Frequently Asked Questions

Webinar: *Setting the Stage: Who Is a Person in Recovery; What Is A ROSC; and What Are the Opportunities*

Presenter: *David Whiters, PhD*, Consultant

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These questions were generated from the "Setting the Stage" webinar presented by David Whiters, PhD on January 30, 2013. While questions during the webinar were directly answered by Dr. Whiters, we received additional questions to which we sent out to our panel of experts in Recovery Management and Recovery Oriented Systems of Care.

Expert Panelists:
Ijeoma Achara, PsyD, Achara Consulting, LLC

William "Bill" White, MA, Emeritus Senior Research Consultant, Chestnut Health Systems

Michael Flaherty, PhD, Founder -Institute for Research, Education and Training in the Addictions; Clinical Psychologist

1) What is the first step in an organization utilizing ROSC in their business?

Responded by, Dr. Achara:
Great question. A recovery-oriented system of care is a value-driven approach to structuring behavioral health systems and the entire network of services and supports. Although no organization on its own can be a ROSC because it is a ***network*** of services and supports, organizations can ensure that their services and supports are recovery-oriented. To this end, one of the first things that an organization can do is lay the foundation for practice change. Often organizations hear about ROSC, recovery management or recovery-oriented services, and stakeholders may be so excited by what they hear that they want to move straight into making significant changes in how services are structured or delivered. We suggest a different approach.

The change strategy employed to transform Philadelphia's behavioral health system has three components—conceptual alignment (core values and principles), practice alignment (services and supports), and contextual alignment (regulations, funding, relationships and community context)—all directed toward supporting the long-term recovery of individuals and families and promoting community health.

Before making changes to any services and supports, it is recommended that organizations invest some time in promoting conceptual alignment. This means helping staff to understand what is meant by concepts like ROSC, recovery management, and recovery-oriented services and supports, and just as importantly, understanding how the practices in a ROSC are different from the practices in a conventional system of care and why they are different.

Implementing recovery-oriented services and supports involves more than just changes to practice. In most organizations it requires a culture change and shift in stakeholders' attitudes and values. It is important to till the soil so to speak for the ensuing practice changes by exposing professional staff, volunteers, the leadership team, the organization's Board of Directors, and other key stakeholders to some of the key concepts associated with ROSC. Facilitate discussions with staff and focus groups with the people that you serve to explore what these concepts might mean for your organization and how services and supports might look different if you fully embraced them. It is important to involve as many stakeholders as possible in this dialogue including the people that you serve.

Once you have established some conceptual clarity, identify one or two concrete practice changes within a ROSC and work to integrate those within your organization. Ask yourselves critical questions such as; If we were doing xxx, how would things look different? What would need to change in terms of supervision? How would the relationships between staff and the people we serve change? How would it impact our assessment, service planning and service delivery processes? What support would staff need in order to successfully implement changes? What additional information or resources are needed? A valuable resource to support this process is William White's website, www.williamwhitepapers.com. This website has a wide array of brief articles and papers that describe many elements of ROSC and recovery management which can assist you in laying a strong foundation for future practice changes.

The most important thing is to just get started. Identify your organization's recovery champions. Those individuals who are passionate about and believe in the need for more recovery-oriented services and empower them to assume formal or informal leadership roles in your change process. Also remember that this is a marathon not a sprint. Creating a more recovery-oriented organizational culture will undoubtedly take time but you can do it!

Responded by, Dr. Flaherty:
a. If an agency, be sure Board, leadership and all staff have investment, understand and commitment to what is possible for them.

b. If a county or region - gather the right people (those in recovery, systems to build ROSC (treatment, families, clergy, transportation, housing CJ, Court, medical, payers, etc.) and do "a" above.

c. In either "a" or "b" use defining "recovery" as a process to see what it should be and what you need to get there for that community. Create the common Vision.

2) How do you see ROSC supported in future national budgets?

Responded by, Dr. Flaherty:
While still disappointed over absence of funding for a ROSC ATTC the silver lining in it may be that ROSC is best defined locally and implemented locally. Still, BRSS- TACS, SAMHSA Recovery to Practice (Yale), ATTCs who continue to help states/ regions, SAMHSA Treatment Capacity Expansion Peer-Ato-Peer (application due March 15th); SAMHSA Drug-Free-Communities Grants (currently solicited) are all examples of Federal grants to build ROSC. Moreover, the State Block

Grants have be defined anew and in a way that allows those funds in part to be used to build or pay for ROSC (this threatens existing providers) if states so choose. Also, in building credentials for Peer-to-Peer Recovery Supports some states, recognizing the value of such, are allowing for reimbursement for it (contact FaVoR for more info).NIDA keeps hearing they too need to do more ... I personally believe that actual clinical practice has much to gain working within a ROSC AND allowing current treatment to "evolve" to include recovery focus in care (e.g. Laudet). One great example of this is that the Founder of Cognitive Behavioral Therapy, Dr. Aaron Beck, M.D. now refers to CBT as CT-R (Cognitive Therapy on Recovery) and CT-R as the natural evolution of CBT! Perhaps ATTCs might want to learn more? He's at Penn. If this is so, the single most validated clinical practice is "morphing" into CT-R. Lastly, there is a critical point Bill White always makes and it beside efforts to gain sustainability of ROSC, we could not cross a very delicate line and replace what is currently provided without financial support by RSS. Work needs to guard and be done here.

Responded by, Mr. White:
If there are progressive cuts to federal and state treatment funding which could happen in response to federal and state budget deficits, then funding some baseline level of community-based recovery support services will be critical for two reasons. First, it will serve as a safety net for reduced clinical services. Second, it will provide services that could reduce service demand by reducing admission of high service utilizers, thus maintaining or expanding treatment capacity for those without prior addiction treatment.

3) Do you have any suggestions for how to better incorporate ROSC into state public health and human services policy initiatives?

Responded by, Dr. Achara:
Currently, there are increased calls for a recovery-focused research agenda in the field. Community-based recovery organizations can play a critical role in laying the foundation for this research agenda by evaluating the role and outcomes associated with their peer-based recovery support services. Regarding the key issues for consideration, they fall into two main categories. First, issues related to the process of the evaluation, and second issues related to the focus of the evaluation.

Regarding the process issues, one key issue to consider relates to who is leading the evaluation process. Is it being coordinated and led by the recovery-community organization (RCO) itself, or is it being coordinated by an outside entity? Communities of color and communities of recovery have a shared history with regard to the ways in which they have been wounded by culturally dominant research practices (White, 2006). As a result, research and evaluation in communities of recovery require high levels of sensitivity regarding the potential for harm and strategies for achieving credibility within the recovery community. These strategies are outlined in a recent article, which details recommendations for external stakeholders conducting research and evaluation in recovery communities. The citation for the article is: White, W.L., Evans, A.C., Lamb, R. & Achara-Abrahams, I. (2013) Addiction recovery communities as indigenous cultures: Implications for professional and scientific collaboration. *Alcoholism Treatment Quarterly*, 31(2), 121-128.

Regarding issues related to the focus of the evaluation, it is recommended that recovery communities consider examining such questions as:

- What are the effects of receiving peer-based recovery support services on long-term recovery outcomes for individuals and family members?
- How does involvement with peer-based recovery support within an RCO influence key dimensions of recovery such as: abstinence rates, elevations in global health and functioning, community re-integration (housing, employment, meaningful roles and activities) and citizenship?
- Are there particular combinations of service/support elements that generate dramatically enhanced effects on recovery outcomes?
- Do peer-based recovery support services generate pro-recovery effects in people who have refused to participate in addiction treatment services?
- Which kinds of services and supports are people accessing with the greatest frequency?
- What are the attitudes of individuals and families toward long-term monitoring and support? What percentage of individuals/families stay involved with peer-based recovery support services at the RCO across key benchmarks (first 90 days, 6 months, one year, three years, and five years)?
- Do in-treatment peer-based recovery support services enhance treatment completion rates?
- Do post-treatment peer-based recovery support services lower post-treatment relapse and readmission rates?
- Are there differences in recovery outcomes when peer-based recovery support services are delivered in voluntary versus paid roles?
- What are the current barriers to implementation?
- Which policy, financing barriers are of greatest concern?
- What are the existing barriers to effective collaboration with treatment organizations?

The questions above, along with many others, are discussed in more detail in a monograph supported by the Great Lakes Addiction Technology Transfer Center in partnership with the Philadelphia Department of Behavioral Health and Intellectual dis*Ability* Services and written by William White entitled "Peer-based Addiction Recovery Support: History, Theory, Practice and Scientific Evaluation (2009).

Responded by, Dr. Flaherty:
Do #1) above with state leaders and see if anything in 2) can help. Set recovery measures in place and benchmark today to them. Bring science, SAMHSA materials, ATTC Monographs, show cost/cost savings, local implementation w process, get related MCOs involved (they will need more help than state/city/county so it is best to remind state/city/county that they (MCO) are paid by state/city/county. Report progress on recovery every 6 mos. with measures to insure accountability.

Responded by, Mr. White:
Add "back end services" to expansion of front end services, e.g., include role of physicians in post-treatment recovery check-ups as well as in screening, brief intervention and referral to treatment. More broadly, link and integrate ROSC efforts to primary prevention, early intervention and harm reduction initiatives.

4) What is the difference between a CDCA and a Recovery Coach? What are the duties that differ?

Responded by, Dr. Achara:
The key difference between a CDCA (Chemical Dependency Counselor Assistant) and a recovery coach is that the CDCA position is a clinically focused, treatment specialist while the recovery coach is a non-clinical, non-professional role that is performed by individuals who are ***experientially credentialed*** to assist others in
1) initiating their recovery, 2) maintaining their recovery, and 3) enhancing the quality of their personal and family life in their communities.

As you can see from the CDCA responsibilities outlined in a current job description below (accessed on February 28, 2013 at https://www.appone.com/MainInfoReq.asp?R_ID=559720&B_ID=5&fid=1&Adid=), a CDCA might be expected to diagnose and treat people and to provide therapy or counseling. A recovery coach is never responsible for diagnosing the individuals that they serve and they do not refer to their support activities as "counseling" or "therapy" (White, 2006).

Example of Current CDCA Responsibilities

- Provide diagnosis and treatment for clients within the range of program services, especially those requiring chemical dependency treatment.
- Act as an advocate for program participants with courts, schools, treatment centers, and other services as appropriate in order to make referrals and conduct follow-ups.
- Provide individual and family counseling; engage clients and families.
- Provide outreach and case management to primary clients.
- Prepare written reports, regular case dictation and summaries for consultation according to program standards and professional ethics.

As compared with the CDCA responsibilities outlined above, the core functions of a recovery coach are:

- Assertive Outreach
- Recovery Capital needs assessment at individual/family/community levels
- Recovery education and coaching
- Recovery resource identification/ mobilization
- Facilitating linkages
- Supporting recovery planning
- Recovery Check-ups
- Companionship and modeling of recovery lifestyle
- Problem solving to eliminate obstacles to recovery

(William White, 2006)

Other key differences outlined by William White (2006) are:

Service Goals and Timing: While the primary focus of addiction counselors is working with individuals who have reached a point where they are ready to change, the recovery coach's role is focused on "preparing the soil in which recovery can grow", transferring credibility from themselves to other helping professionals, and helping people to transition from a culture of addiction to a culture of recovery through lifestyle reconstruction.

Use of Self: While counselors are increasingly discouraged not to engage in self-disclosure, the primary tool for change that recovery coaches leverage is their use of self and their status and experience as a recovering individual. They use their recovery story to connect with the people they serve and to build trust, hope and credibility.

Locus of Service Delivery: The primary question for the addictions counselor is "How do I get this individual into and through a treatment experience?" but the recovery coach instead asks, "How can the process of recovery be initiated and anchored in the person's own natural environment?" Whereas the work of a CDCA is often institution and office based, the ideal location for recovery coaching is the client's real world environment.

Recovery coaches are not assistant or junior counselors. Their role is qualitatively different and it is based on their lived experience with addiction and recovery.

For a more in depth discussion of how the roles of recovery coaches and CDCA may differ, please refer to the article Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity by William White which can be accessed at http://www.facesandvoicesofrecovery.org/pdf/White/2006-05-16_White_Sponsor_Essay.pdf

5) What are the key issues to consider evaluating the value of PIR model in community-based recovery organizations?

Responded by, Dr. Flaherty:
That it be a (healing) "process" with content (outcomes) that the community sets/sees. That it be self-defined by the community - moving with best practice/science toward goals. That it reflect the values of the community/culture. That it have good leadership and sustaining interest. Such a model is Technology Transfer and Knowledge Adoption in action at the same time.