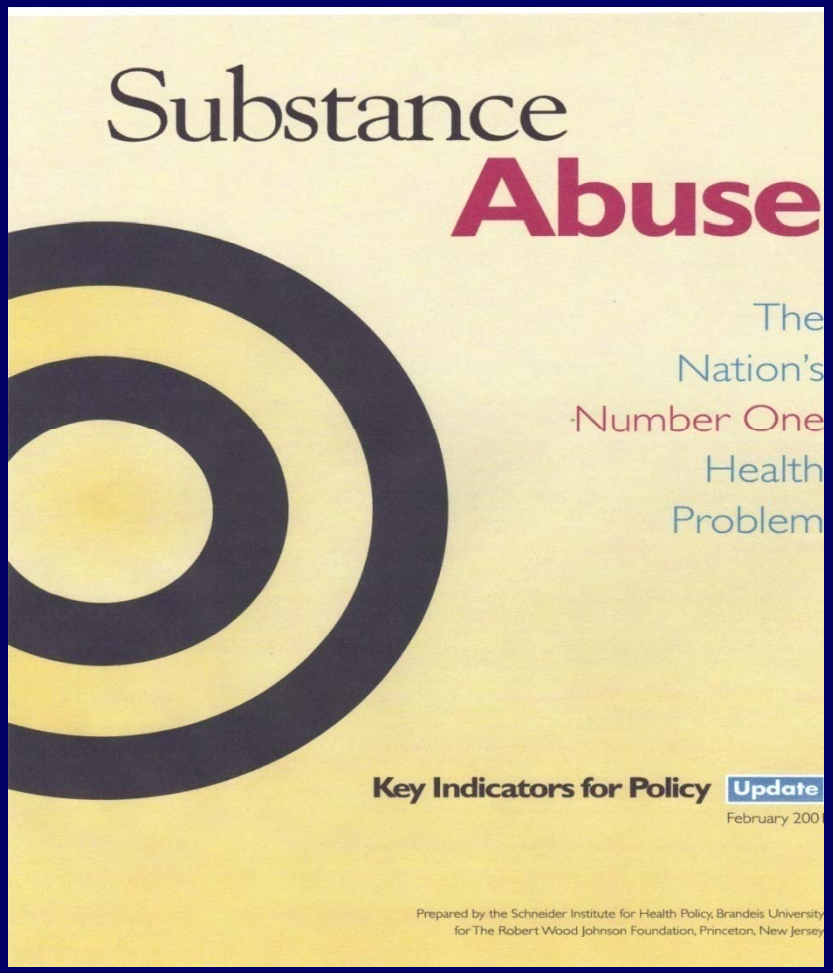
"Drug dependence should be insured, treated, and evaluated like other chronic illnesses."

A Continued False Reality ?

In short, America has been treating a major health problem – substance prevention, use and dependence – with an approach not appropriate to the illness! Many of our systems still do, e.g. unique episodes of care, payment methodologies for acute care, lifetime limits on treatment, prevent or cure and be done, absence of continuing care

Many of our systems, practices and payment methodologies still define the illness as acute!

America's #1 Health Problem ...ambivalence!

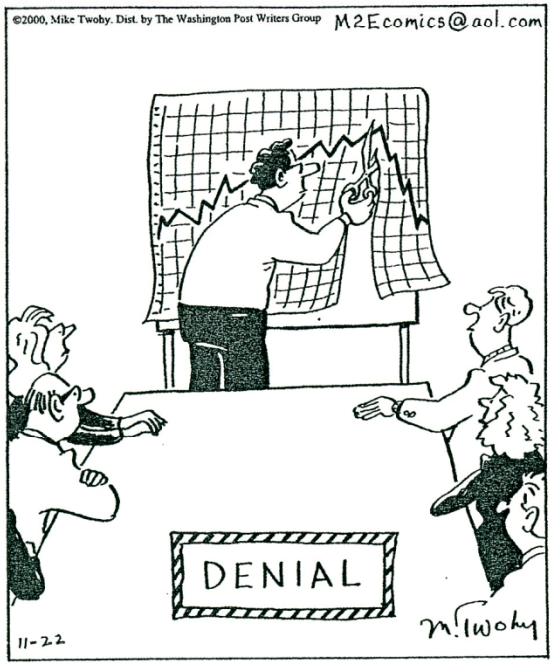


Substance Abuse - #1 Health Problem in America!

- There are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition.

- The abuse of alcohol, tobacco and illicit drugs places an enormous burden on the country. It is the Nation's number one health problem straining the health care system and contributing to the deaths of millions of American's every year and to the cost of health care. It harms family life, the country and public safety. It gives our children and youth a poor start in life while disproportionately affecting the disadvantaged and costs billions of dollars annually.

Societal Denial



IOM – 2001 and 2012

- Chronic conditions are defined as illnesses that last longer than 3 months and are not self limiting, and are now the leading cause of illness, disability, and death in this country. (IOM, 2001, p.16)
  - influenced by genetic heritability, personal, family and environmental risk factors
  - have a defined, progressive trajectory
  - are influenced by behavioral choices & neurobiological changes in the brain that can weaken those choices.

- The IOM and CCC cites that fewer than half of U.S. patients with chronic conditions are receiving appropriate treatment. (IOM, 2001; Wagner, Health Affairs,2001)

- The cost of this inexact model of care is “staggering” (IOM,2001) to our economy; initial estimates begin at $750 billion lost annually up to $1.3 trillion with prevention failures accounting alone for $55 billion or 7.3% of whatever figure is used. (IOM, 2012)

Experts on an "illness" gathered to respond: Is SUD a chronic condition? If so, Does our system address it as such?

"our approach and service model remains one built on an acute (episodic) illness of specific duration and unique payment methods tied to that acute model." (Special Report, 2006)

Participants included experts in all areas of SU Prevention, Treatment and Recovery

- Major *consensus* conclusions:

  - Substance dependence is best understood and approached as an illness potentially chronic in nature.

  - Approaches to the illness at this time – at any level – policy, research, prevention, treatment, funding, et al, do not reflect the scientific understanding of chronic illnesses themselves nor of how this chronic illness can be prevented and treated and how recovery is attained and sustained.

  - Today in America SU is still addressed as an acute illness, within separate models of prevention and restricted episodes of fee-for-service care whose subsequent poor outcomes have lead to increased societal stigma of individuals and families and more costly, punitive indignation for an illness.

The Chronic Model/Understanding emerges and changes Paradigm …

- "Substance use disorders for many, if not most, do meet the criteria to be a chronic health condition. In fact, they expand our awareness of how to prevent and treat all chronic illnesses by showing new ways of providing self-care and peer supports that are only beginning to emerge in other chronic conditions. (Wagner, IRETA, 2006)

- F. (p.6) Care will recognize that effective self-care, prevention, intervention and recovery support and management strategies are complimentary and necessary to address the illness in an ongoing manner. Together these strategies can *prevent* the development of incident (new cases) while decreasing the impact of current use for individuals, families and communities, preventing the advancement of the illness to more advanced stages in both individuals and communities while removing barriers to attained measureable whole wellness and recovery for all. (IRETA, 2006, Principles of CC in SU, p.6 (updated))

In a Chronic Disease Model – the Illness Informs its Cure!

- The overall focus of a chronic model is to prevent and address substance use disorders while focusing on individual recovery within a client's family and community in a culturally relevant manner with the fullest recovery support possible. (p.8)
- As with all chronic illnesses addressed within a public health approach instead of just dealing with an individual's illness we use that illness to inform us of how to build resiliency, wellness and recovery in the individual and in the family and community from the illness.

How the Illness Informs the Cure

- This new chronic model mandates a scientifically and experientially full, interacting *continuum of care that can* address the illness in any manifestation: *prevention – early identification/intervention – treatment ... all surrounded by measured wellness, resiliency and recovery.*

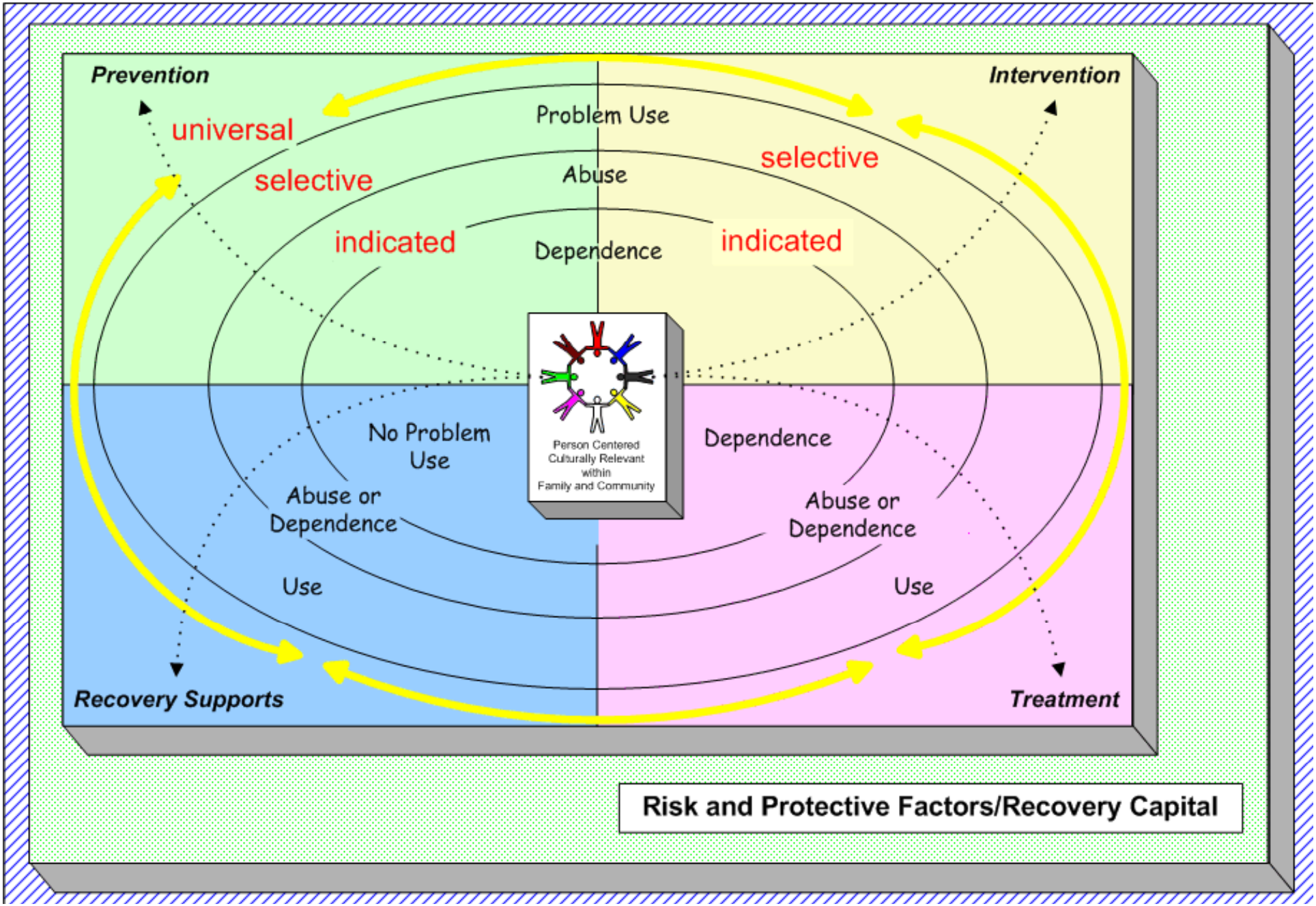
- This new chronic model that address both the pathology and its recovery is not a contradiction to the existing medical model but is in reality the *evolution* of it reflecting the emerging parallel attitudes about the illness and those suffering it now held by consumers, families and communities while eradicating stigma and going beyond person centered care and to be included in the improvement of community's health. (See: *Psychiatric Services* March and May, 2012)

A Chronic Model understanding establishes Prevention's role at all levels addressing an illness

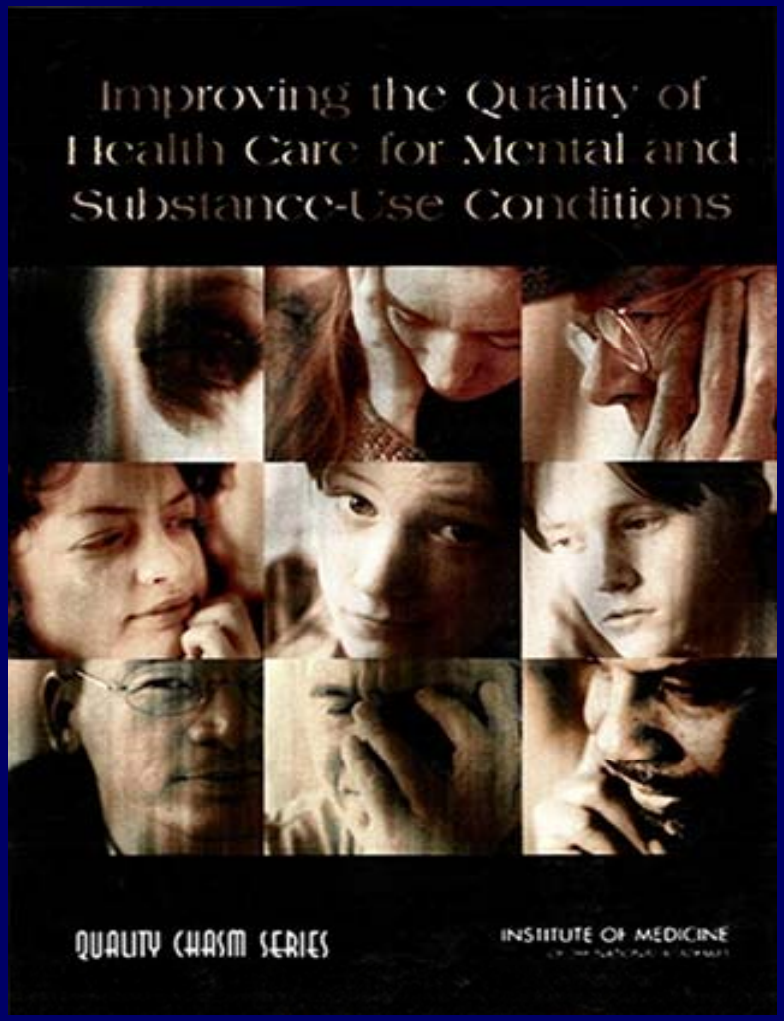
Nothing is more valuable in a chronic understanding of an illness than prevention of the illness in the first place. Next comes the prevention of its early manifestation (intervention) or full presence and severity (treatment). Related conditions and addressing achievable individual, family and community wellness must be included. All policy makers, providers, and those individuals, their families and community have a stake in applying this understanding which is fundamentally applied prevention at the universal, selective and indicated level *simultaneously and continuously.*

A Recovery and Wellness-Based Model for the Prevention and Management Substance Use Disorders

Building the Foundation



IOM Report - 2006



Institute of Medicine. (2006). *Improving the Quality of Healthcare for Mental and Substance-Use Conditions.* Washington, DC: National Academies Press.

IOM 2006

- MH and SU conditions are the leading cause of combined disability and death among women and the second highest among men. (p.1) These illnesses are often more complicated than others needing continuing care. (p.11)

- Each year 33 million Americans use the health care system for MH or SU treatment ...with consequences for individuals, families and the nation as a whole. (p.30)

The Concept of Recovery is born to the Science!

- ...a person (with these more complex disorders) can recover even though the illness is not “cured” .... Recovery is a way of living a satisfying, hopeful, and contributing life even within limitations caused by the illness. (p.32)
- Recovery is the accepted goal ... of all treatment for all individuals with M/SU problems and illnesses. (p.32)

IOM 2006 and the chronic nature of the illness

- The Chronic Care Model has been applied successfully to the treatment of chronic depression and chronic SU making patients themselves the principle caregivers. (p.121-122).
- The Committee calls attention to the Chronic Care Model for use in treating these patients. (p.241) This models fits well with primary care settings, general hospital care, integrated delivery systems and general health settings and where communities seek better coordination and quality of care. (p.242)

So how then does Prevention a Cornerstone of Recovery?

- Prevention creates communities in which people have a quality of life including healthy environments at work and in school; supportive communities and neighborhoods; connection to families and friends and an environment which is free of alcohol, tobacco and other drug and is crime free. (SAMHSA/CSAP,SPF, 2006)

- Effective prevention of mental illness and substance use requires consistent action from multiple stakeholders. (Frances M. Harding, SAMHSA/CSAP, 2011)

Prevention as the Cornerstone of Recovery

- Prevention brings the power to individual citizens, families and communities *within* their institutions.
- Creates a comprehensive plan that everyone can have a stake in and can own.
- Fosters continued systems approaches as the community experiences the outcome of its learning and investments.
- Holds community institutions responsible to reflect best practice and community values.

Prevention as the Cornerstone of Recovery

Must be measured by incidents, consumption reports, consequences of preventing use – at all levels.

- Recognizes that true prevention crosses the lifespan - not just youth; provides a better life for individuals, families and communities.
- Is grounded on evidenced based research and real world experience and qualitative and quantitative data.
- Provides outcomes at the population, community level (not just program level).

Prevention as the Cornerstone of Recovery

- Rather than addressing a single problem or condition, prevention simultaneously considers a potential wide-ranging set of problems that may be related to the disorder, i.e. *anticipatory practice.*
- Rather than focusing only on the individual at risk, it relates all risk and protective factors in the individual to the community's risk and protective factors, AKA, community and individual recovery capital.
- Employs learned interventions that can alter the social, cultural, economic and physical environment in such a way as to promote shifts away from what causes the problem in the first place. Builds individual and community recovery.

Recovery today

- After reviewing some 415 scientific reports William White (2012) estimates today there are some 25-40 millions Americans in recovery from AOD (not including tobacco) in America.
- *The critical question*: what if we asked these individuals, their families and communities to participate in designing our systems of prevention, intervention, treatment and recovery?

Recovery as a Cornerstone of Recovery

- Recovery, with Prevention, accesses those community “subsystems” existent in communities that can support attaining and sustaining recovery, i.e. Recovery Supports and Peers.
- Prevention is a set of steps along a continuum to promote individual, family and community health, reduce MH and SU Disorders, and build resilience, wellness and recovery.
- Good Recovery Management and Prevention focuses on reducing individual and community risk factors while building protective factors and resiliency for all.

Are not the measures of recovery similar?

- AOD use/consequences
- Living environment
- Physical health and health care costs
- Emotional health
- Family /Ally Relationships & health
- Citizenship
- Quality of Life

White, 2008

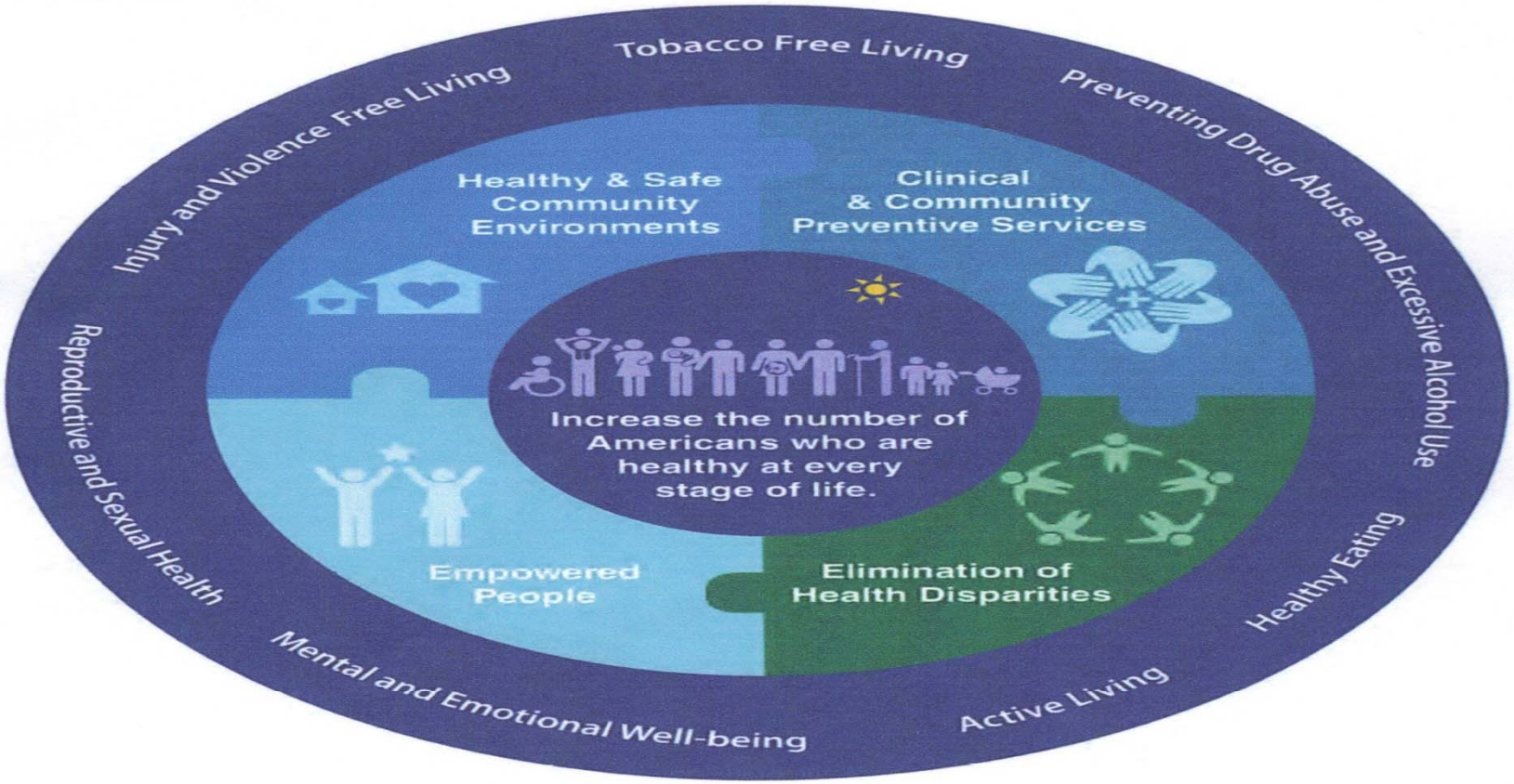
Examples of Recovery focused Treatment

- In Systems: California, Connecticut, North Carolina, Vermont have built state models; Philadelphia and counties across the nation and many states accessing SAMHSA's Access To Recovery where complete systems transformation or enhanced linkage to Recovery Supports have increased access and reduced costs per person while improving clinical outcomes. (SAMHSA 2008, 2010; Zarkin, Bray, Mitra, et al, 2005).
- In *Practice*: In 14 countries who implemented and studies Recovery-Oriented Practice improved treatment in 16 domains of clinical practice. (*Psychiatric Services*, December, 2011)
- In early studies where recovery focused care was integrated into Cognitive Behavioral Treatment (CT-R) GAS scores improved 22% over 18 mos. as both self actualization improved and clinical symptoms decreased significantly. . (Beck, July APA, 2012)

National Prevention Strategy

- Create, sustain, and recognize communities that promote health and wellness through prevention.
- Ensure that prevention-focused health care and community prevention efforts are available, integrated, and mutually reinforcing.
- Empower people
- Eliminate Disparities

National Prevention Strategy
America's Plan for Better Health and Wellness



June 16, 2011

SAMHSA's Strategic Initiative-Prevention Goals:

1.1 With Primary Prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance use and mental illness.

1.2 Prevent or reduce consequences of underage drinking and adult problem drinking.

1.4: Reduce prescription drug misuse and abuse.

SPF-PFS II

1) prevent onset and reduce the progression of substance abuse;

2) reduce substance abuse-related problems;

3) strengthen prevention capacity/infrastructure at the State and community levels; and

4) leverage, redirect and align State-wide funding streams and resources for prevention.

2014-2015 Block Grant - based on HHS National Quality Prevention Strategy

Better Care: Improve the overall quality, by making behavioral health cared more person-, family-, and community-centered, reliable, accessible, and safe.

Build Healthy People/Communities- Improve behavioral health of the U.S. by supporting proven interventions to address behavioral, social, cultural, and environmental determinants of positive behavioral health in addition to delivering higher-quality behavioral health care.

Affordable Care – Increase value of behavioral care.

(HHS, NQS. 2012)

SAMHSA Block Grant (2014-2015 draft) aims:

- Promote the most effect prevention, treatment and recovery practices for behavioral health disorders;
- Assure behavioral health care is person-family-, and community centered;
- Encourage effective coordination within behavioral care, and between behavioral health care and other health care, recovery, and social support systems;

SAMHSA Block Grant (2014-2015 draft) aims:

- Assist Communities to utilize best practices to enable healthy living;
- Make behavioral health care safer by reducing harm caused in the delivery of care, and
- Foster affordable, high-quality behavioral care for individuals, families, employers, and governments by developing and advancing new-and recovery oriented–delivery models.

SAMHSA Block Grant Target Populations:

- M/SUD Services
- Affordable Insurance Exchanges
- Trauma
- Justice
- Parity Education
- Primary and BH Integration
- Health Disparities
- Recovery
- Children and Adolescent
- Tribes
- Those mentioned in SAMHSA's Strategic Initiatives

Health Care Affordability Act of 2010

- Extends health care coverage to an estimated 32 million more Americans by 2014.
- Promises to improve the quality of that care and increase the focus on outcomes and accountability.
- Increased focus on coordination between and the integration of specialty behavioral care with primary care.
- Greater focus on “whole health” approaches that can address all needs – including prevention.
- Increase infrastructure (workforce)

How do we build System Accountability?

- Learning from the illness and its recovery how to best prevent, intervene and eliminate it.
- Measuring the impact of our efforts at reducing illness and building wellness.
- Empowering individuals, families and communities with best science, practice and the proven experience of what works in their community – and proving it!

System Accountability

- Defining our approach to the illness from the science which best offers wellness and a quality of life – not the topical maintenance of an illness or the systems designed to treat a component part. Whole person/community care.

- Reporting on the effectiveness of our approach in both the reduction of illness and reduced related morbidity and mortality but also by measures of achieved individual and community wellness and recovery – and cost savings & efficiencies therein.

Recovery is a Prevention focus at its best!

- A prevention based approach grounded in a chronic understanding of the illness redefines our entire approach to illness at ALL levels for each person and community. It brings “comprehensive” care and coordinated, relevant strategies to the community.
- A recovery focus is a also a preventive approach that simultaneously supports building resiliency, wellness, measureable recovery and quality of life.

Recovery and Prevention

- Recovery from Mental Health and Substance Use Disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their potential - delineated over four dimensions:
  - Health: overcoming or managing one's disease as well as living in a physically and emotionally healthy way.
  - Home: stable and safe
  - Purpose: meaningful life
  - Community: relationships and social networks that provide support, friendship, and hope.

(SAMHSA, 2012)

Recovery Focus Applied

- *Recovery Oriented Systems of Care* (ROSC) are networks of formal and informal services developed and mobilized to help attain and sustain long-term recovery for individuals and families impacted by substance use. A ROSC in not a local, state, or federal treatment agency but a macro-level organization within the community, state or nation.

Recovery Oriented Systems of Care – Treatment's Opportunity?

- Person centered
- Family/ally involved
- Comprehensive care across lifespan
- Systems anchored in community
- Continuity of Care (prevention, intervention, treatment, continuing care and recovery supports)
- Partnership in relationship – less hierarchy in relationship
- Strengths-based – builds resiliency
- Culturally responsive
- Addresses personal beliefs
- Integrates care
- Addresses systems needs for education and training; outreach
- Outcomes driven
- Based on research – adequately funded and flexibly financed.

(SAMHSA/CSAT, 2007)

Principles of Recovery …

- Recovery emerges from hope.
- Recovery is person-driven.
- Recovery occurs from many pathways.
- Recovery is holistic.
- Recovery is supported by peers and allies
- Recovery is supported through relationship, social networks, families and communities.
- Recovery is culturally based and influenced.
- Recovery addresses trauma.
- Recovery builds individual, family and community strengths.
- Recovery is based on respect.

Prevention Principles ...

- Enhance protective factors and reduce risk factors
- Address all forms of drug abuse, including underage use of legal drugs, prescriptions misuse and mis-use of OTC.
- Define the type of drug use in a local community, target modifiable risk factors and strengthen protective factors.
- Tailor programs to the risks specific to a population
- Enhance family bonding, relationships and skills
- Intervene early to address potential risk factors, particularly in academic settings such as elementary, middle and junior high and transition points therein – combining with community where possible.
- Be culturally relevant and research-based. Be long term and foster positive behaviors, reinforcing skills.
- Be cost effective ($1:$10). NIDA (2003).

Recovery Focus Applied

Recovery Management is a philosophical framework for organizing addiction services to provide pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality of life enhancement for individuals and families affected by substance use.

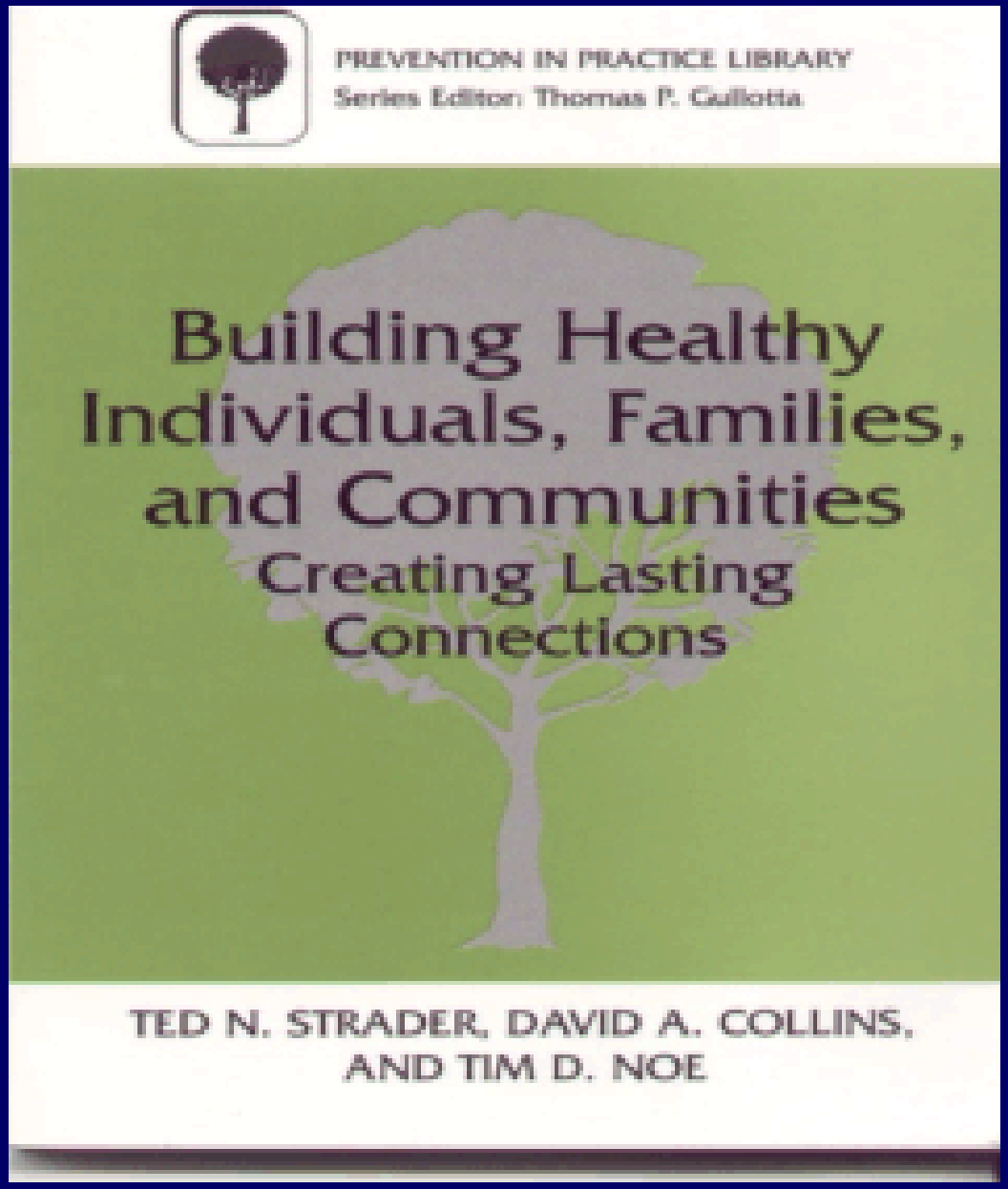
Recovery and Prevention

- Prevention enhances recovery by using its science to build recovery capital to strengthen resiliency.
- Recovery enhances prevention by challenging it to reach its fuller possibilities to develop individual, family and community wellness based on attained and sustained recovery.

Ted N. Strader

Executive Director, COPES, Inc.
(Council on Prevention & Education: Substances)

Program Developer
Creating Lasting Family Connections



COPES' prevention programs have received numerous national awards for excellence.

- COPES' Creating Lasting Family Connections program is currently listed on the **National Registry of Evidence-based Programs and Practices.**
- 2012 – COPES' two new prevention/treatment/recovery programs for reentry populations are currently under review for inclusion on the **National Registry of Evidence-based Programs and Practices**.
- COPES Creating Lasting Connections demonstration projects received the **NPN, NASADAD, and CSAP Exemplary Substance Abuse Prevention Program Awards** for **1989, 1995, 1999 and 2010.**

COPES' prevention programs have received numerous national awards for excellence. (cont'd)

- 2006 - The Creating Lasting Family Connections program was reconfirmed as an **Evidence-based** substance abuse and violence prevention curriculum by the **Office of Juvenile Justice and Delinquency Prevention**.
- 2001 - COPES and the Creating Lasting Family Connections program received a **Special Recognition Award** from the **Executive Office of the President, Office of National Drug Control Policy.**
- 2001 - Creating Lasting Family Connections received the **U.S. Department of Education** Certificate of Recognition.

Since 1980, prevention has demonstrated empirical results by learning to address:

1. **Individual Risk and Protective Factors**
2. **Family Risk and Protective Factors**
3. **Community Risk and Protective Factors**

Since 1980, prevention has demonstrated empirical results by learning to address: (continued)

4. Substance Abuse as a Chronic illness

5. Substance Abuse as a Family illness

6. Substance Abuse as a Community illness

7. Prevention across the full continuum of care.

In 2005, COPES decided to integrate our CLFC prevention knowledge, skill and experience into the prison intervention, treatment and aftercare continuum in order to increase recovery and decrease prison recidivism.

3 Prevention Projects Targeting Recovery

Connect-Immunity Project

Grant # SP013365

Funded by: SAMHSA, CSAP

Jefferson County Fatherhood Initiative

Grant # 90FR0015

Funded by: ACF, OFA

Jefferson County Healthy Marriage Initiative

Grant #: 90FE0007

Funded by: ACF, OFA

The Primary Operating Principle of the CLFC Program:

Behavioral change takes place in a context…

…in an environment

Individuals and Families, & Their Community and Culture Matter!

Prevention = Project Partners in the Community

- Kentucky Department of Corrections
- Dismas Charities
- Volunteers of America of KY
- Kentucky Department of Veteran Affairs
- Center for Women & Families
- University of Louisville WINGS Clinic
- Spalding University
- Seven Counties Services
- Louisville Metro Department of Public Health & Wellness

Prevention = Project Partners in the Community (cont'd)

- Pacific Institute for Research & Evaluation: Louisville Center
- Jefferson County Attorney's Office – Child Support Division
- Louisville Metro Community & Revitalization Services
- Goodwill Industries
- KentuckianaWorks
- PAL Coalition
- Network Center for Community Change
- Department of Community Based Services

- The Connect Immunity Project targeted **adult measures for ATOD, HIV Testing, Recovery Support and Prison Recidivism**.

- The Jefferson County Fatherhood Initiative targeted **adult measures for 9 Relationship Skills, HIV Testing, Recovery Support and Prison Recidivism.**

- The Healthy Marriage Initiative targeted **9 relationship skills** (as a means of increasing recovery support and reduced recidivism).

The 9 CLFC RELATIONSHIP SKILLS are the KEY to accessing all other RECOVERY SUPPORTS

- Communication Skills
- Conflict Resolution Skills
- Intra-Personal Skills
- Inter-Personal Skills
- Emotional Awareness
- Emotional Expression
- Relationship Management
- Relationship Satisfaction
- Relationship Commitment

Connect-Immunity Project Results

Program: N=249 Comp: N=96

- Participants were more knowledgeable about Sexually Transmitted Diseases (i.e. HIV, Hepatitis)
- Participants were less likely to intend to binge drink
- Participants were more spiritual
- **Participants were almost four times less likely to recidivate than comparison group participants.**

Fatherhood Initiative Results

Program: N=387 Comp: N=113

- Participants showed improvement in all 9 targeted relationship skills
- Improvements in those 9 relationship skills that persisted over the course of a year
- **Participants were almost three times (2.94) less likely to recidivate than comparison group participants**
- **82%** of participants volunteered to get tested for HIV

Healthy Marriage Initiative Results

Program: N=288 Comp: =113

- Participants showed improvement in all 9 important relationship skills targeted for both husbands and wives
- Participants showed improvement in the 9 relationship skills of husbands compared to a group of men not participating in the program
- All 9 relationship skill gains persisted over the course of the follow-up period

Articles outlining these results have been accepted for publication in 2 peer-reviewed journals:

Criminal Justice Policy Review

McKiernan, Shamblen, Collins, Strader & Kokoski (December, 2012)

Family Process

Shamblen, Arnold, McKiernan, Collins & Strader (December, 2012)

(also see www.copes.org)

As previously mentioned in the Introduction...

The CLFC Fatherhood Program

&

The CLFC Marriage Enhancement Program

Are both currently under review for inclusion on the National Registry for Evidence-based Programs & Practices.

The CLFC Joint Intervention Meeting (The JIM)

The JIM provides an Illustration of How the Prevention Principles of Collaboration and Leveraging of Skills, Knowledge & Resources Among Partnering Entities can impact Recovery Supports, Peer-Assisted Recovery and other forms of Recovery Capital.

List of Partner Agencies (Participating in the J.I.M.)

- COPES Executive Director
- COPES Case Management Staff
- COPES CLFC Facilitators
- KY DOC Management Staff
- KY DOC SSC Manager
- KY DOC Local SSC Rep
- KY DOC Local P&P Rep
- Dismas Charities Rep
- Any Client exhibiting behavioral slippage
- Client family members (and friends)

CLFC Joint Intervention Meetings

- Key partner agency staff representatives met monthly with selected reentry clients.
- Address early warning signs of behavioral slippage and redirect participants onto a positive path of reentry and recovery in a respectful, pro-active and supportive manner (prior to the need for major sanctions like revocation or treatment).
- A collective and consistent family and community message of strong support, cultural sensitivity, respect, understanding and accountability.

By providing Reentry/Recovering Clients

PREVENTION BASED SERVICES (CLFC Program)

AND

JOINT INTERVENTION MEETINGS (JIM)

Individuals, families and communities were dramatically strengthened!

MANY LIVES WERE DEEPLY IMPROVED,

AND,

SOCIETAL COSTS WERE DRAMATICALLY REDUCED.

(Savings of about $23,000 per person/ per prison year)

Prevention and Recovery can indeed now be seen as foundational cornerstones in a Modern Treatment Approach (the **Recovery Model**) that recognizes substance use disorders as chronic illnesses.

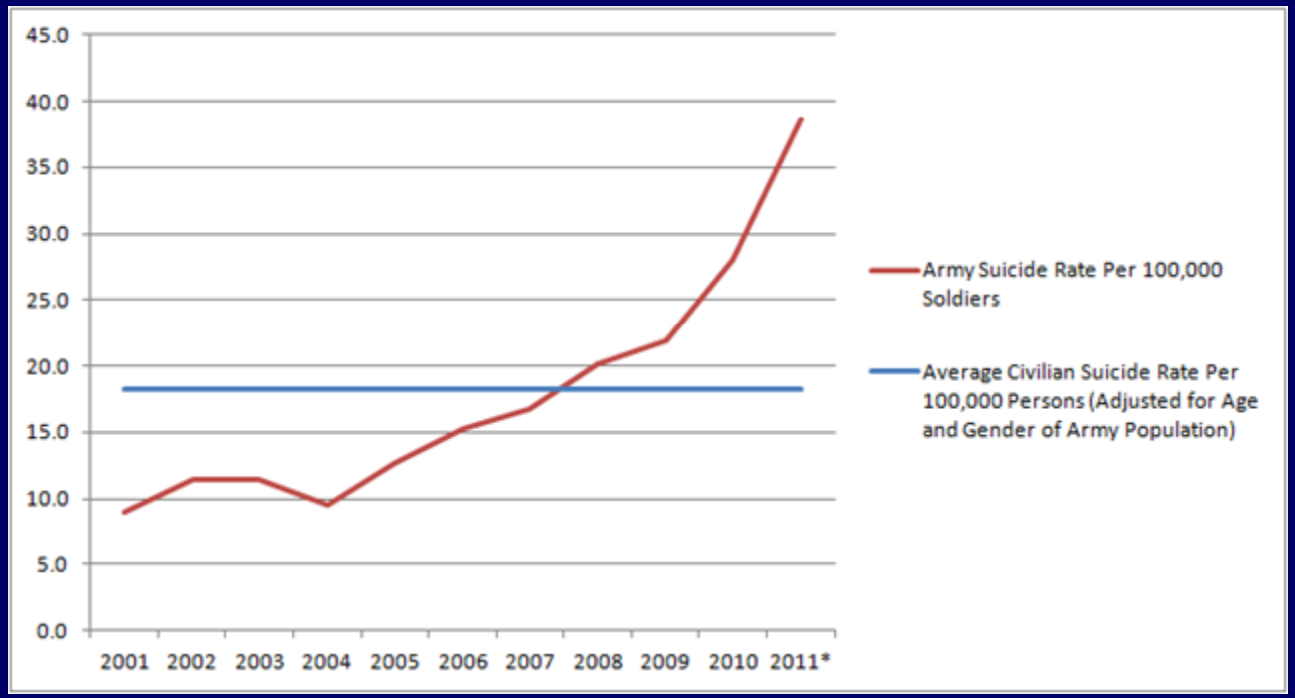
Contact Information

Ted N. Strader, MS, CPS
COPES, Inc.
845 Barret Ave.
Louisville, KY 40204

502-583-6820
tstrader@sprynet.com

www.copes.org

So if we want to end this:



Or this

Or this

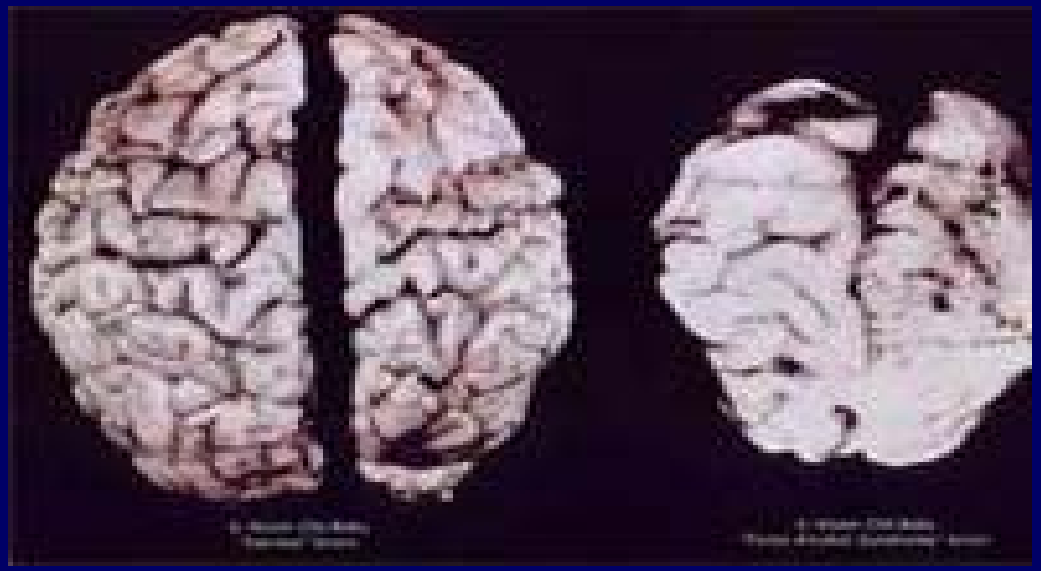

JULY 23, 2012
How to Grow Jobs By Fareed Zakaria / Higgs-teria! / Chipotle's Secret
TIME
ONE A DAY
Every day, one U.S. soldier commits suicide. Why the military can't defeat its most insidious enemy
BY MARK THOMPSON & NANCY GIBBS
www.time.com

let's address this

To succeed at this

U.S. Navy declares September, 2012 suicide prevention month!

So if we are sincere about addressing:



- Integrate prevention and recovery science to their proper status in an illness best treated as potentially chronic in nature.
- Make our resources more accountable by measuring attained reduced prevalence and co-morbidity of illness and attained wellness and recovery of individuals, families and communities.
- Link with recovery supports to develop new roles and opportunities for prevention and recovery knowledge over the full continuum of care.

You see, its really not only about more money.

Its also about being smarter about what we do and how we do it ... its about advancing our knowledge and skills based on the science and proven experience of 30-40 million people.

- use this stronger Prevention and Recovery knowledge as the cornerstones to reduce illness and build recovery; as a science of resiliency, wellness and recovery ... not only of pathology and illness.
- Defeat our innate stigma for this illness

You are the leaders in the new paradigm! The opportunity has never been greater nor more important. The value of this new Paradigm is FAR greater than currently appreciated or applied daily by our policy makers and payers.

So do not leave this webinar believing you are just advocates for the prevention, intervention, treatment and recovery from a unique, acute illness ... you are leaving holding the greatest opportunity here-to-fore known to our profession to bring the true evolution of this evolved understanding of the illness - and its prevention, treatment and recovery - into the future.

As today's leaders I plead with you now to accept this challenge ... to stand up and lead in defining these experientially proven approaches that reflect not only primary prevention but the strength of treatment and recovery itself to fortify resiliency, wellness and recovery in those who come to us, their schools, families, communities - and lives. Evolve the science ... renew the hope.

Because:

Prevention and recovery are the cornerstones of successful treatment in chronic illness.

Now:

"Let's go make some history."

- William White

Thank you !

flahertymt@gmail.com

tstrader@sprynet.com

IOM Report

- Consumers in service and design:
  - decrease negative stereotyping
  - reduces stigma
  - prevents relapse
  - promotes timely reentry to treatment
  - increase recovery capital or chances for recovery

Institute of Medicine. (2006). *Improving the Quality of Healthcare for Mental and Substance-Use Conditions.* Washington, DC: National Academies Press.

Scientific Support for Shift from Acute Care to Sustained Recovery Management

1. The need for post-treatment check-ups and sustained recovery support services intensifies as problem severity increases and recovery capital decreases. Those sickest usually have the least family and social support. White, W. (2005). Recovery Management: What if We Really Believed Addiction was a Chronic Disorder? *GLATTC Bulletin*. September, 1-7.

   "*Recovery capital* is the quantity and quality of internal and external resources that one can bring to bear on the initiation and maintenance of recovery." Granfield, R. & Cloud, W. (1999). *Coming Clean: Overcoming Addiction Without Treatment.* New York: New York University Press.

Scientific Conclusions

2. Addiction treatment outcomes are compromised by the lack of sustained recovery support services.
   - Less than 50% admitted to Tx complete
   - Over 50% discharged use AOD in the first year following discharge (80% of those within the first 90 days)
   - "Durability" (15% relapse rate) takes 4-5 yrs of remission

De Soto, C.B., O'Donnel, W.E., & De Soto, J.L. (1989). Long-Term Recovery in Alcoholics. *Alcoholism: Clinical and Experimental Research*, 13, 693-697.

Scientific Conclusions

3. Professionally-directed, post-discharge continuing care can enhance recovery outcomes, but only 1 in 5 clients actually receives such care.

Dennis, M.L., Scott, C.S., & Funk, R. (2003). An Experimental Evaluation of Recovery Management Checkups (RMC) for People with Chronic Substance Use Disorders. *Evaluation and Program Planning*, 26(3), 339-352.

Godley, S.H., Godley, M.D., & Dennis, M.L. (2001). The Assertive Aftercare Protocol for Adolescent Substance Abusers. In E. Wagner and H. Waldron (Eds.), *Innovations in Adolescent Substance Abuse Interventions* (pp. 311-329). New York: Elsevier Science Ltd.

Ito, J. & Donovan, D.M. (1986). Aftercare in Alcoholism Treatment: A Review. In W.R. Miller & N. Heather (Eds.), *Treating Addictive Behaviors* (2nd ed., pp. 317-336). New York: Plenum Press.

Johnson, E. & Herringer, L. (1993). A Note on the Utilization of Common Support Activities and Relapse Following Substance Abuse Treatment. *Journal of Psychology*, 127(1), 73-78.

McKay, J.R. (2001). Effectiveness of Continuing Care Interventions for Substance Abusers: Implications for the Study of Long-Term Treatment Effects. *Evaluation Review*, 25(2), 211-232.

Scientific Conclusions

4. Participating in peer-based recovery support groups following treatment enhances recovery outcomes, but there is high attrition in such participation following discharge from treatment.

Emrick, C.D. (1989). Alcoholics Anonymous: Membership Characteristics and Effectiveness as Treatment. *Recent Developments in Alcoholism*, 7, 37-53.

Kelly, J.F., & Moos, R. (2003). Dropout from 12-Step Self-Help Groups: Prevalence, Predictors, and Counteracting Treatment Influences. *Journal of Substance Abuse Treatment*, 24(3), 241-250.

Makela, K., Arminen, I., Bloomfield, K., Eisenbach-Stangl, I., Bergmark, K., Kurube, N., et al. (1996). *Alcoholics Anonymous as a Mutual-Help Movement: A Study in Eight Societies*. Madison, WI: University of Wisconsin.

Tonigan, J.S., Miller, W.R., Chavez, R., Porter, N., Worth, L., Westphal, V., Carroll, L., Repa, K., Martin, A., & Tracy, L.A. (2002). *AA Participation 10 Years After Project MATCH Treatment: Preliminary Findings*. Poster Presentation, Research Society on Alcoholism, San Francisco, July.

Scientific Conclusions

5. The resolution of severe substance use disorders can span years (sometimes decades) and multiple treatment episodes before stable recovery maintenance is achieved. Chronic = recovery

Anglin, M.D., Hser, Y., & Grella, C.E. (1997). Drug Addiction and Treatment Careers Among Clients in DATOS. *Psychology of Addictive Behaviors*, 11(4), 308-323.

Dennis, M.L., Scott, C.K., & Hristova, L. (2002). The Duration and Correlates of Substance Abuse Treatment Carrers Among People Entering Publically Funded Treatment in Chicago [Abstract], *Drug and Alcohol Dependence,* 66 (Suppl. 2), 44.

Scientific Conclusions

6. For many individuals, recovery sustainability is not achieved in the short span of time treatment agencies are currently involved in their lives. Point of recovery sustainability--risk of future lifetime relapse drops below 15%--is 4-5 years of stable remission.

De Soto, C.B., O'Donnel, W.E., & De Soto, J.L. (1989). Long-Term Recovery in Alcoholics. *Alcoholism: Clinical and Experimental Research*, 13, 693-697.

Hser, Y., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-Year Follow-Up of Narcotics Addicts. *Archives of General Psychiatry*, 58(5), 503-508.

Jin, H., Rourke, S.B., Patterson, T.L., Taylor, M.J., & Grant, I. (1998). Predictors of Relapse in Long-Term Abstinent Alcoholics. *Journal of Studies on Alcohol*, 59(6), 640-646.

Simpson, D.D. & Marsh, K.L. (1986). Relapse and Recovery Among Opioid Addicts 12 Years After Treatment. In F. Tims and C. Leukefeld (Eds.), *Relapse and Recovery in Drug Abuse* (NIDA Monograph 72, pp. 86-103). Rockville, MD: National Institute on Drug Abuse.

Scientific Conclusions

7. Addiction treatment has become the revolving door it was intended to replace.
   - 64% of persons entering publicly funded treatment in the United States have already had one or more prior treatments.

Office of Applied Studies. (2005). *Treatment Episode Data Set (TEDS): 2002. Discharges from Substance Abuse Services* (DASIS Series S-25 DHHS Publication No. (SMA) 04-3967). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Scientific Conclusions

8. The majority of those who achieve stable recovery in treatment do so after 3-4 episodes of care – linking reduces number of episodes and hastens re-entry to treatment when needed

Anglin, M.D., Hser, Y., & Grella, C.E. (1997). Drug Addiction and Treatment Careers Among Clients in DATOS. *Psychology of Addictive Behaviors*, 11(4), 308-323.

Dennis, M.L., Scott, C.K., Funk, R., & Foss, M.A. (2005). The Duration and Correlates of Addiction Treatment Careers. *Journal of Substance Abuse Treatment*, 28(Supplement 1), S51-S62.

Grella, C.E., & Joshi, V. (1999). Gender Differences in Drug Treatment Careers Among the National Drug Abuse Treatment Outcome Study. *American Journal of Drug and Alcohol Abuse*, 25(3), 385-406.

Hser, Y., Anglin, M., Grella, C.E., Longshore, D., & Prendergast, M. (1997). Drug Treatment Careers: A Conceptual Framework and Existing Research Findings. *Journal of Substance Abuse Treatment*, 14(3), 1-16.

Hser, Y., Grella, C., Chou, C., & Anglin, M.D. (1998). Relationship Between Drug Treatment Careers and Outcomes: Findings from the National Drug Abuse Treatment Outcome Study. *Evaluation Review*, 22(4), 496-519.

Scientific Conclusions

9. There is a growing body of evidence that enmeshing clients with high problem severity and low recovery capital within sober living communities can dramatically enhance long-term recovery outcomes.

Jason, L.A., Davis, M.I., Ferrari, J.R., & Bishop, P.D. (2001). Oxford House: A Review of Research and Implications for Substance Abuse Recovery and Community Research. *Journal of Drug Education*, 31(1), 1-27.

- E.g. Oxford House as compared to traditional post-treatment “aftercare”: 50% less relapse, twice monthly income, 1/3 incarceration

Jason, L.A., Olson, B.D., Ferrari, J.R., & Lo Sasso, A.T. (2006). Communal Housing Settings Enhance Substance Abuse Recovery. *American Journal of Public Health*, 96(10), 1727-1729.

Recovery – A Provisional Definition

- Sobriety – Abstinence from alcohol and all other non-prescribed drugs
- Improved quality of life for self and others as measured by the following six domains (Bonomi, Patrick, Bushnell & Martin, 1999):
  - Physical
  - Psychological
  - Independence
  - Social
  - Environment
  - Spiritual

Bonomi, A.E., Patrick, D.L., Bushnell D.M., & Martin, M. (1999). Validation of the United State's Version of the World Health Organization Quality of Life (WHOQOL) Instrument. *Journal of Clinical Epidemiology*, 53 (2000), 1-12.