INTERVIEWS & PROFILES

Interviews, Profiles and Recovery Voices

William L. White — Selected Papers, Volume IX

11 Papers

Conversations with leaders in addiction treatment and recovery — including White's own interviews, profiles of recovery pioneers, and oral histories from the field.

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Selected Papers of William L. White

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

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An Anniversary Tribute to a First Lady

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October 4**,** 2007 marks the 25th anniversary of the opening of the Betty Ford Center—a fitting time to honor the resilience and fortitude of a family, the courage of a most remarkable woman and the contributions of an important institution in the history of addiction treatment.

In the decades following the repeal of prohibition, American women faced a unique cultural double bind. They were targeted for unrelenting product promotion by the alcohol, tobacco and pharmaceutical industries at the same time social stigma increased for addicted women. Only a few women of prominence (e.g., public health pioneer Marty Mann, actresses Lillian Roth and Mercedes McCambridge) braved such stigma to publicly acknowledge their recoveries from alcoholism, and women struggling with narcotic addiction, such as Jazz singer Billie Holiday, broke into public visibility only when they were arrested or died.

In such a climate, unknown numbers of women lost their dreams and their lives to alcoholism and other addictions. Many sought help only in the latest stages of their illnesses, with many dying early in their recoveries from medical disorders spawned from prolonged years of secret addiction to alcohol and other drugs. It could justifiably be claimed that these women died, not from addiction, but from stigma. Recovery advocates during the mid-twentieth century dreamed of a day when a woman of unprecedented prominence would go public with her recovery story and by doing so forever shatter America's stereotype of the alcoholic as a depraved Skid Row wino. That dream was about to come true in a way that would forever demarcate before and after in the history of addiction and recovery among American women.

In April 1978, former President and First Lady Jerry and Betty Ford announced to the nation that Mrs. Ford had sought treatment and was recovering from addiction to alcohol and other drugs. That moment stands as the height of destigmatization of alcohol and other drug problems in America. Here stood one of the most prestigious women in the United States and, at a more personal level, a woman deeply respected and revered by the American public for her independence, spunk and candor. We had sensed earlier as a citizenry that this was a woman who cared about us and would tell us the truth. She had demonstrated those traits

by openly sharing her battle with breast cancer and using that experience to educate us as a nation. And here she was again standing with her husband and family talking to us about recovery from alcoholism and drug dependence. In doing so, Betty Ford and her family, as they had done before, found a way to elevate their personal crises to a higher level of meaning and purpose. In 1978, Betty Ford did for alcoholism what a few years later a famous actor, a beloved professional athlete and a brave young boy would do for AIDS. She put a face on alcohol and drug dependency that shattered the public stereotype of the alcoholic and in that moment brought us all a step closer to telling the truth about how these problems had touched our own lives.

The manner in which Mrs. Ford initiated her recovery process was also significant in that it challenged the popular notion that nothing could be done to stop addiction until the person who was addicted had personally hit bottom and reached out for help. News that Betty Ford's daughter, Susan Ford, had initiated a formal family intervention process that resulted in Mrs. Ford's admission to treatment and opened the doorway to her recovery conveyed three crucial lessons to the nation: 1) there is hope for families facing addiction, 2) the family can play a catalytic role in the recovery process, and 3) individual family members and the family as a whole need to recovery from the effects of addiction. Mrs. Ford, President Ford, Susan and the other Ford children offered themselves as living proof of those propositions!

The public reactions to the First Lady's announcement and the sustained evidence of her successful recovery brought women into addiction treatment in unprecedented numbers. The number of individuals and families transformed by the Fords' gift of their own story is incalculable. In the years that followed, family-centered addiction treatment and support reached its apex, and intervention as a therapeutic strategy entered the American consciousness. This alone would be a proud legacy, but the Ford family was not finished. At the encouragement of Ambassador Leonard Firestone, Betty Ford brought her support and her name to a new non-profit addiction treatment center on the grounds of the Eisenhower Medical Center in Rancho Mirage, California. Lending her name to this center served as a permanent reminder that addiction can touch any family and that recovery is possible for those who seek it.

In the intervening quarter-century, the Ford family has remained actively involved in the Betty Ford Center through participating in Board meetings, assisting with fund raising, lecturing to patients, and cooking hamburgers for staff and patients at their annual picnic. Most important to Betty has been the quality time interacting with patients. The Ford family has remained the force at the core of the Betty Ford Center serving as a constant reminder that addiction treatment and recovery at their best are family-centered processes. Susan Ford Bales' assumption of the Chair of the Board of the Center signals that this involvement and influence will continue long into the future.

In the years since the Betty Ford Center first opened its doors, some 79,000 individuals have been treated at the Center—more than half of whom have been women. Through these years, the Center has developed specialized programs for licensed professionals, innovative programs of focused continuing care and state-of-the-art family and children's programs. In 2006, Betty Ford announced the establishment of the Betty Ford Institute, which will operate independently from the Betty Ford Center and focus its efforts on recovery-focused research dissemination, public and professional education and policy advocacy.

How can we as a field offer adequate thanks for such contributions? Mrs. Ford, know that we love you and that we promise to carry your legacy into the future. To the Ford Family, know that inviting us as a nation to share your pain and your healing has informed and inspired us. Know that previously doomed people are today living full lives because you put a compassionate face and a passionate voice on addiction

and recovery. To Susan Ford Bales who is carrying forward Mrs. Ford's leadership as Chair of the Board of the Betty Ford Center, we thank you for sparking this chain of historical events and for accepting this mantle of continued leadership. We will try to heed your call to create a future of addiction treatment in America that is recovery-focused and family-centered.

To everyone involved with the Betty Ford Center and the Betty Ford Institute, we remind you that your name carries a power possessed by no other addiction-related institution in the world and that this distinction brings obligations and opportunities of enormous proportions. We honor your twenty-five years of service, and we call upon you to use the power of your name, the resources of the Betty Ford community, the talents of your staff and volunteers, and the spirit of courage and hope out of which you were born to cast a beacon of innovation that will help shape the future of addiction treatment and recovery in America.

About the Author: William L. White is a Senior Research Consultant at Chestnut Health Systems, a member of the Executive Council of the Betty Ford Institute, and the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*.



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Changing Profile of the Drinking/Drugged Driver: Implications for Clinical Assessment

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Problems arising from acute and chronic alcohol and other drug intoxication constitute significant public health and safety issues in America. Of particular concern is the role alcohol and other drug impairment continues to play in traffic fatalities on the nation's highways. The rate of alcohol-related fatalities per vehicle miles traveled has dropped dramatically in the past two decades (from 1.64 in 1982 to 0.59 in 2003), but alcohol-related traffic fatalities continue to constitute 40% of all traffic fatalities—more than 17,000 persons killed per year (NHTSA, 2005). At the same time, new understandings about the profile of the drinking driver challenge many long-standing assumptions upon which intervention programs have been built. This article describes the evolution in our understanding of the drinking driver, highlights current research on the "hard core drinking driver," and discusses the clinical implications of these research findings.

Early History

Concerns about alcohol, drugs, and public safety have a long history. Early nineteenth century temperance literature is filled with images of bottle waving, drunken young men careening through city streets in horse-drawn carriages. Such threats led to drinking and driving laws that predate the invention of the automobile. Prohibition promised to end growing concerns about intoxicated drivers, but Repeal brought a new wave of drinking and driving problems in the 1930s as well as regulations aimed at reducing them. It wasn't until the Alcohol Safety Action Program (ASAP) emerged in the 1970s that America launched a comprehensive approach to reducing risks to public safety posed by the alcohol-impaired driver.

Funded by the National Highway Traffic Safety Administration, the ASAP was first piloted within 35 local projects and then widely replicated throughout the United States. The ASAP created local assessment centers whose staff determined if impaired drivers were problem drinkers or social drinkers, linking the former to treatment and the latter to brief remedial education (White,

2004). This system provided an efficient means of processing hundreds of thousands of offenders arrested for driving under the influence (DUI), but came under increasing criticism in the mid-1980s (Kramer, 1986). Evaluations revealed that the ASAP programs were lowering recidivism among the less problematic drinkers but were not producing reductions in rates of alcohol-related crashes (Nichols, 1990). It turns out the ASAP model was based on the "myth of the social drinking DUI offender" (Crancer, 1986)—a myth that continues to influence arrest, evaluation, sentencing, and treatment decisions. This myth is historically rooted in three flawed assumptions.

The first assumption was that the DUI offender is generally a law-abiding citizen—he or she is not a criminal. This assumption was challenged by studies revealing that 40-70% of first-time DUI offenders had prior criminal offenses, most of them alcohol and drug related, e.g., illegal possession of alcohol or controlled substances, illegal transportation of alcohol, disorderly conduct, larceny, criminal damage to property, resisting arrest, public urination, and assault and battery (Taxman & Piquero, 1998; Chang & Lapham, 1996). Collectively, these studies portrayed the DUI offender as anything but an otherwise model citizen and a significant threat to public safety.

The second assumption was that the majority of DUI offenders are not alcoholics or problem drinkers, but social drinkers whose impaired driving represented an isolated error in judgment. This assumption was challenged by studies finding that:

- It takes between 100 and 2000 repetitions of impaired driving violations to statistically generate one arrest (Borkenstein, 1975; Jones & Joscelyn, 1978; Voas & Hause, 1987; NHTSA, 2001).
- The accuracy of alcohol use disorder diagnoses among DUI offenders is seriously compromised by reliance on self-report data, with the rate of retrospective alcohol dependence diagnoses tripling in five-year follow-up studies (Lapham, C'de Baca, McMillan, & Hunt, 2004).
- The majority (most studies now suggesting between 70-80%) of DUI offenders are experiencing significant problems in their relationship with alcohol and/or other drugs (Timken, 1999; Lapham, Smith, C'de Baca et al., 2001).
- The percentage of drivers registering a detectable amount of alcohol in their bloodstream has dropped significantly since the mid-1970s (Yi, Williams, & Dufour, 2002), indicating that the number of social drinking drivers are shrinking, leaving in their wake a residual pool of "hard core drinking drivers" (Simpson & Mayhew, 1991).

The third flawed assumption was that DUI offenders could be educated to moderate their drinking patterns and reduce their threat to public safety. The most methodologically rigorous evaluation of the early ASAP programs concluded that remedial education produced increased knowledge about the effects of drinking and driving but did not reduce rates of drinking and driving, re-arrest, or involvement in future alcohol-related crashes (Nichols & Ellingstad, 1978; Nichols, Ellingstad, & Reis, 1980).

The "Hard Core Drinking Driver"

The total pool of drinking/drugged drivers represents millions of American citizens, but recent studies confirm that the majority of total impaired driving trips are committed by a much smaller core of "hard core drinking/drugged drivers" (HCDD). This group is made up of individuals who, despite education, threats, and punishments, continue to drive frequently (at least monthly) at high BAC levels (above 0.15%) (Simpson, Beirness, Robertson, Mayhew, & Hedlund, 2004). Two recent studies highlight the profile of the hard core drinking driver (White & Gasperin, in press; Syrcle & White, 2006). HCDDs (those at highest risk for re-arrest for DUI and/or future involvement in an alcohol-related crash) are predominately single, separated and divorced males

between the ages of 25-45 with 12 or fewer years of education transiently employed in non-white collar positions and who are enmeshed in a social network of heavy drinkers and drinking drivers. HCDDs are distinguished from non-recidivist offenders by greater family histories of AOD problems; prior exposure to drinking and driving by parent and peer role models; early age of onset of regular drinking (age 14 or earlier); early onset smoking, heavy smoking, and failed efforts to stop smoking; and past year use of drugs other than alcohol. Their first DUI arrest was likely to be characterized by a high BAC (greater than .15) without gross signs of intoxication, collateral charges, and refusal to take a Breathalyzer test. HCDDs believe they can drive safely after consuming large amounts of alcohol, believe penalties for impaired driving should be less severe, and perceive their arrest for impaired driving is a product of bad luck or targeting by police. They are more likely than non-recidivists to have criminal arrests predating their first DUI arrest; have prior DUI arrests in which consequences were avoided, delayed, or minimized; and to have high-risk driving records (e.g., multiple moving violations, prior crashes). In terms of clinical history, HCDDs are more likely to report symptoms of, and/or prior treatment of, psychiatric illness; medical/criminal histories reflecting injury to self and others; and are more likely to exhibit diminished capacity for empathy, guilt, remorse, failure to take personal responsibility, impulsivity, risk-taking, and aggression.

Clinical Implications

The majority of those arrested for impaired driving either already have, are in the process of developing, or will go on to develop a significant problem in their relationship with alcohol and/or other drugs. Traditionally, addiction professionals were asked to answer two questions related to the impaired driver: 1) Does he or she have an alcohol problem and if so, how severe? 2) How can this problem be best resolved, e.g., recommendations that could influence judicial sentencing or probation supervision. It was assumed that answers to these questions would address the larger question of threat to public safety and how that threat could be minimized. But data on HCDDs suggests that effectively evaluating of the degree of the future threat to public safety and containing that threat require a far more comprehensive assessment process and more sophisticated intervention technologies than those traditionally offered.

The changing profile of the alcohol/drug impaired driver and growing recognition of the inordinate role HCDDs play in the total volume of impaired driving trips suggest the need for sophisticated global assessment instruments and advanced interviewing protocol whose conclusions can be used to guide evaluation, prosecution, sentencing, treatment, probation monitoring, and license reinstatement/denial decisions. The growing presence of drugs other than alcohol as threats to highway safety suggests the need for 1) better technologies for the identification, field evaluation, and arrest of drug-impaired drivers, 2) assessment instruments that evaluate the whole spectrum of psychoactive drug use, 3) an expanded menu of treatment options for impaired drivers whose primary dependence is upon a drug other than alcohol, and 4) increased use of drug testing as a monitoring tool for the DUI offender. The clinical profile of the HCDD further warrants more comprehensive assessment protocol (focused on broader driving, criminal, and psychiatric histories), more intense and enduring treatment options, and sustained monitoring of post-treatment status and assertive early re-intervention strategies.

The development of public safety measures to address the threats posed by alcohol- and drug-impaired drivers must be dynamic and accommodate changes in global patterns of substance use, changes in the profile of the American drinking driver, and changes in the characteristics of those increasingly recognized as “hard core drinking/drugged drivers”.

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This interview is part of *Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-Oriented System of Care*, the second in a series of monographs on recovery management published by the Great Lakes Addiction Technology Transfer Center (ATTC).

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The Addiction Technology Transfer Center Network
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The Recovery-Focused Transformation of an Urban Behavioral Health Care System

An Interview with Arthur C. Evans, PhD
By William L. White, MA

INTRODUCTION

Beginning with Dr. Benjamin Rush's eighteenth-century writings on chronic drunkenness as a medical disease, the City of Philadelphia has held an honored position in the history of addiction treatment and recovery in America. That history of innovation continues today in a bold vision of integrating mental health and addiction services within a conceptual framework of long-term recovery. Leading that innovation is Dr. Arthur Evans, Director of the Philadelphia Department of Behavioral Health and Mental Retardation Services. The following is an interview I conducted with Dr. Evans in November, 2006 on behalf of the Great Lakes Addiction Technology Transfer Center. In this wide-ranging interview, Dr. Evans eloquently describes the behavioral health system-transformation process that is underway in the City of Philadelphia. In my writings I have posed the question, "How would we treat addiction if we <u>really</u> believed that addiction was a chronic disorder?" Answers to that question are emerging in Philadelphia in a way that will influence the future of addiction treatment in America.

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GREAT LAKES ATTC: Could you summarize your professional background and the circumstances that brought you to Philadelphia?

DR. EVANS: I'm a clinical and community psychologist and have been working in the addictions field for the last 19 years, first as a practitioner and program manager, then in policy-level positions in the State of Connecticut. I served as the Director of Managed Care and then Deputy Commissioner for the Connecticut Department of Mental Health and Addiction Services. In that role, I was very much involved in strategic planning and leading system-transformation efforts in Connecticut. I was then invited to come to Philadelphia to fill a newly created position following the city's decision to combine all of its behavioral health services into an integrated system. I was recruited to continue building on the history of innovation in Philadelphia's behavioral health system.

GREAT LAKES ATTC: Provide an overview of how behavioral health services are organized in Philadelphia.

DR. EVANS: Pennsylvania has a county-based delivery system, with all dollars flowing through each single county authority. On the mental health side, our single authority is an Office of Mental Health, which receives all statewide grant dollars allocated for the city of Philadelphia and is one of three units within the Department of Behavioral Health/Mental Retardation services (DBH/MRS). The Office of Metal Health is responsible for services to primarily indigent individuals who have problems related to serious mental illness. There's also an Office of Addiction Services, which receives state dollars and federal grant dollars for people with addictive disorders. And then there is Community Behavioral Health (CBH), which is a private, non-profit, 501(c)(3) managed behavioral healthcare organization that is fully owned and run by the city. I'm the president of the Board of CBH, and the executive director of CBH reports to me. CBH administers behavioral health payments for practically all of the Medicaid populations that are served in the city. So those three entities allow us to manage practically all of the behavioral health dollars in Philadelphia as a single public system.

GREAT LAKES ATTC: How did the vision develop to redesign mental health and addiction services toward greater recovery orientation?

DR. EVANS: When I came into this position, the city had a fairly long history of innovation, particularly around how it has organized and administered behavioral health services. Through our initial discussions with multiple community constituencies, there was a desire to move our system of care toward greater recovery orientation, which was consistent with national policy directions as indicated by the New Freedom Commission Report and recent Institute of Medicine reports. What emerged from these discussions was a clear vision: *an integrated behavioral health care system for the City of Philadelphia that promotes recovery, resiliency, and self determination.*

GREAT LAKES ATTC: You made a decision early on to use the recovery orientation as the bridging concept between mental health and addiction services. How has this vision guided your work?

DR. EVANS: It is clear that many of the people we serve have co-occurring mental illness and emotional disorders. As we listened to the stories of people in recovery, it quickly became clear that we needed to find a way to serve these people more holistically. It was critical for us to have a vision of recovery that really incorporated both addiction and mental health, and an integrated vision through which we could plan and allocate funds for both mental health and

addiction services. Because of the unique structure of the Department of Behavioral Health in Philadelphia, we have been presented with an incredible opportunity to make this integration real at every level. Our goal is to move toward a unified framework of behavioral healthcare. Two early steps were important in this process. First, we brought together representatives from the mental health and addiction fields, including recovery advocates, people in recovery and family members, and providers of services, and we developed the following shared understanding of recovery:

> *Recovery is the process of pursuing a fulfilling and contributing life regardless of the difficulties one has faced. It involves not only the restoration but continued enhancement of a positive identity and personally meaningful connections and roles in one's community. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices, and opportunities that promote people reaching their full potential as individuals and community members***.**

Second, we developed a set of nine core recovery values that would guide our system-transformation process in both mental health and addiction service settings. Those values were *hope, choice, self-direction/empowerment, peer culture/peer support/peer leadership, partnership, community inclusion/opportunities, spirituality, family inclusion and leadership, and a holistic/wellness approach.*

GREAT LAKES ATTC: You've described the ongoing system-transformation process as unfolding in three overlapping stages: aligning concepts, aligning practices, and aligning context. Could you describe those stages?

DR. EVANS: Our goal is systemic and lasting change in the design and delivery of behavioral healthcare services. As a result, we made a conscious effort to think about: 1) how we want thinking to change, 2) how we want people's behavior to change, and then 3) how we want to change the policy, fiscal, and administrative contexts to support the behavior and thinking that we ultimately would like to see in the system. All of our system-transformation activities keep these three areas of focus in mind. For example, if we focus only on trainings that introduce a particular area of behavioral change—let's say the increased use of motivational interviewing—but we haven't aligned our policies and funding decisions to support that shift, this behavioral change won't be able to be sustained over time. Alternatively, if we focused on trainings that promoted a certain philosophical viewpoint without giving people practical ways that their behaviors needed to change in order to reflect this new viewpoint, those trainings would not effectively support systems transformation. These three areas—concept, practice, and context—are interrelated and cyclical. Our ability to obtain conceptual clarity influences our ability to successfully operationalize our transformation values. The manner in which recovery-oriented practices are defined and implemented shapes the regulatory and fiscal support necessary for lasting change. Regulatory and fiscal policies in turn have an immediate impact on the kinds of services and supports we can develop for people seeking recovery.

GREAT LAKES ATTC: There are growing calls to transform behavioral health care agencies into truly "recovery-oriented systems of care." How did you convey to your service providers exactly how service practices would change within such systems of care?

DR. EVANS: We engaged service consumers and providers in dialogue about how practices would change, and in our published plan for system transformation we outlined twelve areas in which we expected services to change and outlined the direction of such changes. The chart below illustrates our summary of those changes within our *Blueprint for Change*.

***Service Engagement*:** Expand outreach services to reach people (individuals, families, communities) at earlier stages of problem development.

Service Access: Continue the rapid level of service access that has long-characterized some components of the Philadelphia behavioral health service system (e.g., substance abuse treatment services) and increase the ability to access services in other areas (e.g., psychiatric access, housing with community supports, etc.)

Recovering Person's Role: Emphasize the rights of people in recovery to participate in and direct service decisions, plan for services, and move toward self-management of their own recovery journeys in collaboration with the people who serve them.

Service Relationship: Shift the primary service relationship from an expert-patient model to a partnership/consultant model.

***Assessment*:** Move toward assessment procedures that are global (holistic), strengths-based (rather than pathology-based) and continual (rather than an intake activity).

Clinical Care: Move to clinical care services that are recovery-focused, evidence-based, developmentally appropriate, gender-sensitive, culturally competent and trauma informed. These services recognize that excellent clinical care is critical but is only one aspect of service needed among others in a recovery-oriented system.

Service Retention: Enhance service retention rates (reducing rates of service consumer disengagement and rates of administrative discharge) by increasing the quality of clinical services and enhancing in-treatment recovery support services.

Locus of Service Delivery: Increase the delivery of community integrated, neighborhood- and home-based services and expand recovery support services in high-need areas. This enhances normalization and the effectiveness of skill teaching and skill retention, and decreases stigma.

Peer-based Recovery Support Services: Dramatically expand the availability of non-clinical, peer-based recovery support services and integrate professional and peer-based services.

Dose/Duration of Services: Provide doses of services across levels of care that are associated with positive recovery outcomes. The intent is that intensity of services will naturally decrease over time as recovery stability and quality increase, but that recovery checkups and, when needed, early re-intervention will continue for a considerable period of time. The system will develop innovative means for this connection (e.g., assertive phone follow up). Our vision is continuity of contact in a primary recovery-support relationship over time.

Post-treatment Checkups and Support: Shift the focus of service interventions from acute stabilization to sustained recovery management via post-treatment recovery check-ups. Support the use of Peer Specialists for post-treatment follow up, stage-appropriate recovery education, assertive linkage to recovery communities and, when needed, early re-intervention. Shift from passive aftercare to assertive approaches to continuing care.

Relationship to Community: Greater collaboration with indigenous recovery support organizations (e.g., faith community), more assertive linkages of clients to local communities of recovery, greater role in recovery education/celebration in larger community and greater role in recovery advocacy (e.g., issue of stigma and discrimination).

Source: *Recovery-Focused Transformation of Behavioral Health Services in Philadelphia: A Declaration of Principles and a Blueprint for Change,* Philadelphia Department of Behavioral Health and Mental Retardation Services

What we tried to achieve in our *Blueprint for Change* was to outline how the practices of our Department and our service providers would change through the system-transformation process, and how consumers and family members and other community resources could play important roles in this process.

GREAT LAKES ATTC: How did you plan the system-transformation process, and what constituencies did you involve in this process?

DR. EVANS: We think an inclusive, "big tent" approach is very important. From the very beginning, we engaged a variety of stakeholders, including people in recovery, providers, our staff, diverse community groups, and the faith community, because we had to find ways that the concept of recovery would resonate with all of those various constituencies. We created a Recovery Advisory Committee (RAC) that spent several months developing the consensus definition of recovery and core recovery values that all of those various groups could embrace. We continue to host regular community forums where people from across the city can come and share their thoughts and ideas about the system-transformation priorities. We believe that such partnering and ongoing input are critical for the long-term success of systems transformation.

GREAT LAKES ATTC: What are the early priorities that emerged out of that process?

DR. EVANS: For the next two years, we will be focusing our change efforts within seven priority areas: community inclusion/opportunity, holistic care, peer culture/peer support/peer leadership, family inclusion and leadership, partnership, extended recovery supports, and quality of care.

GREAT LAKES ATTC: In your presentations describing the system transformation, you have talked about the importance of parallel process. What do you mean by this?

DR. EVANS: What I mean by this is that the relationship we want to see between our direct-care providers and those they serve must be mirrored inside our department, both in the relationship between our department and the treatment providers and in our relationship with other community organizations. This realization has forced us to think about our own behavior and how it helps or hurts our system-transformation efforts. An early and ongoing priority for us was to make sure that the way we were doing business was consistent with the way we wanted our service providers to do business. For example, in planning new initiatives, we are involving the provider and recovering community in the early stages of thinking and development of ideas, rather than "telling them" what we want them to do. In the same way we are hoping that providers will tap the expertise of people in recovery, we are also trying to tap the expertise of providers in solving the problems that confront us both. Also, stressing the importance of dignity and respect in how we interact with one another has been a cornerstone of these efforts.

GREAT LAKES ATTC: How are you continuing to work at system transformation at the same time you have to maintain much of the system's functioning?

DR. EVANS: When you're running a billion-dollar organization, most of your energy and the organization's energy is focused on keeping the organization going, and relatively little of that energy is directed towards strategic planning, visioning, and taking the organization in a new direction. So first we had to build an infrastructure. We had to develop roles that allowed people to devote time to conceptualizing where we wanted to go, working on new initiatives, engaging various stakeholders, and developing the many products that were crucial to the system-transformation process. We did this by hiring a director of strategic planning, who would work in partnership with the director of policy and planning to develop and move system-change efforts forward. We created an internal steering group, the Systems Transformation Steering Committee, composed of representatives in key positions across the department. This group is also charged with developing and moving system-change initiatives forward. We have used national and local consultants to add expertise to the already existing skills of our staff and to support our major change initiatives. We developed specific targeted projects to implement our vision. Right now, for example, we are transforming our maintenance partial hospitalization system into a recovery-oriented, community-integrated system of services and supports. In order to do this, we are introducing all the transformation priorities into these transformed programs. We are working in partnership with people in recovery and providers in all aspects of the development of these programs. We are working with the State to break down regulatory and funding barriers to the provision of recovery-oriented services. This same process is happening in many new initiatives.

GREAT LAKES ATTC: Describe your use of workgroups to plan and implement change for particular service areas.

DR. EVANS: That's an example of where we had to behave in ways that were consistent with the recovery philosophy. One of the first things we did was to identify those areas where we thought it was important to have concentrated work—issues that we felt were critical to achieving a recovery orientation. Spirituality, for instance, is important to many people in recovery, and yet the linkages between the Department and the vast faith community in Philadelphia were weak. We developed our faith-based task force to work at developing these partnerships, which are envisioned to be reciprocal in nature. We bring resources to the table for the faith-based organizations, and they bring resources to us.

We know that, in a recovery-oriented environment, expert clinical care is critical. The Evidence-Based Practices (EBP) workgroup was developed to review the current state of the science and to develop recommendations for current EBPs, promising practices, and support structures for their implementation and installment in organizations. One outcome of our work in this area is the development of a new partnership with Dr. Aaron Beck and the Beck Center for Cognitive Therapy. This will have a direct impact on clinical care as we introduce cognitive therapy throughout our service system.

The Trauma Task Force is looking at the critical role that trauma plays in many addiction and mental health disorders, and is developing creative ways to incorporate trauma-informed services into our provider organizations.

The content of these workgroups is important, but the process for developing them is equally important. We staffed the workgroups by opening them up to everyone in the organization. I sent out an email that basically said, "We have a variety of workgroups. Anyone in the organization, regardless of your role, has the opportunity to be a part of the workgroups." Well, one of the interesting things we found out is that people who were in non-programmatic administrative and support positions signed up to help with these groups. We found out that many people in our organization were in recovery or had family members who were in recovery or struggling with addiction or mental health problems. They wanted to be a part of this service-improvement process, and they brought a very important perspective that the programmatic staff didn't always bring. The message their inclusion sent was that, if we truly believe in partnership at all levels, if we truly believe in the idea of people rising to their highest level of potential, we had to create opportunities like that internally, as a way of modeling what we wanted our providers to do. This engaged a whole layer of the organization who, quite frankly, had been underutilized in the past. It engaged them and got them really excited about the work we were doing.

This same process is happening at provider organizations across the city. As they catch the vision, or feel freer to pursue the vision they have been developing in the past few years, they are reaching out to new people within their organizations. They are engaging community partners, working with faith-based organizations in new ways, looking at the evidence for their clinical practices, and increasing their trauma awareness and capacity for intervention.

GREAT LAKES ATTC: You developed a very close relationship with the Pennsylvania Recovery Organization—Achieving Community Together (Pro-Act) and other recovery-advocacy organizations. How important do you think those relationships have been to the transformation process?

DR. EVANS: Engaging the recovery community, and engaging the recovery community in new ways, has been one of the most important things that we have done. Pro-Act has been terrific in the process. They have been out front in helping to put a face on recovery, something that we support tremendously. They have helped us engage the recovery community in a variety of activities, and they've been able to carry the message of recovery and the hope of recovery to communities that we may not have been able to reach as a department. They have pushed our thinking about what we should be doing as a department, both with our funded service organizations and with the larger community. It is hard to imagine having done this work without the partnership with Pro-Act.

GREAT LAKES ATTC: In relationship to the broader community, you made a decision early on to involve the faith community in this initiative. How did you come to that decision, and what has been the outcome of that involvement?

DR. EVANS: There are several reasons we felt it was important to involve the faith communities. First was our recognition that many people recover within the perspectives, beliefs, and contexts generated from their faith. As a result, we felt it was important to recognize the potential role of spirituality in the treatment and long-term recovery process. We also knew that there are many people who will not engage in treatment without the blessing of their faith communities. People often seek help initially from within their faith communities, and we wanted to build connections between these communities and our behavioral health service system. We felt the faith community, particularly the clergy, was in a position to help us achieve our goals, and at the

same time that we could be of service to them. We were particularly interested in the support that faith communities could provide to people during and following addiction treatment. We wanted to help those entities in the community that were there to support people coming out of prison and out of treatment, and to help them do that work on a long-term basis.

GREAT LAKES ATTC: How did you prepare the existing addiction treatment agencies for the changes that would be coming through the system-transformation process? There must have been considerable anxiety about what this would mean for everyone.

DR. EVANS: We did a number of things. First, we engaged them from the very beginning, articulated the vision of where we wanted to go, and invited them along on the journey.

We brought in top people from around the country, people like Bill White and Mike Hogan, to help articulate and legitimize our vision and to generate excitement about where we were going. We continue to involve the provider community in the major decisions we have made and are making as part of the whole transformation effort. For most major efforts we have cross-system workgroups that involve providers, people in recovery, and family members, as well as DBH staff. We've tried to be very transparent about our decision-making. Finally, we've tried to make sure that what we are promoting is clearly reflected in the Requests For Proposals for funding that we issue. We have tried to be consistent in our messaging and catch ourselves when we are doing things out of old habits that violated those core messages.

GREAT LAKES ATTC: Do you think that the fundamental relationship with the provider community has changed through this process?

DR. EVANS: I think that they are becoming more trusting of and more open with us. We are trying to move away from a policing role—the "gotcha mentality" that we in government can drift into. We are trying to move toward a partnership model that emphasizes our need to work together toward a shared recovery vision. Through developing workgroups that involve all stakeholders on different topics, we are tapping into the expertise of the provider community as we plan and develop new initiatives, practices, and vision. Our addictions group is currently involved in a process that involves all stakeholders in planning the next steps in transforming this segment of the system.

GREAT LAKES ATTC: What are some of the changes that you've seen already through the system-transformation process?

DR. EVANS: The thing I get the most satisfaction from is the fact that people have a voice now who historically have not had a voice within our system. Foremost among these are people in recovery and their family members who are not a part of the "professional" advocacy groups and had not historically participated in the Department's planning efforts. We have hired people in recovery in the Department to help us in this transformation. We are training and mentoring them to assume leadership roles in the future. We recognize that, while many organizations have people in recovery on staff or on boards, it takes additional support and training to have them assume true leadership roles. We are committed to this process.

We have also opened ourselves to input from the larger non-professional community in ways that are unprecedented. These are just people in the community, including faith leaders and

leaders of grassroots community-based organizations, who now are engaged with us in very important ways. There are also several other things that come to mind.

We have committed to train and hire 100 peer specialists in the system over the next year. These are people who have mental illness and/or co-occurring disorders who have moved to a place in their recovery where they are ready to "reach back a hand" to someone else. Hiring these trained people into our provider organizations will be a huge step forward in advancing the voice and leadership of people in recovery.

We are moving our "monitoring process" to one which is less focused on adherence to regulation and more focused on recovery and recovery outcomes. We're redoing our evaluation process with a focus on recovery outcomes, as opposed to traditional process measures. We are developing funding models that support recovery-oriented services and incentivize recovery outcomes. We're looking at how to create funding mechanisms where dollars follow the client. We're looking at funding mechanisms that provide people with a menu of services, as opposed to site-based services where people don't have those kinds of options.

GREAT LAKES ATTC: You've taken people inside your organization who for years have seen themselves in a policing function and transformed them into technical consultants and partners with agencies. That is a radical change in the monitoring process.

DR. EVANS: That is a huge change that we are still working on. An example of progress that we are making in this area is with our monitoring and credentialing process. Providers have often complained that this process is too focused on minor details (e.g., a missing signature), rather than on the bigger picture of quality of care. Recently I have had a number of providers share with me that they had a great credentialing visit—that it was very helpful. This is something we'd never heard before. This is a credit to our staff, who are really focusing on quality and making a variety of important changes to move the system forward and improve care. Providers are starting to see us as collaborators in this process—as people who are trying to help them provide a better service. We've still got a long way to go, but we're clearly making progress.

GREAT LAKES ATTC: As you look back over this process, are there any lessons that you think you would share with other cities or states wanting to pursue a similar system-transformation process?

DR. EVANS: I can't say enough about the issue of parallel process that we touched on earlier. Consistency—walking the talk—is very important. You can't have a singular external focus of telling the providers what they need to do in order to be more recovery oriented. It has to be, "What do we collectively need to do to conduct our business in a way that is consistent with these values? And then how do we help and partner with our providers and consumers and other stakeholders to make this transformation happen?" To me, the most important aspect of this is having a mindset that is collaborative, that is supportive, and that is consistent with the values of recovery. After that, there are a number of things we've learned. First of all, transparency is very important. You can't promote a recovery-oriented system and then make decisions about how you're going to fund and who you're going to fund with opaque processes that people don't understand. That doesn't work. I think the other thing that we've learned is: communication, communication, communication. You have to keep putting the message out, letting people know what you're doing and why you're doing it. I think it's also important to give people practical examples of what you want them to do. So you're not only articulating that a

recovery orientation is important, but you're also providing people with opportunities to get training and support around how they're going to change their practice.

Another key lesson is the role that relapse plays in this systems transformation work. This is another example of our parallel process. Providers, people in recovery, and families are all used to doing things one way, and the pull back to the familiar is always there. "Relapses" of many kinds will happen. We are learning to plan for them, to learn from them, and hopefully to build in supports to lessen their occurrence.

GREAT LAKES ATTC: You've made an incredible investment in training through this process, both local training and bringing outside people in for training. Could you comment on that?

DR. EVANS: We've had to do that. The training that most behavioral health professionals get offers no consistent recovery orientation. You can't assume people have been trained from this perspective, so it must become part of everyone's orientation and training within the field. We felt that we needed to put a significant amount of resources into training, to help people have a different way of thinking about the work, but also help them have a different way of behaving. The trainings are designed to give people different options in terms of how they design and deliver high-quality services. We also made an important strategic decision about the nature of this training. People in recovery, providers, and staff from the Department are trained together. This format has modeled the kind of partnerships we are working to develop and has definitely increased the impact of the training. Training in this way is another example of the parallel process.

In the next 12-18 months we are going to build on this basic training through providing training that advances, not just our collective understanding of recovery, but also the implementation of recovery-oriented practice across the behavioral health system.

GREAT LAKES ATTC: As you look back over this process, what are some of the areas of system transformation that you feel you've had some of the greatest success in?

DR. EVANS: I think we have a considerable amount of buy-in from multiple constituencies at this point in the process. We try to keep our ear to the ground in terms of what people are really saying, and we create opportunities for people to tell us what they're really thinking, through focus groups and other mechanisms. We now have almost universal acceptance of our core ideas by our stakeholders. I think that's huge.

One other area that really excites me is what I see happening among the communities of people in recovery. We have people in recovery now working as consultants within DBH on major projects. There are people involved in change-management teams at provider organizations. There are people sharing their recovery stories in many public venues; and there is a new energy, enthusiasm, and emerging leadership capacity within that community. This is critical in terms of moving us toward a "consumer-directed" system.

We also are developing new initiatives that are true partnerships. We recently funded several prevention initiatives but required that the applicants for those funds demonstrate partnerships between providers and local grassroots organizations. We are providing seed-grant funding for enhancement of programs over the next year to providers who are willing to commit to moving our system-transformation priorities forward in innovative ways.

All these seemingly separate initiatives create a synergy of vision, energy, and momentum that will support moving this transformation forward.

GREAT LAKES ATTC: One of the obstacles that people often cite in discussions of moving toward greater recovery orientation and shifting from models of acute care to sustained recovery management is the question of financing. Do you have any thoughts about where service financing models will go in the coming years to support this recovery orientation?

DR. EVANS: We are going to need different kinds of funding models, because many of the things that support recovery are not what we are reimbursing in the fee-for-service rates through which we currently pay service providers. We're going to need to move to more risk-based financing models that give people more flexibility in how to use the dollars that they receive and place the emphasis more on service outcomes and less on units of service delivery. The other thing we need to think about is how we can support giving people a menu of options, and how providers can offer those options in ways that are financially viable. We're attempting to do that with a major redesign of our partial hospital programs and our day-treatment programs. We're attempting a radical redesign based on the notion of giving people a menu of choices, having fewer site-based services, and providing more services in the community. We're working with the state to develop a financing model through Medicaid that will allow us to do that. We have to invest energy, time, resources, and commitment to work on those issues.

GREAT LAKES ATTC: Have federal programs and regulatory guidelines helped or hindered the transformation process in Philadelphia?

DR. EVANS: Medicaid policies have been the most difficult. With State grant dollars, we have more flexibility to purchase services that are more supportive of people's long-term recovery. The biggest impediment for us is the medical necessity criterion that is required through Medicaid, and how narrowly that's defined. If I were to identify one barrier, that would be it.

There could be many other examples, but another one that impacts us daily is the division between mental health and addictions funding and regulations. This division stands in the way of a truly unified behavioral health system organized around the needs of the person in recovery.

Another is Medicaid's perspective that "treatment services" are best provided on site, when in actuality people's lives happen in their communities. This presents an obstacle to providing resources to support true learning in people's natural environments.

Both of these barriers are being worked on now with key policy makers at the State.

But it's not just external obstacles. Our own regulations have sometimes been an obstacle. We're constantly fighting them. We can be our worst enemy at times, by doing things because of tradition and history. We are involved in an internal process to continue to move toward flexibility and a base of regulations that promotes recovery and support for the person's recovery plan. One project that is assisting with this is our Unit Recovery Planning Initiative. Each unit within the Department is going through a process to explore the implications that our system-transformation priorities have on their daily work and decision making. As a system, we have spent a significant amount of time developing a shared vision. Now internally we are

examining what that vision means for our internal practices, policies, and fiscal strategies. Consistent with the collaborative and inclusive approach that we have taken thus far, each member of each unit is a part of this process. Through engaging in this work, staff are developing an increased sense of ownership in the transformation. They are also identifying the tension between our current practices and our envisioned system of care, and as such helping us prioritize our focus.

GREAT LAKES ATTC: How are you planning to evaluate the system-transformation processes that are underway?

DR. EVANS: We're going to do a number of things. One of them is that we've established a recovery baseline assessment of our whole system. We basically required all of our providers to complete a recovery assessment that collected information about the perception of the recovery orientation of each program from the viewpoint of the management staff, the director, the staff, and service consumers and their families. We scored them and rated them, and we will reassess the system after a year or so to see how these key dimensions have changed. We are doing ethnographic studies of the processes we have used to implement the change process. And we are also looking at recovery outcome measures at individual, program, and system levels.

GREAT LAKES ATTC: What do you see as the next major steps in the system-transformation process in Philadelphia?

DR. EVANS: One of the exciting but challenging things about this process is that it has so many facets. I think there are several key things we need to focus on in this next stage. One critical area is continuing to build on the momentum that we created thus far around increasing, not only the involvement, but also the leadership of people in recovery in the system. As such we will continue to support people in recovery in achieving and maintaining diverse leadership roles and having opportunities to participate in policy decisions going forward. To advance this goal, we are currently exploring a partnership with a local community college to develop a leadership program for people in recovery that will lead to an Associates degree. We will also be exploring the development of more consumer-operated services.

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A second major area that I think we have to continue focusing on is changing our own internal policies to be more consistent with a recovery orientation. I think we still have some work to do internally to be an organization that conducts its business within a recovery-focused framework. In order for this transformation to take root and lead to sustained change, we are going to have to be even more consistent in walking our talk and creating policies that will support the transformation. We have begun this next phase in partnership with providers and people in recovery. One of our system-transformation priorities, for instance, is community integration. As providers have begun to change their practices to facilitate increased opportunities for people to become fully integrated into their communities, they have expressed concerns about balancing consumer choice with their professional assessment of an individual's readiness to engage in certain activities. They want to know, when there is a discrepancy between the two, what should they do? They have also asked about how their liability as providers is factored into all decision making. To address tensions such as this, we are developing ad hoc workgroups such as our risk assessment workgroup. This consists of a diverse group of stakeholders who are exploring together what risk assessment should look like in a recovery-

oriented system of care, and what monitoring policies and practices need to be changed within our department to support the providers' movement in this direction.

In addition to tackling some of the tensions that emerge as we increasingly strive to operationalize and implement recovery-oriented care, we are also seeking to develop demonstration projects which can be models of recovery-oriented care for the rest of the system. Right now we are in a competitive application process to award mini grants to providers and community-based organizations. Innovative projects that result from this and other initiatives will be highlighted and celebrated at a one-day conference early next year. We believe that a critical part of this phase of the transformation process will be creating opportunities for the development of a learning community where our department, people in recovery, family members, and providers can come together to share lessons learned and celebrate successes.

This next phase will also involve an increased focus on enhancing naturally occurring recovery supports in the broader community. We have people in recovery coming to us right now wanting to start mutual-help groups that don't currently exist in their neighborhoods. We are developing a training program for these leaders on how to develop, implement, and sustain mutual-support groups. These groups will be in the community, drawing from the community and giving back to the community. We are also increasing our focus on supporting grassroots community-based organizations and faith-based organizations where many people in recovery turn for help, and ensuring that linkages between this informal "treatment" system and the formal treatment system are strengthened.

Finally, in this next phase of the transformation, we are going to increase our focus on delivering more services and supports that are evidence based. The people we serve deserve the best, and we need to get tooled up to deliver it.

We have much to do, but we are very excited about these new directions that the stakeholders in the system have chosen.

This interview is part of *Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-Oriented System of Care*, the second in a series of monographs on recovery management published by the Great Lakes Addiction Technology Transfer Center (ATTC).

GREAT LAKES attc
The Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration
Unifying science, education, and services to transform lives

Recovery as an Organizing Concept

An Interview with H. Westley Clark, MD, JD, MPH, CAS, FASAM
By William L. White, MA

INTRODUCTION

The effort to achieve a more recovery-focused system of care in the design and delivery of addiction treatment services has received considerable impetus from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). Through programs such as National Recovery Month, the Recovery Community Support Program (RCSP), Access to Recovery (ATR), and the Recovery Summit, to name just a few, CSAT has moved recovery to the conceptual center of its efforts to enhance the availability and quality of addiction treatment in the United States. I conducted the following interview with Dr. H. Westley Clark, Director of CSAT, January 12, 2007, on behalf of the Great Lakes Addiction Technology Transfer Center (GLATTC). The interview provides one of the most compelling statements to-date on this shift toward a recovery paradigm.

William L. White, MA
Senior Research Consultant
Chestnut Health Systems

GREAT LAKES ATTC: Dr. Clark, could you highlight your professional background and the circumstances that brought you to CSAT?

DR. CLARK: I'm a psychiatrist and addiction medicine specialist, and have worked in the addictions field off and on for the past 30 years. Before coming to CSAT in 1998, I had most recently worked for the Department of Veterans Affairs in San Francisco, serving vets with substance use disorders, psychiatric disorders such as Post-Traumatic Stress Disorder, and

medical disorders such as HIV. I also have a degree in Public Health and a degree in Law, which have increased my sensitivity to some of the policy issues germane to the substance abuse arena. My professional interests before coming to CSAT included such diverse areas as substance use among pregnant women, workplace drug testing, and working with substance use in the criminal justice system. I also worked as a senior policy advisor for the Robert Wood Johnson Foundation's Substance Abuse Policy Research Program.

GREAT LAKES ATTC: During your tenure at CSAT, recovery has emerged as a central organizing concept, both at SAMHSA and at CSAT. Could you describe the background of this shift in emphasis?

DR. CLARK: Recovery has been a key construct in the substance use disorder arena for some time. Recovery, as you know, is an integral construct of 12-step and other self-help programs. It became clear to me as a clinician that it is not simply acute intervention that helps a person. It's the ability to receive ongoing contact and support from others, either through professional support or through a community of recovering peers. Recovery is more than an abstinence from alcohol and drugs; it's about building a full, meaningful, and productive life in the community. Our treatment systems must reflect and help people achieve this broader understanding of recovery.

A few things happened at SAMHSA that facilitated the evolution of the recovery construct over the past five years. SAMHSA adopted recovery as its central vision. Our vision is a life in the community for everyone, and our mission is one of building resilience and facilitating recovery. CSAT, in turn, developed the vision of "Making the hope of recovery a reality…." Prior to 2002, we had a Recovery Community Support Program (RCSP) that organized people in recovery to advocate for themselves at the state and local community levels. We then translated that into a focus on peer-based recovery support activities within local communities. We made significant strides in building relationships in the community and expanding local recovery support services. The next major milestone was Access to Recovery, a Presidential initiative that provided a hundred million dollars a year for further expanding recovery support services provided by grassroots recovery community organizations and faith-based organizations. The new SAMHSA and CSAT missions and these two CSAT programs helped push recovery to the forefront of our activities at CSAT.

GREAT LAKES ATTC: CSAT's Recovery Month activities have grown exponentially in recent years. What do you see as their collective goal, and to what do you attribute such phenomenal growth?

DR. CLARK: Communities across the country have been concerned about the misuse of substances and the wide range of people affected by such misuse. National leaders and local community leaders recognize that we need the community benefits of recovery, and we need local communities to support people in recovery. And we want to provide a framework through which people in recovery can help others in need of recovery. That's what I've been promoting. We want support for those in recovery. We want people in every community to know that treatment works, that recovery is possible, and that long-term recovery is a reality. We want recognition for those in recovery, for their service providers, and for the efforts of local communities. Recovery Month provides such recognition through an ever-widening range of activities, including ballgames, picnics, pow wows, recovery celebration walks, and educational events. These events reward the hard work of people in recovery, their families, and the various organizations that have supported the recovery process. Seeing thousands of people in recovery gathered together reinforces the possibility and promises of recovery.

These events also provide a venue for organizing community response to new or resurging drug problems. A recent issue is methamphetamine. Large numbers of communities are seeing a drug that they hadn't seen before. In the beginning of the methamphetamine phenomenon, a number of people proclaimed that those affected were hopeless. What that meant for the community was that they would have to write off their sons and daughters. I think the community at large is loath to do that. Recovery Month offers an antidote to such pessimism by offering living proof of long-term recovery and its blessings to individuals, families, and communities.

GREAT LAKES ATTC: CSAT recently sponsored its first national Recovery Summit. What do you think was most significant about this event?

DR. CLARK: We are facilitating multiple discussions about recovery as a construct. We think that through the ATR and RCSP programs we can play a critical role in championing the impact of the holistic community-based system aiding recovery. The Recovery Summit helped articulate principles and guidelines that can guide our work. If we are going to foster recovery, we need to have a clear understanding of the range of recovery experiences and the elements that go into long-term recovery. We need the participation of the recovery community, the treatment community, and the research community to do that. I was quite happy with the Summit and our work to begin this dialogue across communities that often have little contact with one another.

GREAT LAKES ATTC: One of the most significant initiatives under your leadership at CSAT has been the Recovery Community Support Program. What do you think are some of the most significant contributions of the RCSP?

DR. CLARK: The RCSP program has demonstrated that people in recovery can in fact participate in offering assistance to other people who either are beginning the recovery process or need to have their long-term recovery efforts supported. The RCSP program is designed to help reduce stigma and barriers to service. We have two models. We have professionally facilitated recovery and peer-based recovery. Both models operate on the principle that the consumer can play a critical role in the recovery process. The peer support model offers several examples of services that are consumer driven and that can serve as important adjuncts to formal substance abuse treatment and prevention efforts. Peer-based recovery support services build on and extend the effects of acute intervention.

I think one of the things coming out of our ATR program is the understanding that the outcomes of acute intervention can be enhanced and sustained. We don't want to just describe the substance use disorder as a chronic relapsing disease and just leave it at that. What our peer support services, facilitated support services, and recovery model do is to stretch the effects of our interventions, while at the same time reducing the frequency of such acute episodes. We don't have to wait until a person completely relapses, with all the attendant problems with the family, the workplace, and the law. Recovery support services provide a vehicle to prevent relapse or to prevent lapses from progressing into full relapses. And we don't have to wait for people to hit bottom. What peer support efforts do is lift the bottom, so that individuals can find recovery before they've alienated their families, their employers, and the legal system.

GREAT LAKES ATTC: What do you envision in terms of the future of the RCSP program?

DR. CLARK: Well, as with all of our programs, we are tied to available funds. We are currently collecting performance data on the RCSP program, to make sure that we're achieving our goals and objectives. I'd like to continue to support the RCSP program, because it does represent the efforts of individuals in recovery. We would like to see if we can get the state agencies to acknowledge the utility of recovery support services as a part of their continua of care. We hope to demonstrate that peer-based recovery support services are more cost effective for individuals, families, and the community, and that they complement rather than compete with professionally directed treatment services. In fact, peer-based recovery support services enhance the impact of professional care by sustaining the effects of such care long after the intervention is completed. When I used to run a 28-day program, I would ask myself, "What happens on day 29?" Then, when I worked in an intensive outpatient program, I saw somebody 3 or 4 times a week, but I only saw them a few hours out of a 24-hour day. What did they do the rest of the time? You quickly learn—especially early in the process—that from a neuropsychological point of view, people are a lot more vulnerable in the early stages of recovery, after acute treatment. So I wanted something that would help me do my job. Recovery support services help me do my job, and they help the professional's patients build a life in recovery after the professional has helped initiate that recovery process.

GREAT LAKES ATTC: There have been recent calls to shift addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management. To what extent does this represent a fundamental change in the historical design of addiction treatment?

DR. CLARK: Substance use disorder treatment in the United States is being scrutinized from multiple perspectives, and the whole notion of sustained recovery management is consistent with the notion of disease management that you find elsewhere. The chronic disease model recognizes that there is no acute solution. You break your leg, you put a cast on it; it heals, and you go on with an otherwise unchanged life. You don't have a problem—unless, of course, you're into extreme sports. But if you've got asthma, you're going to have asthma off and on for awhile. If you've got diabetes, your diabetes is going to require different management strategies over a prolonged period of time, if not for the rest of your life. Some strategies are just diet and careful monitoring of what you eat. Other strategies include oral pills. Another strategy is insulin. These are different strategies, but they all require a fervent effort. Like long-term management of any other chronic disease, the substance use disorder recovery management strategy offers a framework for sustaining and actively managing recovery over a lifetime.

What recovery management does is allow you to differentiate and titrate the intervention. Not everybody needs an intervention at the same time or at the same level of intensity. Relapse is a common event early in the treatment and recovery process, and there are points of heightened vulnerability later in the recovery process. The recovery management model acknowledges this vulnerability but posits that relapse is not inevitable if the ongoing recovery process is actively managed.

We also have people with multiple problems, such as co-occurring depression or anxiety disorders. We've got complex medical issues, like HIV, Hepatitis, and AIDS. We've got other issues in the recovery process, like homelessness or involvement with the criminal justice system. So a recovery model says, "Okay, from the public's point of view, we have to deal with all of these complexities." We've got individuals who've been physically and sexually abused, or are victims of domestic violence or other kinds of violence and stress. So we need to have support for individuals depending on their unique situations, and that support must extend beyond the point of crisis stabilization. Beyond detox, beyond medical maintenance, what else happens in that person's life? We need to be doing aggressive post-treatment monitoring and

support—in part, because drug dealers are interested in having people buy their products, and they will be doing aggressive post-treatment monitoring and marketing.

Our data at the Substance Abuse and Mental Health Services Administration shows that 73 percent of the people who meet criteria for needing treatment for drugs perceive no need for treatment. Eighty-eight percent of people who meet criteria for needing treatment for alcohol use perceive no need for treatment. Now, they endorse all of these things, saying, "My life is adversely affected as a result of my alcohol or my drug use." But these are people—73 percent, 88 percent—who are not seeking treatment. They see no need for treatment. So when we talk about recovery being a community phenomenon, my question is this: "How is it that a person on a self-administered test can endorse 'I'm having problems with alcohol and drugs and with my job, my family, my health, the law, my life, but I don't need treatment'?" In many cases it's because their environment is saying, "You don't need treatment," whether it's because of stigma, whether it's because of denial for other reasons, whether it's because there's a conspiracy of silence. This person is already endorsing, "I'm having problems." This isn't somebody who's just using alcohol casually, or occasionally using an illicit drug. These are people who endorse a sufficient severity of their substance use that treatment is warranted. So, if that's the case, we need a recovery management strategy that helps promote the notion that the individual needs to be in recovery. The community needs to be in recovery. They need to work together on that.

GREAT LAKES ATTC: One of the things that is coming out of CSAT's recovery support initiatives is a more assertive approach toward actually identifying and engaging these people and altering that perception.

DR. CLARK: Right. We also believe that the recovery process needs to be a part of an integrated health care delivery system—one in which substance use problems are perceived as health issues and not simply as a mental health issue or an issue of concern only to substance use disorder treatment practitioners. The message we are trying to promulgate throughout the whole health care delivery system is the value of brief intervention and referral to treatment. We are trying to help healthcare providers talk about substance use in nonjudgmental ways and intervene skillfully when they encounter substance-related problems. We are trying to get these practitioners to intervene early and to sustain their support, just as they would in response to hypertension, diabetes, or other chronic disorders.

GREAT LAKES ATTC: Do you envision a much closer integration of primary healthcare and addiction treatment in the future?

DR. CLARK: That is our hope. That is what our screening/brief intervention effort is trying to facilitate. The recovery process, as you know, is plagued with problems of compliance similar to those found with hypertension and diabetes. What we are doing is promoting a one-stop shop, meaning that the health centers would be authorized to provide early intervention. We don't have to wait until the person crashes and burns and finally arrives at the doors of substance use disorder treatment, usually via the criminal justice system. By the time you get into the criminal justice system or the child welfare system as a result of drug use, you've usually got a long list of severe and complex problems. We believe that issues with alcohol and drugs adversely affect the person's health and the person's well-being, given that these problems have to manifest elsewhere. Early intervention will allow us to respond to these problems early and to begin to work with the person from a motivational point of view. The goal is to deal with these problems before they're exacerbated to more severe levels.

GREAT LAKES ATTC: There are recovery-oriented systems transformations underway in states like Connecticut and in cities like Philadelphia. Do you see such efforts as the wave of the future?

DR. CLARK: Connecticut has done a brilliant job with the recovery model. Tom Kirk has a very good theoretical model, which could be widely replicated. I applaud the visionary efforts of Connecticut and Philadelphia and others who are leading this recovery-focused transformation of substance use disorder treatment. The field of substance use disorder treatment will have better outcomes as we move towards a recovery-oriented service system. What is emerging in these frontier efforts is the development of an integrated system that mobilizes both the formal and informal resources of a community toward the goal of widening the doorways of entry into recovery and providing the support needed for people to move from a community's problems to a community's assets.

GREAT LAKES ATTC: There is growing evidence that sustained post-treatment monitoring and support, assertive linkage to recovery communities, and early re-intervention enhance long-term recovery outcomes. Do you think such services will become standard practice in most addiction treatment programs?

DR. CLARK: The real question is how we define post-treatment monitoring. We need to be careful about characterizing post-treatment monitoring. We know that some people, particularly those with more severe problems, need ongoing support following primary treatment, and the evidence confirms that post-treatment recovery support services can help reduce relapse and facilitate early re-intervention. We could also use toxicology screening as feedback to an individual and an opportunity for early re-intervention. Post-treatment monitoring and support need to be recovery focused, with an emphasis on support as opposed to simply a policing function. That gets us back to recovery management. The question is, "Is the recovery management service that is monitoring the individual also supporting and helping the individual?" From assertive community treatment, we recognize that these are things that have to be put in place. Recovery support services will offer you the same dynamic and can be tailored to individual problem severity and recovery support needs. But the whole key is the experience that you are part of a community and the community cares about you. The community is supporting you. Monitoring sounds like an externally imposed mandate. What I'd like to see is recovery support services conceptualized as a voluntary phenomenon—something that is chosen because it is in the best interest of the individual.

GREAT LAKES ATTC: Several of the states and cities are committed to the development of ongoing recovery support services but are wrestling with the challenge of finding the best financing models to get these services into the field. "Do we enhance existing rates for inpatient and outpatient treatment that include recovery support services? Do we bill these as separate services?" Do you have any thoughts about future financing of post-treatment support services?

DR. CLARK: Part of a performance-driven system is looking at what we are getting from our existing system. That accountability becomes a key variable in what we're doing. As I pointed out, our delivery system addresses the needs of only a small minority of the individuals who need our services. If the majority of people who suffer from alcohol and drug problems presented for treatment, we would truly be overwhelmed. Our existing waiting list is miniscule compared to the potential demand. So the question for political leaders and those charged with managing behavioral health care systems is, "How do I determine service priorities?" You can look at recovery services in isolation, or you can ask what such services will mean to other costs

that substance use disorders impose on the community. What will these services mean to demands upon the mental health system, the child welfare and the criminal justice systems? If I collect one dollar for taxes, I can spend that dollar any number of ways. The savings that accrue within the criminal justice system and the child welfare system can be used to support the recovery of people who no longer demand the resources of those systems. We need to take the long view.

We're trying to get people to 5 years out. If I can get you to 5 years out in recovery, the chances of your getting to 10 years of recovery goes up dramatically. You see the potential. If you see the dollar as only the dollar from Medicare or the Block Grant, people will fight over that dollar. If you see the dollar as a whole dollar, a taxpayer's dollar, then people must ask how we can enhance recovery outcomes while minimizing demands for repeated episodes of high-cost services. If we can stabilize and support people in recovery, they won't need repeated episodes of such higher-cost interventions. What we pay for repeated episodes of detox and inpatient treatment will pay for a lot of post-treatment recovery support services. We will come to see the recovery support services as a good financial investment.

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GREAT LAKES ATTC: What do you think are some of the most significant obstacles to treating severe alcohol and other drug problems in a manner similar to the management of other chronic illnesses?

DR. CLARK: As we begin to integrate substance use disorder treatment and primary health care, such parallels will become more obvious. What Tom McLellan and others are trying to do is to promote the parallels between other chronic health conditions and their treatment and substance use disorders and how they can best be treated. We're just beginning to understand the chronic care model in primary health care. What we will be doing in substance use disorder treatment is finding better ways to shorten and actively manage the prolonged course of many substance use disorders. Our message in Recovery Month to individuals, parents, friends, relatives, and employers is that these are solutions to these problems, and resources need to be mobilized to deal with these problems until they are brought under control. Our screening and brief interventions can help resolve these problems before someone crashes and burns. And with a recovery-oriented system of care, we can mobilize resources for those with the most severe and complex substance use disorders.

We want service providers to recognize that they have a sustained obligation to such clients, and that we have an obligation to use the best science and the best clinical strategies to promote long-term recovery.

GREAT LAKES ATTC: How is CSAT helping the treatment field make the transition toward more recovery-oriented systems of care? What do you see as the role of the ATTCs in helping the field through this historic transition?

DR. CLARK: CSAT recently hosted a Recovery Summit that brought together multiple stakeholders, including the major professional associations from the substance use disorder field, as well as leading substance use disorder researchers and key recovery community organizations. The focus was on how to use this new recovery orientation to enhance our research knowledge about recovery and how to improve the quality of substance use disorder treatment. We'll periodically consider whether we need additional recovery summits to guide our future efforts. We are continuing to work with visionaries like Tom Kirk in Connecticut to disseminate working models to other states and local communities. We have funded the Legal Action Center to document issues related to recovery barriers, social stigma, and confidentiality

issues in the delivery of recovery support services. One of our primary functions continues to be bringing together diverse stakeholders such as recovering individuals, family members, mutual aid organizations, system professionals, and those providing peer support services for policy review and systems planning. The systems transformation we envision goes two ways: the bottom to the top, and the top to the bottom. Our ATTCs are playing an important role in disseminating new information as it becomes available.

GREAT LAKES ATTC: Some of the organizations that CSAT has funded, such as White Bison, Inc., are integrating a recovery orientation with primary prevention activities. Do you think this growing recovery orientation will lead to a greater integration between treatment and prevention?

DR. CLARK: I think SAMHSA will increasingly move toward an integrated model that bridges and integrates primary prevention, early intervention, treatment, and recovery support services. The issue with early intervention is to bring evidence-based practices to bear on the human manifestations of our prevention failures—to reach those who didn't receive or heed our prevention messages. So rather than seeking a dichotomy between prevention and treatment, I think it is best to see these as a single continuum. A message common to all is that, once you start using, drug use is powerfully reinforcing and can quickly escalate out of control. With the strategies we develop and employ, we need to be able to reach people across this continuum of drug involvement—from people who have never used to people who are in long-term recovery, and all points in between. We need interventions that reach people who have diminished control over their decision-making. We know brains are in transition once drug use begins. We need to continue to make sure that the prevention and treatment interventions we employ are appropriate for each individual, family, and community.

GREAT LAKES ATTC: CSAT has done a wonderful job of reinforcing the idea that the recovery support services need to be nuanced across developmental age and gender and cultural context. That seems to be a very important contribution in what you've done the last several years.

DR. CLARK: Thank you. This is the product of a conscious and sustained effort on the part of many dedicated staff.

This interview is part of *Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-Oriented System of Care*, the second in a series of monographs on recovery management published by the Great Lakes Addiction Technology Transfer Center (ATTC).

GREAT LAKES attc
The Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration
Unifying science, education, and services to transform lives

Creating a Recovery-Oriented System of Care

An Interview with Thomas A. Kirk, Jr., PhD
By William L. White, MA

INTRODUCTION

Across the country, references to the State of Connecticut pepper discussions about behavioral health systems transformation. Many states are attempting special recovery-focused initiatives and pilots, but Connecticut stands at the forefront of attempts to totally transform a state behavioral health care system into one permeated with this recovery orientation. I conducted the following interview with Tom Kirk, Commissioner of the Connecticut Department of Mental Health and Addiction Services, on September 26, 2006, on behalf of the Great Lakes Addiction Technology Transfer Center (Great Lakes ATTC). This interview provides one of the most probing examinations to-date of the process of behavioral health systems transformation.

William L. White, MA
Senior Research Consultant
Chestnut Health Systems

GREAT LAKES ATTC: Could you summarize your background before becoming Commissioner of the Connecticut Department of Mental Health and Addiction Services (DMHAS)?

DR. KIRK: My graduate training in psychology was at Catholic University in Washington, DC, after which I joined the faculty of Virginia Commonwealth University (VCU) in Richmond, Virginia. While still on faculty, I did some part-time consulting work at one of the larger adult prisons in Virginia. It was around this time that drug use and related offenses were placing extraordinary pressure on correction systems. I eventually left my tenured position at VCU and established a private consulting practice which emphasized criminal justice system and addiction-related issues. Thereafter, my professional journey included increasingly responsible

public-sector positions focusing on the design and management of services for persons with substance use and co-occurring (mental health) disorders in the Washington, DC area.

GREAT LAKES ATTC: When and how did you first come to Connecticut?

DR. KIRK: I came to Connecticut in 1990 to direct Liberation Programs, Inc., a rather large substance abuse prevention and treatment agency in Stamford. In that position I interacted with my colleagues in other community-based addiction service agencies who were under contract with the Single State Addiction agency. In July of 1995, John Rowland became governor of Connecticut and proposed to merge or create a new agency that combined mental health and addiction services. My concern, frankly, was that the mental health component (Department of Mental Health) was so much bigger that the addictions component would be neglected. After I had voiced my concerns about this, some people asked me whether I would be interested in being considered for a Deputy Commissioner's position in this new department, to oversee addictions services. One thing led to another, and in October of 1995, I became the Deputy Commissioner for addiction services in this new Department of Mental Health and Addiction Services (DMHAS). When the Deputy Commissioner for Mental Health subsequently left and the Commissioner retired, I was asked to be the Commissioner and assumed this role in May of 2000.

GREAT LAKES ATTC: When would you pinpoint the beginning of the recovery initiative in Connecticut?

Dr Kirk: When you are interviewed for appointed positions, you must go before the legislature, who will then vote on your nomination. During that process you provide written testimony and are queried about the service philosophy you will bring to the agency for which you are being considered. In my interview and testimony in October, 1995, I talked about the need for recovery as a driving force for service design—and have done so in every subsequent reappointment session with the legislature, and periodically read those testimonies to remind myself of that focus. At the same time, the heavy emphasis really didn't take hold until around 1997.

GREAT LAKES ATTC: Were there conditions in the late 1990s in the addiction and mental health fields that really contributed to this, sort of ramping this up as a major initiative?

DR. KIRK: One such condition was the sense in both mental health and addiction services that a lot of people were repeatedly going in and out of this system without achieving stable, long-term recovery. One of the things that I wanted to do was to identify persons who were high service utilizers—people who were recycling in detox and rehab—and to see what we were missing in our work with them. One of the strategic goals that we worked on, beginning in 1998 and heavily through 2002, was to revamp services for those who were either poorly served or underserved in our service system. The recognition of high service utilizers and the dollars we were investing in them without positive outcomes was prompting legislators and staff from the Governor's Office of Policy Management to suggest restrictions on how many times someone could be admitted in a year. These were difficult fiscal times in Connecticut, so the pressure to cut or restrict services was intense. That forced us to look at what we were doing and how to respond better to people with severe problems and long and complex service histories. The fiscal pressures created extraordinary challenges but, in retrospect, were opportunities for changes in the system.

GREAT LAKES ATTC: How did you respond to these challenges?

DR. KIRK: Rather than batten down the hatches or just close things down, we began to ask, "How do we rethink what we are doing and move forward in an informed way?" So the fiscal pressures forced us to examine quality-of-care issues and conclude, "What we are doing is just not good enough; something has to be done." So we started moving from the acute-care mentality and the acute-care funding system to what some people are calling a chronic-care or recovery-management model.

GREAT LAKES ATTC: You seem to have involved the recovery advocacy organizations very early in this process.

DR. KIRK: In late 1998 and early 1999, we started asking the question, "What does recovery really mean?" and we involved our DMHAS-funded addictions and mental health advocacy organizations to help us answer that question and to help us formulate core recovery values and principles. Those groups started out like oil and water but eventually came together under the leadership of Bob Savage, the founder and first director of the Connecticut Community for Addiction Recovery, Inc. (CCAR) and Yvette Sangster of Advocacy Unlimited, Inc. (AU), to create the Recovery Principles and Core Recovery Values that have been the foundation of our subsequent work.

GREAT LAKES ATTC: It is amazing the role that service consumers have played in reshaping behavioral health services in Connecticut.

DR. KIRK: One of the things I've learned, and I don't pay as much attention as I should, is to listen to the people who actually are the recipients of services and those who've moved on to long-term stable recovery. They'll give you a better idea what it is that you should be doing or could be doing. They may not always be right or have the complete picture, but they can help keep you focused on the things that are important. I remember presenting some really complicated structural proposals—fancy PowerPoint presentations and all that sort of stuff—to a mental health consumer group in the northwest part of the state, in the Danbury area, and when I was finished a guy in the front row says, "All I want to know is, am I still going to have a case manager?" From his point of view, his case manager was the system.

GREAT LAKES ATTC: How did you go about the process of planning the kind of system transformation you have led in Connecticut?

DR. KIRK: There were several key steps. The first one was to refine our vision and our plan. We came up with an initial strategic plan that had four major goals. The first goal—to promote an infrastructure that would support quality services—was based on the belief that service quality is the driving force of recovery. The second strategic goal was to focus on underserved, poorly served populations, including a stronger emphasis on cultural competence. The third goal was to enhance the management effectiveness of DMHAS. And the last goal was to be aggressive in our development of resources and partnerships.

Let me elaborate on some of these. Our work on the first goal included identifying recovery values and principles in collaboration with Bob Savage and Yvette Sangster. This in turn led to discussions about quality measures, recovery outcomes, and how to assess an agency's degree of recovery orientation.

One component of the second goal involved several strategic decisions. We made informed decisions to focus our attention on four or five issues that we felt could quickly elevate service quality. The issues we chose to focus on were culture, gender, trauma, and co-occurring disorders. We believed a focus on these issues in terms of information, training, service enhancement, etc. would produce a measurable improvement in the quality of the system. Our work in these areas has been significant and sustained, and has achieved that goal

The third goal, to enhance our management capability, involved a major change in our system that had begun with a decision made by my predecessor. That decision was to not turn over management of the contractual funds that drove our service system to a private managed care company. We decided to use managed care principles, but to administer that process ourselves. We chose not to lose 20 percent of our funds via an outside management contract. But that meant we needed to recruit a different caliber of player into the state agency system. We needed and found individuals who had managed care experience in the private sector, but who were open to administering such a system within the framework of public sector values.

The fourth goal, aggressively pursuing additional funding, led to sophisticated approaches to garnering increased federal dollars to support our system. Since 1998, we've brought in over $120 million in federal grant awards to help build and sustain parts of our service system. We hired people to help us procure that money, with the understanding that we would never go after grant dollars for the sake of grant dollars, but to strategically seek dollars that would support our larger vision.

GREAT LAKES ATTC: Creating that vision at the same time you were forging a new agency must have been an incredible challenge.

DR. KIRK: My predecessor had a great line. He said, "We are not merging mental health and addictions. We're creating a new agency, and one plus one is going to give us three." We had to create a new culture. The addictions and mental health cultures are both so strong. It wasn't a surprise to us that shaping this new culture took some time, but through this effort we ended up with a new culture that not only respects the best and brightest and most sensitive components of each of the two systems, but also moved us to a new level. We redefined ourselves as a healthcare agency, not a social service agency. People with substance abuse and psychiatric conditions have a healthcare condition. They share illnesses with behavioral components rooted in the chemistry of the brain. Seeing ourselves as a healthcare agency helping people manage and recover from these illnesses served as a bridge between the mental health and addiction cultures. It gave us a common platform. Our mission is to promote wellness and health and to help people with behavioral health disorders regain their health and reclaim their lives.

GREAT LAKES ATTC: How were you able to transform your system and still maintain its maintenance functions?

DR. KIRK: That's the key. You're trying to reengineer the system at the same time you have to keep it running. One of the things that I did was to say to Arthur Evans, PhD, my Deputy Commissioner at the time: "I want you to run a research and development component within DMHAS." I freed him of most operational responsibilities and asked him to form work groups to look at everything we had done in recent years, including the federal initiatives, and to pick the best ideas and practices. I asked him take the recovery values that our advocacy groups had put together and to translate them into DMHAS policies. So we created a draft Commissioner's Recovery Policy outlining the move toward a recovery-oriented service system, and then met in

retreats with boards, providers, consumers, our own staff, and all sorts of other groups to complete our foundational recovery policy. (See www.dmhas.state.ct.us, then click on "Recovery" under "Major Initiatives".) That statement is as valid and important now as when we first signed it in 2002. Arthur Evans skillfully created and guided much of this development effort, and also added Dr. Larry Davidson from Yale University and others within DMHAS to help us implement this new recovery vision. Dr. Evans eventually left his position to assume responsibility for a large public entity in Philadelphia, while Dr. Davidson subsequently established and staffed at Yale a special program on recovery. Both of these professionals were critical to driving the changes we were implementing

GREAT LAKES ATTC: How did this R & D unit relate to your operations staff?

DR. KIRK: We made a mistake early in the process in keeping Arthur's group separated from operations a bit longer than we should have. We had one track that was improving service operations and a separate track with our recovery initiative. They were both progressing so well that they almost took on lives of their own. You had two different focuses in the agency, and people were not necessarily tying the two of them together. So we reached an awareness that we needed to bring these two tracks together. I brought together all of our key leaders in the agency, as well as the private non-profits, and said, "We're not moving away from the four major goals, but we're going to come up with one single overarching goal that integrates our work on these goals." And that overarching strategic goal was to develop and maintain a value-driven, recovery-oriented service system. We had to convince our own staff and the service providers that this was not a "flavor of the month" thing but an overriding philosophy that would shape everything in the coming years.

We had to stop people from thinking, "It's the *project du jour*. Don't spend too much energy here, because it's going to be something different a year from now." We had to convince everyone that we were going to seek the highest quality of service at the most realistic cost. And we had to help people operationalize their understanding of what a recovery-oriented system would mean for their programs and their roles. To do that, we had to promote recovery-oriented concepts such as recovery capital, recovery supports, sober housing, recovery-conducive employment, etc. We said, "We want you to continue to focus on co-occurring, on gender, on culture, on trauma, and on some other areas that truly are improving the overall value index of the service system, but we want you to place all of these initiatives within this larger recovery orientation." We did that in 2002-2003.

Staying the course with some basic core elements is extraordinarily important, and the recovery practice guidelines that we just recently put together form a crucial piece that has defined our recovery policy in practice terms.

GREAT LAKES ATTC: As you went from the conceptual to changes in practice, what obstacles did you encounter, both inside DMHAS and with your provider community?

DR. KIRK: The first challenge was people saying, "We're already doing that; this is not new." There were two variations on this. First, there were people who really had been pushing this and had not been heard. Some of these people were angry that it took us so long to get to this orientation. Some said, "I've been talking about this for 10 years, and no one has listened, and you come along in 2000 and talk about recovery as if this is the latest and best thing. I've been championing this for years before you ever got here." So we had to listen to these people and get them on board with us. This was a group who did believe in this orientation and were already doing it to the best of their abilities. Others said, "We're doing it," but when we looked at

the way they ran their agencies and the way their services were provided, they were a long way from the recovery values we were extolling. For them, we had to define these recovery values at a practice level, so they could see the ways in which they were really not providing recovery-oriented care.

GREAT LAKES ATTC: Helping agencies self-evaluate their recovery orientation must have been a crucial part of this process.

DR. KIRK: Yes. Larry Davidson worked with us to develop a scale that could help agencies measure their degree of recovery orientation. This work ("Findings from the DMHAS Recovery Self Assessment") is posted on the DMHAS website (www.dmhas.state.ct.us) under "Major Initiatives," "Recovery," "Reports and Position Papers." We built recovery orientation into the language of all our contracts, along with a contractual requirement that each agency had to conduct a recovery self-assessment process. We are currently working on further refining recovery outcome measures. We followed that self-assessment process with coaching and technical assistance to move toward greater recovery orientation. We also created something called **"**The Recovery Institute," a training curriculum consisting of a series of recovery-focused courses designed particularly for people working in private non-profit service agencies. More than 5,000 people have attended one or more of these courses. After establishing "The Recovery Institute," we set up what we call **"**Centers of Excellence." This consisted of a competitive process that would provide funding for agencies to receive consultation in one of six areas, such as outreach, strength-based assessments, culturally informed services, and so on. We picked agencies that either saw themselves as particularly good in these areas or really wanted to become excellent in their competencies in these areas**.** Considering we were only paying for consultation services through the financial assistance of SAMHSA technical assistance**,** we were amazed at how many applicants responded to this RFP. We made a big to-do out of it, recognizing those we selected as Centers of Excellence in Connecticut. They ranged from hospitals to private addiction or mental health agencies, to some of the state-operated mental health components.

GREAT LAKES ATTC: Did you also take steps during this early period to support recovery advocacy and support organizations, and to ensure their involvement in the system-transformation process?

DR. KIRK: We increased funding to such groups, to allow them to expand their operations on a statewide basis. There was federal money supporting some of their activities**,** e.g., CCAR, and we added state dollars to supplement this. We've since increased our state funding of these advocacy organizations. This has helped strengthen consumer involvement in our system and expand peer-based recovery support services. We also met with the executive director and board representatives of each of the person–in-recovery/consumer groups under contract with DMHAS. We discussed their contract requirements, listened to their vision and goals, and focused on affirming our joint vision and mission.

GREAT LAKES ATTC: How did you manage the system-transformation process inside DMHAS?

DR. KIRK: A couple of different ways. The communication strategy was very important. In late 2000, we started putting out "Messages from the Office of the Commissioner." This communication piece came out every two weeks or so and was sent to everybody in the service system, external and internal, including all of our 3,500 DMHAS staff. The messages the first couple years were typically from me, but then we involved other people in crafting these messages, such as a message from Bob Savage [who was then Director of the Connecticut

Community of Addiction Recovery] or a message from members of my executive staff. To-date, there have been over 130 such Messages. So there was a steady emphasis on this recovery initiative and what it would mean to everyone in the system and in DMHAS. A second communication piece started in 2000 was "INFORMATION…foundation of good policy." It is a one-page brief, based on data, and released several times a year. Approximately 80 have been published since 2000. The "Messages from…" and the "INFORMATION" documents cover numerous angles—recovery management, recovery support services, our work with high-service utilizers, linkage to care, employment, housing, and new approaches to public managed care. We used these communications to highlight what we were doing and the kind of problem solving we were trying to do. All are at www.dmhas.state.ct.us.

GREAT LAKES ATTC: Could you provide some examples of such problem solving?

DR. KIRK: We have a state-operated facility in Hartford that provides detox and residential services, and in the same neighborhood a private non-profit treatment agency that provides similar services. I kept hearing that people couldn't get into either facility. I put in place a daily census count that each facility needed to call in to the central office, and we continued to get complaints that people couldn't get in, even when our counts showed empty beds. So we did a review and came up with something called SATEP: Substance Abuse Treatment Enhancement Project. We reconfigured the beds and added some supplemental services, such as a 24-hour access telephone line and transportation funds that allowed people in need to get transported by taxi to treatment, or from one service component to another. These strategies increased service access.

Another problem we had was with people who were opiate dependent who would repeatedly use primary treatment services but fail to follow through on any continuing-care services. We started OATP, an Opiate Agonist Treatment Program that identified these individuals and assigned them a recovery specialist, who tracked them through the system and assertively linked them to continuing-care services. This service also increased service utilization rates within many of our funded agencies. We took the same capacity and increased access and improved linkage to follow-up care. This lowered the admissions of our high service utilizers and opened up beds for other people. To achieve that system wide meant we had to confront various bureaucratic stupidities. For example, we had one of our state-operated programs that had a policy that they did not admit on Friday afternoons. Needless to say, we changed such policies that had emerged as roadblocks to people's recoveries.

A third area involved our use of alternative living centers. These are not treatment centers but sober living environments used by long-term substance users who had achieved sobriety. Providing such sanctuaries helped these people achieve stable recovery and became an important step-down level of care within our system that further decreased admissions by our high service utilizers. And we did it for a fraction of the cost of a detox or residential treatment day. Staff heard so much about recovery and these recovery-focused problem-solving efforts that it just became a part of the internal culture.

GREAT LAKES ATTC: It sounds like the whole understanding of levels of care changed through this process.

DR. KIRK: We dramatically expanded the range of services. This is really important. We modified ASAM criteria, what we call Connecticut ASAM, to get providers as well as the people seeking services more focused on what people needed rather than what was available. We pushed a widened definition of levels of care with more precise admission and continued-stay

criteria. Our goal was to get out of a situation where, if you showed up at a clinic that does A, B, and C, you would get A, B, C, even when you needed D, E, F. Our efforts to expand the service menu and refine the process of matching people based on their needs helped shape a service system in which both service providers and consumers made more informed choices about levels of care. Adding some really good measures helped that. One of our most critical measures was continuity of care, e.g., was each client actually linked (not just referred) to follow-up care within 7 days of his or her discharge? This had a significant influence on our readmission rates.

GREAT LAKES ATTC: You have made a significant investment in Connecticut in developing non-clinical recovery support services within your behavioral health care system. Could you describe the impact these services have had?

DR. KIRK: The recovery support services have had a significant impact on decreasing repetitive use of acute high-cost services. Recovery support services have served as an important vehicle for reaching out and engaging people in treatment and recovery processes. They have also served as an effective bridge in moving people across different levels of care within the clinical service system. Recovery support services have represented a relatively low-cost means of sustaining people's recovery without the need for sustained treatment or the multiple treatment episodes that might otherwise be required.

GREAT LAKES ATTC: What would you recommend to directors in other states who don't currently have recovery advocacy and support organizations?

DR. KIRK: I would recommend that a director and his or her staff get to as many forums as possible that provide opportunities to interact with people in recovery. And I would suggest they keep a log of what they have heard in these forums. I gave a talk last year at the annual meeting of the National Alliance on Mental Illness. I had someone help me put it together, and I junked a good part of it because it just wasn't people oriented enough. Instead I added "What I heard along the way." Let me just give you a couple examples, because I think that this is something that anybody could do. One of the things I heard along the way is, **"**when I get too functional, I lose my services**."** In the acute-care system of addiction treatment, people actually get penalized via loss of support when they get better. Another message I heard was, "When I come to this clinic, I feel like I'm a junkie, and I'm not a junkie anymore." What does that say about our service system? I asked another person I met in one of our clubhouses, "If you could ask for something, what would you ask for?" He said, "I just wish people had more time to talk to me." These are things that any state director and his or her staff can get by going into these situations and listening and asking themselves the implications of such comments for the design changes needed in the service system.

You have to work with and nurture the development of peer advocacy and support organizations, and you have to help them mature beyond the "us against the world" stance that often characterizes the early days of such organizations. As I told one advocate, "You have to understand when you're beginning to win something and stop chasing windmills all the time, because, after a while, people don't pay any attention to you anymore." It's not only working with these organizations; it's helping them mature as organizations. I'm more comfortable with an approach that doesn't place the advocates as employees of the state agency. We've shifted from these groups being our watchdogs to these groups being our partners in transforming our system of care.

GREAT LAKES ATTC: How do you think financing models are going to have to change to become congruent with this recovery model?

DR. KIRK: Great question, and an interesting one, because we're in the midst of that issue right now. I'll give you one example. We just had a needs assessment. We asked some folks to conduct a survey for us that, in part, identified about 850 service consumers who were having significant problems of one type or another. One of the striking findings was that a significant percentage of these people were assigned to services judged to be what they needed, but in which the people were not participating. For whatever reasons, they were not engaging in what others saw them needing. This is a clinical question, but it is also a fiscal question. If the services we are paying for are not engaging those they are intended to serve, perhaps it is time we altered the service menu. And that may include paying for things, such as peer support services, which have not been historically reimbursable services. We need funding guidelines that allow us to think outside the box and support services that are responsive to recovery needs. If post-treatment recovery support is critical to long-term recovery outcomes, we need to fund such services, as we recently did by funding our recovery advocacy agency to provide telephone-based recovery support services to people for 12 weeks following their discharge from primary treatment.

We have to ask: What are the components that would serve to engage people and link them between different levels of care more effectively? What new levels of care do we need to add to the existing service system? What are the components that would dramatically increase access to and utilization of existing services? If sober housing is critical to recovery maintenance, then we need to think about supporting housing initiatives. Tying recovery support services with existing levels of care challenges traditional funding mechanisms, through which the former were not reimbursable services. We're looking at different ways of combining components into a service level of care, to achieve good continuity of care. In short, we are building on the work of Tom McLellan, Bill White, and others to shift towards treating severe addiction as a chronic or continuing-care disorder like my high cholesterol or somebody else's high blood pressure. What would that mean? You could move toward a system that was not based solely on fee-for-service and that redefines an episode of care.

Let's say that Tom Kirk shows at agency X, and based on an assessment it is determined that I will likely need involvement in formal treatment across multiple levels of care for the next year. And the formal treatment might be—I don't know—detox. It might be intensive outpatient. Based upon that, we say that we will fund the agency to have responsibility for providing this episode of care for me during the year, up to a set dollar value. They can spend the money on services for me at their discretion, as long as it supports my recovery process.

This new definition of an episode of care could involve different combinations of clinical and recovery support components that I could benefit from, and that my service provider or I could purchase on my behalf. We could tie outcome measures to my entering and remaining in what I call a "recovery zone"—sober and stable functioning in the community. What are being paid for are services that support my stability, not just high-cost crisis interventions. What does that mean in terms of financing? One of the approaches we're looking at for the future is the idea of **"**covered lives"—paying agencies to provide comprehensive services for a given number of people per year, rather than paying for delivered service units.

GREAT LAKES ATTC: Do you see primary healthcare integrated into this vision of sustained recovery support?

DR. KIRK: This is an extraordinarily important issue. One of the things I'll pay attention to over the next year is the primary healthcare needs of the people we have in our private non-profit and state-operated service system. On the mental health side, the lifespan of a person with psychiatric disability is something like 15 years less than other persons, and when we look at the data for people we have in our service system, they're not dying of suicide; they're not dying of drug overdoses. They're dying of cardiac conditions, respiratory conditions, and the kinds of things that the rest of us suffer from. So if we're really going to talk about a recovery-oriented holistic system, we have to pay attention to primary healthcare needs.

One of the major priorities for my medical director is to focus on a greater linkage between the physical healthcare needs of our people and their substance abuse or mental health needs. We have what's called PARS. PARS is our Performance Assessment Reviews for all of our managers. I just finished identifying the things that I would expect them—including the 10 CEOs of the major state-operated facilities—to focus upon this year. One of them relates to addressing the physical healthcare needs of the people we have in our service system. Co-occurring disorders, employment, physical healthcare, and recovery orientation are the four major initiatives that we are focusing upon this year in terms of improved services.

GREAT LAKES ATTC: Did you run into regulations inside DMHAS, or federal regulations, that actually got in the way of the system transformation that you've been attempting?

DR. KIRK: Yes, particularly licensing authorities. The program licensing authority in the State of Connecticut is the Department of Public Health (DPH), which is very medically oriented. Here's the kind of situation that comes up. In the programs for women and children that we run, a mother may come in for services, and she might have one or two young children come with her, and other women may watch her children while she is in group or meeting with her counselor. Public Health looks at this and declares that we must have separate therapeutic childcare for such situations, which is extraordinarily expensive. Those are the kinds of conflicts we're trying to work through with DPH**.** It's a conflict in philosophies. They may cite a program for not being medical model oriented at the same time we are trying to move that program from a medical model to a more peer-based recovery model. I meet with the Public Health Department once a month to work out such issues. There've been dramatic changes in some ways, yes, but it's a process. Being in a process, we still have a long way to go.

GREAT LAKES ATTC: Have the federal agencies that you work with been supportive of the directions that you're going?

DR. KIRK: We've gotten good support from CSAT and CMHS as well as CSAP in the recovery focus. We're one of the Mental Health Transformation states, as well as an Access to Recovery state and one of the Strategic Prevention Framework states. Between the technical assistance they gave us in support of the Centers of Excellence and the Strategic Prevention Framework grant we have from CSAP, the federal agencies have been supportive of our system-transformation efforts. The real challenge is with Medicaid regulations. We've had site visits where their philosophies and ours conflict, and we've had to balance our recovery orientation with meeting the regulations that flow from their medical model.

GREAT LAKES ATTC: When you look back over the history of the recovery initiative, what do you personally feel best about?

DR. KIRK: I feel best about the direction we set and the fact that the resulting focus and energy are producing real change in the way people who receive services in our system think about themselves and their hope for recovery. I feel good that our recovery philosophy is filtering throughout the system. You hear people talking about things today that we talked about two years ago, but they've made it a part of them. There's a bumper sticker that says, "When people lead, their leaders will follow." I think in an interesting sort of way we've been able to create a movement where people—service consumers and people in recovery—are becoming more and more energized, and they're guiding the system-transformation process in ways that the service professionals could never do by ourselves. If I got fired tomorrow, I would feel real comfortable that the movement would continue long after I left the system.

The question is, "How do you institutionalize things so that people take ownership of these innovations and carry them forward?" I strongly believe that we all stand on the shoulders of the people who came before us. I talk about the recovery stuff so much, and I spend so much time talking with the Governor and legislators about it, that I now hear them using the words. It's something to listen to the Governor talking about behavioral health systems transformation in her own words.

GREAT LAKES ATTC: As you look ahead, what do you see as the next steps in the system-transformation process in Connecticut?

DR. KIRK: As much progress as we have made, we still have a long way to go in the recovery-oriented focus, because it involves total system change, not just one program. So we will continue to identify "lessons learned" from our experiences—how Access to Recovery or related activities can be embedded into the service system versus being the latest grant. I also believe that we have to work on identifying and cultivating staff—management and line staff—whose leadership and other skill sets can serve to model what a recovery-oriented system really is like. We will be intensely focusing on things like employment, the addition of recovery support services to the basic service menu, and physical healthcare and co-occurring disorder services. Another focus will be on pushing the service design toward wellness promotion and recovery support services that groups of people in different areas of the state need, rather than toward what the historical structures dictate that we continue to fund. A third area will be shifting the financing of the overall system to support a continuing-care model. We must change the financing mechanisms.

GREAT LAKES ATTC: As a final question, are there any tips you would offer your counterparts on how to manage similar efforts at systems transformation?

DR. KIRK: One tip would be to focus the transformation process through an overall message that allows people to see the individual initiatives as fitting into a whole. System transformation will fail if it is just seen as a bunch of discrete initiatives. You have to continue to hammer away about how existing things and new initiatives tie into this larger picture. You also have to honor what people have done in the past and not inadvertently demean their efforts. The message is, "We want to take the gems that we can learn from you, based upon your experience, and elevate them within what we are building." When I was at the agency in Stamford talking about some of this, a guy who had been running our methadone program from day-one said, "Sometimes when I hear you talk about this**,** it's as if I've been doing the wrong stuff for the last 20 years." That's not the message we want to convey. We need to understand what they've been doing in the trenches, what they've learned, and build on that.

This interview is part of *Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-Oriented System of Care*, the second in a series of monographs on recovery management published by the Great Lakes Addiction Technology Transfer Center (ATTC).

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Funded by Substance Abuse and Mental Health Services Administration
Unifying science, education, and services to transform lives

Recovery Management and Technology Transfer

An Interview with Lonnetta Albright
By William L. White, MA

INTRODUCTION

The Great Lakes Addiction Technology Transfer Center (Great Lakes ATTC) is one of 14 such centers in the United States and its territories. The centers are funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA, CSAT) to improve the quality of addiction treatment by enhancing cultural appropriateness, advancing the adoption of new knowledge, developing and disseminating tools, building a better workforce, forging partnerships, and encouraging ongoing treatment system self-assessment and improvement. Each Addiction Technology Transfer Center (ATTC) takes on special initiatives that are of interest to their state constituencies and needed in their regions. In 2005, the Great Lakes ATTC began developing products and training presentations to help their state agencies and regional treatment providers shift from an acute-care model of addiction treatment to a model of sustained recovery management. In the brief interview below, Great Lakes ATTC Director Lonnetta Albright discusses this initiative.

William L. White, MA
Senior Research Consultant
Chestnut Health Systems

GREAT LAKES ATTC: Briefly describe your history of involvement in the addictions field.

LONNETTA ALBRIGHT: Early in my career I ran a Group Home for adolescent girls. On a number of occasions we would observe what I didn't know at the time were co-occurring disorders. These young women experimented, mostly with drugs, and at least half of them were receiving counseling and/or psychiatric help. Without any background in treatment, we started what were called "Rap Groups," and we reached out to the social service community. We were fortunate to have an organization called South Suburban Council on Alcoholism, which served this population. Their staff would conduct in-services for our team, as well as work with our girls. That early collaboration marks my first involvement in the field of addiction treatment. Following this initial involvement and understanding of the affects of substance use, it became clear that we all (staff, volunteers, and clients) needed to better understand how alcohol and drug use could prevent any progress and/or healing, and why at times it seemed we were spinning our wheels. And now, as I think about it, stigma, denial, shame, and a lack of understanding also perpetuated the problems that our communities faced. The schools, churches, and families all believed that alcohol and drug use were matters of morality and poor judgment. And to be honest, my basic beliefs were in line with that belief, associating stigma and discrimination with people whose problems I didn't understand. The science and the facts about addiction were all but non-existent.

Then (thankfully) during the next decade, my understanding of and education about addiction was developed by professionals in the treatment field who believed that people deserved help with their battle against drugs. As my career continued in the late 80's and early 90's, I became familiar with the TASC agency in Illinois, which exposed me to the criminal justice system and addiction and the nexus between the two. My education, training, and hands on experience led me to study and take a deeper look at addiction. I was trained in the neurobiological aspects of addiction and in other recent breakthroughs in knowledge that have revealed the tremendous gap between what was being learned in the research arena and what was actually happening on the front lines of addiction treatment. Interest in closing that gap brought me to my current position as Director of this region's ATTC. As a former educator, I thoroughly embrace the importance of clinician education in elevating the quality and effectiveness of addiction treatment. I was interested in how research could inform us about what works—not just on paper, but in the actual processes of assessment, engagement and retention, treatment planning, and long-term recovery support.

I've spent the past nine years helping systems and the workforce integrate what we're learning from the research and apply it affectively in practice, and this has been no small or easy task. We've learned there are cultural differences and myriad other factors that have to be addressed to effect change. I personally believe that change is good, particularly when it takes the best of what we already have and integrates new knowledge and technologies. These are very exciting and encouraging times for people and communities that have suffered so much. To the extent that this suffering has been exacerbated by the lack of understanding, I feel like we're making an important contribution as a source of healing for individuals, families, and communities.

On a personal level, addiction (primarily to alcohol) has also touched my immediate family. I've lost an aunt, uncle, and cousin to alcoholism and the medical complications brought on by this disease (e.g., hepatitis, kidney and liver failure, and stroke). None of my affected family members ever sought treatment or even acknowledged that they had a problem. They alienated themselves from the family, although the family was always there for them. My dad was what we called a functional alcoholic. When the floor bottomed out for him (a long, and touching story), he decided that the drinking was not worth what he stood to lose. Seeing both addiction and recovery close-up intensified my commitment to this field.

GREAT LAKES ATTC: Provide a brief overview of GLATTC's mission and activities.

LONNETTA ALBRIGHT: The ATTC Network's stated mission is: *Unifying Science, Education and Services to Transform Lives*. At our Center's 2006 annual strategic planning and team-building session, we defined our regional mission as one of *Building Bridges That Foster the Advancement of Treatment and Recovery*. We use training, technical assistance, systems change, and technology transfer based on the latest science and evidenced-based and promising practices to: improve the knowledge and practices of substance use disorder (SUD) providers; build culturally competent recovery-oriented systems of care; and develop the SUD workforce in our region. I believe that the success of our regional effort is in large part due to the partnerships, collaboration, inclusiveness, and diversity of our key stakeholders, experts, and constituents. Our activities are driven by significant input from the communities we serve and based on the results of our various needs assessments. Beyond the region, all of our work is disseminated nationally via the ATTC Network.

GREAT LAKES ATTC: How did you first decide to involve the Great Lakes ATTC in the promotion of recovery management?

LONNETTA ALBRIGHT: Well, I've always believed in a comprehensive and holistic approach to care that encompasses medical, psychological, social, cultural, and spiritual dimensions of recovery. My decision to provide full support to the promotion of recovery management is both personal and professional. Several of our colleagues and staff are recovering practitioners. Many of them were embarking upon efforts to serve the people and communities that we work with more effectively. We all agreed that there is so much more to people in trouble—any type of trouble—and that dealing with only one part of the person (e.g., treatment needs) does not at all respect or acknowledge the fact that all people are more than their problems. More important, I personally believe that people can and do get better. I'm an eternal optimist, and I believe that people can change. And if supported effectively, we all have the power within us to continually develop, improve, and heal.

Our colleagues who were engaged in the CSAT-funded RCSP program around the country pulled us in a couple of years ago. They believed that the ATTC could assist them in developing various models, and in the development of what I frequently refer to as the recovery community workforce. And then, while GLATTC was involved in this work with the RCSPs, I began reading Bill White's writings and talking with him about Recovery Management (RM). I became a student of RM, and I can't tell you how much excitement this has generated within our team and across our region. As an ATTC, we also look at the science that supports the practices that we promote. The work Dr. Tom McClellan and his colleagues have done in documenting the parallels between addiction and other chronic diseases was also very influential in our decision to take on this initiative. On a personal note, I have first-hand experience observing my dad's eventual healing using these RM principles (another long story with a happy ending)

GREAT LAKES ATTC: What activities have you pursued to-date in the recovery management arena?

LONNETTA ALBRIGHT: To begin our initiative, we first worked to raise awareness about the recovery management model throughout the treatment and recovery field. This first step led us to develop papers and newsletters that were widely disseminated. We wanted to get the word out, to introduce people in our region to the key RM principles, service roles, challenges, and language. Our *GLATTC Bulletin* newsletter was the first publication on RM that was widely

distributed across our region and throughout the National ATTC Network. The ATTC National Office has posted this body of work on the home page of the network's national web site. Other ATTCs have produced reprints and disseminated our work in other parts of the country.

The response to the first newsletter was so positive that we followed it with a monograph on RM that included essays by Bill White, Dr. Ernie Kurtz, and our own Mark Sanders. This was the beginning of what we see as an ongoing Recovery Management Monograph Series. We've supplemented these written materials with more than 20 professional presentations, including conference keynote addresses, workshops, and panel presentations.

To-date, we have five significant RM collaborations underway. In Ohio, we're working with the Single State Agency to help them develop a Recovery Management approach for their offender re-entry program. In Michigan, we're working with their Office of Drug Control Policy on a statewide Workforce Development Initiative, and as part of this initiative we're training clinical supervisors in using RM principles and approaches. In Illinois, we've received a request to assist a Hispanic-Latino treatment provider to shift their service orientation toward an RM model. In Indiana, we're just beginning a system-transformation process focused on recovery management. Finally, we're collaborating with two other ATTC regions on projects working with policy makers interested in shifting their state treatment systems to a recovery management model.

I am most proud of our RM Symposium for Policy Makers from the Midwest states this past March. Fourteen states attended, Dr. Clark was our keynote presenter, and our panel of presenters was phenomenal. Not only did our regional single state agencies support and attend the day-long session, but leaders from around the Midwest—including 4 ATTCs and our national ATTC office—were on hand as well. Since that event the past few months have been full of requests from participants who are now pursuing system-change efforts to transform their treatment systems to Recovery Oriented Systems of Care.

GREAT LAKES ATTC: What has been the response from the states and from front-line service workers to this initiative?

LONNETTA ALBRIGHT: To be honest, I've been pleasantly surprised. I'd anticipated some resistance, particularly given the field's track record with change. But it's as if our states and front-line workers had been waiting for this. When we launched our work, the response was overwhelming. We are now challenged to figure out how to keep up with the demand for information, workshops, and more information and workshops. Each of the states in our region decided to include Recovery Management as a major part of its annual conference. Then there are academic institutions that have purchased hundreds of copies of the RM Monograph to use in their Addictions Studies coursework. And our partners and other members from the Recovery Community have embraced this body of work and tell us how pleased they are that we're looking at a long-term or sustained recovery approach that involves the community.

GREAT LAKES ATTC: To what do you attribute such a positive response?

LONNETTA ALBRIGHT: I think the model makes sense, not to mention that the data and science support it. When I first began in the human services field, working with children and families in the child welfare system, these same principles worked. What I mean is that we worked, not only with the client, but also with the family, school, faith community, friends, employers, and anyone else the client believed were important. As a former certified Reality Therapist—a model that also believes in a person's own power, strengths and assets to deal with and

overcome personal challenges—I am not surprised that the field sees the benefit and promise of RM. I also believe that the timing is right. For the past eight or nine years we have been working with the field around adopting evidence-based practices. We have made some great inroads into reducing resistance and helping individuals, organizations, and systems change, not only their practices, but also their attitudes and mindsets. I think we're a smarter field today that is open to new approaches that can positively impact people's lives. That's hopeful and encouraging.

GREAT LAKES ATTC: What do you hope to achieve in establishing the Great Lakes ATTC as a Center of Excellence in Recovery Management?

LONNETTA ALBRIGHT: This Center of Excellence in RM has moved from a vision to an actual plan that we are now implementing. We are especially excited about having a new partner in this effort. The Northeast ATTC has agreed to collaborate on developing and implementing this new Center of Excellence. As with any new model, there will be many different interpretations of principles and variations in practices. We run the risk of lots of misinterpretation and fragmentation of the model. Rather than just raise awareness, we need to facilitate a clear definition of this model and how its core elements can best be implemented. And we want to make sure that we incorporate what we're learning from the research at every step of this process. I frequently quote Dr. Timothy Condon, Deputy Director at NIDA, who says "we want to teach what we *know*, not just what we *think* or *feel*."

This shift is about system change, and there is a process. We intend to follow the appropriate and most effective steps from the ATTCs' perspective. There are many organizations and people who will have a role in helping the field adopt a sustained recovery support approach to helping people with substance use disorders. We have carved out a role for our ATTC that begins with awareness and education. We plan to follow that by helping the field look at service redesign and ways in which the model can be implemented. We plan to use our successful technology transfer strategies to help us develop the workforce, including front-line staff, peer coaches and mentors, clinical supervisors, faith-based providers, and the next generation of leaders and trainers. We will also focus on new professionals (students at academic institutions and other vocational programs).

GREAT LAKES ATTC: What do you see as the future role of the ATTCs in helping shift addiction treatment from a model of acute care to a model of sustained recovery support?

LONNETTA ALBRIGHT: I am continually impressed by the effectiveness and success of the ATTC Network, particularly related to helping the field develop a comprehensive and collective approach that is replicated across the country. The network has a well thought-out strategic approach for harnessing our varied and diverse levels of expertise, abilities, and resources. We have worked hard to "master" the art of collaboration, which as you know is easier said than done. When we started this effort, others joined us. Many partnerships have formed, and new projects are continuing to be formulated. As a network, we are getting the message out across the country and internationally. I anticipate that an ATTC Network response will be developed and implemented at the various levels (workforce development, policy and system change, products, and best practices). We will use all of the tried and proven strategies, and other strategies will be developed by this very creative, responsive, and committed network of professionals who work in partnership with our communities and constituents.

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Frontline Implementation of Recovery Management Principles

An Interview with Michael Boyle
By William L. White, MA

INTRODUCTION

Many of the core recovery management principles and practices were piloted and refined within the Behavioral Health Recovery Management (BHRM) project. This was a collaborative effort of Fayette Companies in Peoria, Illinois; Chestnut Health Systems in Bloomington, Illinois; and the Center for Psychiatric Rehabilitation at the University of Chicago, was funded by the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse. Since the inception of the BHRM project, Fayette Companies has served as a model of recovery-oriented systems transformation in a community-based behavioral health organization. I conducted the following interview with Michael Boyle, President and CEO of Fayette Companies and Director of the BHRM project, September 29, 2006, on behalf of the Great Lakes Addiction Technology Transfer Center (Great Lakes ATTC).

William L. White, MA
Senior Research Consultant
Chestnut Health Systems

GREAT LAKES ATTC: Mike, could you begin by summarizing your background and how you came to your current position?

MIKE BOYLE: I've been with Fayette Companies and its predecessor organizations here in Peoria, Illinois my whole career. I started as a youth outreach worker and then ran an alcoholism treatment center that consolidated in 1976 with four other organizations to form what

is now the Human Service Center. Fayette Companies serves as the parent management corporation of a family of behavioral health service units that include the Human Service Center; White Oaks; Human Service Center Foundation, a 501(c)(2) property investment company; and Behavioral Health Advantages, providing Employee Assistance Programs and consultation services to businesses and industry.

Human Service Center (HSC) provides mental health treatment and recovery support services to about 1,600 people each year with serious mental illness. HSC also operates a methadone treatment program, a work release program, a transitional housing program for federal probation, and a long-term women's addiction treatment program. White Oaks offers a full array of addiction treatment services, from a medical detoxification unit to gender-specific residential programs for men and women, as well as gender-specific intensive outpatient and day programs serving over 2,000 people per year. We offer a specialized program for older adults who are in need of in-home substance use disorder (SUD) treatment services, and we have youth programs that provide both mental health and SUD treatment services, as well as prevention services. We presently have 18 service locations and more than 380 staff. Our programs are supported primarily through state contracts, Medicaid reimbursement, and corporate insurance. The mission of the Human Service Center is to "Engage people in a life of recovery and assist them to live their lives well."

Over the past 32 years, I have served as Vice President of Operations, as Executive Vice President, and currently as President and CEO. In recent years, I have focused on implementing an integrated vision of mental health and addiction treatment services and evidence-based treatment practices. I have also been fortunate to be a participant in the Network for the Improvement of Addiction Treatment (NIATx), which has taught me how to use process-improvement techniques to impact quality of care in addressing addictions.

GREAT LAKES ATTC: Describe how the behavioral health recovery management program came into existence.

MIKE BOYLE: Ten years ago, behavioral health leaders were scrambling to prepare for or implement managed care. During this time, I found myself drawn to national conferences on managed care that included presentations from primary care physicians on disease management. Organizations like Kaiser Permanente were often presenting on what they were doing to deal with chronic medical disorders. That's when I started thinking, "We say addiction and serious mental illness are chronic conditions; why are we using such an acute-care model to treat them?" I wondered why we were not using disease-management approaches like those that were emerging in primary medicine. Then in 1999, my local state representative approached me and asked if we had any legislative needs that he could help with. We began to discuss some of the needs of the field, and that led to writing legislation that would support the development of a disease-management approach to addictions and serious mental illness. We put together a legislative bill for a three-year project that would fund the development of this approach, and it passed the House and Senate and—with a little negotiation—was signed by the Governor.

We asked for a million dollars over a three-year period to support the project. In the course of moving the legislation through, the Secretary of the Illinois Department of Human Services became very interested in the project and offered to fund the idea if the legislation was passed. This was very helpful, since the bill would then not need an appropriation tied to it. As this came to fruition, I approached Chestnut Health System's Lighthouse Institute and recruited Bill White as an Associate Director of the project. David Loveland, now Director of Research at Fayette

Companies, became the other Associate Director, with a specialty in serious mental illness and co-occurring disorders. Pat Corrigan from the University of Chicago, Center for Psychiatric Rehabilitation later joined as a third partner in the Behavioral Health Recovery Management project.

GREAT LAKES ATTC: What distinctions were you making between recovery management and disease management as this project developed?

MIKE BOYLE: It was Bill White who came up with the concept of recovery management rather than disease management. I remember at the time, I said, "Well, everybody knows now what disease management is. It's been around for a decade. No one has ever heard of recovery management." And Bill said, "In three years, they will." That was enough to sell me. Disease management (DM) has basically been built on the foundation of evidence-based practice—what science says will generate the best outcomes for specific chronic diseases. DM emphasizes science-based clinical guidelines for service practitioners, and DM also tries to actively engage each individual in managing his or her own illness rather than leaving everything to the physician and other health care professionals. Recovery Management (RM) incorporates the DM approach, but shifts the focus from the disorder to the person, from symptom management to building a life in recovery. RM approaches also place greater emphasis on natural supports within the family and community that can be aligned to enhance recovery initiation and maintenance. RM asks: "How can we build recovery support within the larger community? How can we assertively link the individual to such recovery support resources?" RM, because it focuses on the whole life rather than the disorder, is also broader in its scope, encompassing such areas as social and recreational activities, employment, education, housing, and life meaning and purpose. It is about making recovery a very enjoyable and positive experience.

GREAT LAKES ATTC: For readers unfamiliar with recovery management, could you briefly summarize how traditional clinical practices change in this model?

MIKE BOYLE: Thresholds of engagement are lowered, with a considerable emphasis placed on outreach services. Motivation is viewed as an important factor but seen as an outcome of treatment rather than a precondition for treatment admission. There is an emphasis on assessment processes that are global, continual, strengths-based, person- and family-centered, and culturally grounded. The service menu is broadened, and the eventual locus of services shifts to homes and neighborhoods. The service relationship is based on a partnership model that is much longer in duration and less hierarchical. Perhaps most distinguishing is the shift in emphasis from acute bio-psychosocial stabilization to long-term recovery monitoring and support; assertive linkage to communities of recovery; and, when needed, early re-intervention.

GREAT LAKES ATTC: Was the RM approach a natural progression in the overall development of Fayette Companies and its service units?

MIKE BOYLE: Actually, it's really ironic. We formed our first organization, Human Service Center, by consolidating four mental health, drug, and alcohol treatment programs in the 1970s, but we had never really integrated care. So, in the late '90s, I started an initiative to fully integrate co-occurring disorders. We'd already been making some progress in trying to integrate the treatment of serious mental illness with primary healthcare by establishing a primary care clinic within our outpatient mental health center. We really needed to address the co-occurring substance use disorders and all mental illnesses, particularly serious mental illness. About half of the population that we serve have both disorders. People with serious mental illness were often abusing or addicted to substances, and our addiction programs were

filled with people suffering from serious mental illness, mood disorders, and anxiety disorders, including post-trauma effects and Posttraumatic Stress Disorder. We formed a quality improvement committee with multi-disciplinary representation across the functions of the organization, with the mission of fully integrating treatment services across the continuum of care. That's when, in 1998, we really started implementing evidence-based practices. The recovery management project shared that objective, and it was a natural evolution from the integration of treatment for co-occurring disorders to a more comprehensive vision of assisting people with the long-term recovery process. This moved us beyond thinking about biopsychosicial stabilization to the broader issues involved in recovery maintenance and enhancement of quality of life. Our focus began to shift toward long-term recovery and the role we could play in that.

GREAT LAKES ATTC: How did you begin to prepare staff for some of the changes that were implemented through this process?

MIKE BOYLE: Early on in our co-occurring project, we realized that we had to address staff's values and beliefs, their attitudes, and the different cultures of our mental health and addictions programs. We took all our clinical staff and divided them into small groups (12-15 staff each) that gathered in brown-bag lunch meetings every week. These meetings were facilitated by members of our co-occurring committee. We developed a list of statements we called "fire starters," to elicit and discuss beliefs and feelings about particular issues. Examples of our fire-starter statements include:

- Addictive and psychiatric disorders are both significant chronic conditions often characterized by episodes of exacerbation, remission, and relapse.
- All persons should be retained in service and treated with great respect in spite of non-adherence with treatment plan recommendations, including not taking prescribed medications or a return to use of the drug of choice.
- Addiction and mental illness are both no-fault disease categories.
- No behavioral health problem is so grave that an individual cannot be engaged in the recovery process.
- It is more important to convey caring and concern than to avoid being manipulated or conned—even at the cost of "enabling."
- Medication can be an effective strategy in the treatment of both disorders.
- Recovery begins with hope, not abstinence from drug use or reduction of psychiatric symptoms.

GREAT LAKES ATTC: Did this help "unfreeze" the cultures across programs?

MIKE BOYLE: It worked very well. We had intense debate over issues such as whether somebody who was on methadone treatment could be considered to be in recovery. One staff member would declare, "You couldn't be in recovery on methadone; You're still using an addictive drug!" That would trigger counter-responses from other staff: "Wait a minute. I've got people who are on methadone who are not using any alcohol or non-prescribed drugs. All the urine drug screens are clean. They have a family and a job, and they're doing great. What do you mean, they're not in recovery?" That type of interaction opened people's eyes and their minds. Here's another example. A person who worked in our detox program said, "People with addictions make a conscious choice to go back to using. They go to the bar. They go buy

some marijuana or cocaine, whereas people with serious mental illness really don't make a choice when they relapse." Mental health staff responded, "People make a conscious choice to not take their medications any longer. That's analogous to making a choice to drink or use a drug. Both populations know the risks and the likely events that will follow."

GREAT LAKES ATTC: Were there staff people who couldn't make this transition?

MIKE BOYLE: We made it clear to everyone, "We're going west, and the wagon train is leaving. We don't know exactly where we're going to end up. We're not sure if it's going to be in California or Oregon, but if you want to stay with this organization, you've got to get on board the train and make this journey with us." We made our expectations explicitly clear in written documents that outlined the attitudes, values, knowledge, and skills that we saw as the core of this shift toward recovery management and behavioral health service integration. Not all made it, but most did.

GREAT LAKES ATTC: Training seems to have been a crucial part of your system-transformation process.

MIKE BOYLE: Yes. All of this involved bringing outside trainers into the organization. In fact, we started the co-occurring initiative by bringing in Dr. Ken Minkoff to conduct a full day's training that was the largest clinical training in the history of the organization—with more than 120 staff. He does a great job of motivating people and getting them laughing at some of the stupid things we do. And then we followed up with a lot of evidence-based training for both mental health and substance abuse. We started with Motivational Interviewing (MI), which led to a major cultural change in our service units. That training was a milestone in shedding the culture of confrontation that had long-pervaded some of our service units. Rather than verbally beating people into superficial compliance, we redefined our jobs as helping people take a look at the pros and cons of the choices they have and the discrepancies between their life goals and their behaviors. That was probably the most important cultural change we made in both our mental health and addiction services.

We followed the MI training with a series of other trainings. The manualized treatments covered included Community Reinforcement training provided by Bob Meyers, Contingency Management training provided by Nancy Petry, Strengths-Based approaches by Leigh Steiner, Illness Management and Recovery from Kim Mueser, and Supportive Employment from Pat Corrigan and associates. We also provided basic training on recovery management principles. These trainings collectively moved us closer to evidence-based practice and toward a stronger recovery orientation. We also moved to person-centered care that required us to give up some of our delusions that we had control over people's individual decisions that impacted their lives. Rather than prescribing techniques, we had to engage individuals as partners in the pursuit of recovery.

GREAT LAKES ATTC: It seems like there was an interesting relationship between the BHRM project and Fayette, in which you used the service programs as a kind of laboratory to test out emerging ideas and approaches. Is that accurate?

MIKE BOYLE: That's very accurate. I'll give you one example. Four years ago, the local state-operated psychiatric hospital in Peoria closed. We took that opportunity to look at how we could improve services as some of the savings from the hospital closing were provided to us to expand our community-based services. One of the services we developed was recovery coaching. We said, "Wait a minute. If we're going to keep people coming through the front

door, we need to open a back door for sustained recovery support." One of the evidence-based practices we were using at the time was assertive community treatment, the ACT model from Madison, WI. The ACT model, as it was widely implemented, was a life sentence of case management. We rethought that position. We hired two people to be recovery coaches, and we went through all of our case management caseloads to identify people who were doing well whom we could graduate from case management and put on this other team that would provide ongoing recovery support and monitoring. That was probably our first foray into recovery coaching and ongoing monitoring. Many are coming here only because they need to see the doctor every 90 days to continue to monitor their psychotropic medications. They don't need anything else from us. So we've developed criteria, and we're trying to link these people to primary care, particularly a federally qualified health center that we work with, and totally graduate them from the organization, saying, "If you ever have a return of symptoms, or you need help, we'll always be here. Call any time. You are no longer a mental health client." The primary care physician can monitor their psychotropic medication while he or she is treating other physical disorders like diabetes and hypertension.

GREAT LAKES ATTC: Mike, describe your changing philosophy about client access to services and the importance of retention.

MIKE BOYLE: Recovery management can increase access by lowering barriers to entry, but our access was pretty open even before the BHRM project, with one exception. We did have exclusionary criteria that resulted in our rejecting people with co-occurring disorders for both our mental health and addiction services. We had to work to eliminate these service-entry barriers, which we were able to do with considerable success. Our bigger issue was retention. We were fine bringing people back who had had previous treatment episodes, but we were throwing a lot of people out for lack of motivation or for petty rule violations. Particularly in addiction treatment, if people didn't say the right things and do the right things, we were throwing them out or making them feel unwelcome enough that they'd leave. Our philosophy had been that they were not ready for recovery and that they needed to get back to the streets and accumulate some more pain in their lives. This is an area in which we saw dramatic change in staff attitudes.

GREAT LAKES ATTC: Elaborate on that change.

MIKE BOYLE: We started accepting people for where they were and respecting them for telling us the truth. Our new position was, "You don't have to say that you're here because you really want to stop using all drugs. It's okay to be ambivalent. It's okay to say, 'I'm only here because the court's forcing me to be here, or because I have to be here to get my kids back'." Training on motivational interviewing changed the culture. We grew from blaming people for their lack of motivation to attempting to understand their current circumstances and desires. This change in philosophy was enhanced through our involvement over the past three years with the Robert Wood Johnson Foundation's Network for the Improvement of Addiction Treatment. We have tried to make the environment in our treatment programs very welcoming, rather than conveying the feeling that you're being processed into jail. In fact, we're trying to use the term "engagement" rather than "retention." You can retain people in jail or a locked psychiatric unit. Engagement implies the establishment of a relationship in which the person wants to be involved in the services. The whole atmosphere has changed.

GREAT LAKES ATTC: That must have generated a significant change in the nature of the service relationship.

MIKE BOYLE: One of the BHRM principles is development of a recovery partnership rather than a hierarchical dominance by the treatment program and the treatment professional over the individual. That has been a huge, huge change across the whole organization and reflects the strengths-based approach that Charles Rapp endorses for people with serious mental illness. Our messages are clear: We're here to work together. We want to understand what your goals are. What do you need to start and sustain your recovery? How can we help you achieve that? Our focus extended beyond treatment to each person's goals for his or her life. Often, a "non-treatment" goal will help the person realize that participating in treatment activities will assist them in reaching their goals. For example, obtaining and maintaining employment may be a primary goal, and taking psychiatric medications and reducing use of alcohol or drugs may be an important step toward meeting the goal of employment.

GREAT LAKES ATTC: You have argued that administrative discharge is a form of clinical abandonment.

MIKE BOYLE: A decade ago, we discharged people because they were violating our numerous rules and because we determined that they just weren't really ready to change. Our first step was to get rid of a lot of stupid rules that had little to do with someone's recovery. We've had to step back and ask, "Why are we doing this?" Many times, it's because we've always done it that way, and we can't even remember how the policy or practice started. I'll give you an example. We had a blackout period in our residential programs during which individuals weren't allowed to make phone calls or have visitors for a period of time. The clients were saying, "Hey, I really wanna call my kids and let them know how I'm doing." I remember a young woman who had a very close and supportive relationship with her father saying, "I really want to call my dad. I just want to talk to him." We finally said, "Okay. Let's do away with this blackout period. See what happens." The myth was that people would get homesick or hear the call of the streets and leave. Well, guess what? They stayed. Our average length of stay went up significantly as our AMA (leaving against medical advice) rate dropped after we changed this policy. In one of our programs, the AMA rate dropped from 30 percent to between 11 and 12 percent. And that happened by changing how we treated people. That's what it comes down to. Listening to our customers. Listening to what they want. Taking the strengths-based, Motivational Interviewing approach and avoiding confrontations and power struggles with our clients. We were often discharging people because we were picking fights with them. We had to abandon our philosophy of "It's our way or the highway." Our administrative discharge rate is now about 4 percent, a fraction of the national average, and usually results from someone bringing drugs into the program, or from violence.

GREAT LAKES ATTC: It seems you've found effective clinical alternatives to administrative discharge.

MIKE BOYLE: Today we're more likely to move someone to an alternative level of care than to sever the service relationship with the agency, and to stay involved with someone who wants to pursue a decision we think may not be a good one. Today, if someone says, "I don't want to stay longer in residential care," we work with them to find an outpatient alternative. We stopped dictating what people "should" do and started offering them choices at every step in the process. As a result, we're minimizing treatment dropout, and we've substantially increased the number of people involved in step-down care following residential treatment. For a recent 18-month period, the percentage of clients continuing in outpatient treatment following completion of residential care increased to 94 percent from 69 percent for the previous 18-month baseline period. Furthermore, participation in outpatient increased from 19 percent to 34 percent for those who didn't complete residential care.

A few years ago, if somebody used while they were in one of our outpatient programs, it would be an immediate administrative discharge. That whole attitude has changed. Now, if somebody comes in and says "I had a relapse over the weekend," we work with that experience. What went wrong? How can you prevent that from happening again?

GREAT LAKES ATTC: The changes you describe in the service relationship are striking.

MIKE BOYLE: We've learned how very important it is to empower the individual. We've shifted from, "How do we keep this person out of the hospital?" to "How do we enhance this person's quality of life in the community?"

GREAT LAKES ATTC: Another area of innovation in which you've invested considerable time and resources is the integration of primary healthcare and behavioral health treatment.

MIKE BOYLE: Another key recovery management principle is the importance of moving beyond the integration of mental health and addiction treatment toward the larger integration of behavioral health with primary healthcare. A large number of the individuals with serious mental illness and with severe drug and alcohol problems whom we serve have co-occurring physical health problems and needs. The medications we use, the new atypical antipsychotics, have side effects that can include weight gain. This may contribute to the potential development of hypertension, diabetes, and other weight-related disorders. For another example, on the addiction side, the attending physician for our women's program tested all of the women for Hepatitis C and found that 25 percent were positive for Hepatitis C; but, of that population, only 40 percent who were positive knew they were positive. It's time we started looking at the whole person—looking at global health.

GREAT LAKES ATTC: What strategies have you found effective to link people to primary healthcare in your programs?

MIKE BOYLE: We work very closely with a federally qualified health center (FQHC) that was established here in Peoria about 3 years ago. In fact, we were a sponsor in getting the organization started. They have assumed responsibility for the primary care clinic that is operated within our mental health center. Our goal is to enroll everyone in the FQHC who doesn't have an ongoing primary care relationship. On the addiction side, we work closely with the FQHC to link clients to the FQHC, other clinics, or primary healthcare providers. We are also increasing our referrals to primary health care from our detox program. Also, with client consent, we have standard letters that we can use to inform someone's primary physician of his or her admission to addiction treatment, letters that request the support of the physician in the patient's ongoing recovery. Examples of these forms can be found on the BHRM web site at www.bhrm.org in a guideline for linking addiction treatment with primary care. Our recovery coaches also play a major role in linking people to primary health care.

GREAT LAKES ATTC: How do you currently view the importance of recovery coaches in recovery management?

MIKE BOYLE: Let me describe what we've done with recovery coaching in our addiction treatment units. Two years ago, we took some existing funding and hired two women, both of whom were in addiction recovery, to pilot a recovery coaching program for women in our residential addiction programs. When women are within 4 to 6 weeks of completing treatment, we ask them if they would like to have a recovery coach, and we explain that the recovery

coach will work with them to develop their own personal recovery plan as part of their transition out of residential treatment. We have guidelines, and the forms we use are all on the BHRM website; people are welcome to adapt them to their own programs. The recovery coaches work with women on 8 domains:

- Recovery from substance use disorders
- Living and financial independence
- Employment and education
- Relationships and social support
- Medical health
- Leisure and recreation
- Independence from legal problems and institutions
- Mental wellness and spirituality

This plan is developed before they leave residential treatment, and recovery coaching remains available to them even if they leave AMA, or for any other reason before they complete treatment. When they do leave, the recovery coach transitions with them into the community, to help them implement their personal recovery plans and also to evaluate and modify their recovery plans as necessary.

What we found is that half of the women who accepted the recovery coach—and most do want it—were homeless upon leaving. One of the first efforts of the recovery coach is often linking our women to a local shelter or recovery home so that, on the date of discharge, they have a place to go that's safe and recovery-conducive. A lot of attention is also focused on helping clients gain employment, so they can get into their own apartment or sober living situation. Whatever their goals are, we help them pursue what they want.

At six-month follow-up, the results have been very encouraging. Seventy percent of the women have improved their living situations. At admission to drug treatment, only 4 percent of the women were employed. At six-month follow-up, we have 54 percent employed. Also noteworthy is the fact that 36 percent are involved in some type of educational activity. We're looking at adding some type of supportive education services to the recovery coach program that would help people with three levels of education: providing pre-GED, for people who need to improve their math and writing skills to get in a GED program; helping getting people enrolled in a GED adult diploma program; or helping people get enrolled in secondary education, particularly at our junior college. A big goal of many of the women we serve is to improve their education. We are also putting computer labs into our residential facilities so people can start building computer expertise while they're in residential treatment. This will also provide access to web-based resources and recovery supports that will expand significantly in the next few years. In fact, we're working on the development of these web-based recovery treatment and support interventions with the Innovations to Recovery project headed by Dr. David Gustafson at the University of Wisconsin.

GREAT LAKES ATTC: You've referenced some efforts to evaluate your shift toward a recovery management model. Could you describe some of these efforts in more detail?

MIKE BOYLE: In the past four years, there has been tremendous synergy between the implementation of Recovery Management and our participation in the Network for the Improvement of Addiction Treatment (NIATx). NIAtx has taught us methods of process improvement for increasing access and retention, essential goals of Recovery Management.

One of the principles of BHRM is lowering the threshold to treatment. We have a central assessment unit for women that had an average length of one to fourteen days between the date of her calling and the date of her assessment. We simply did away with scheduling appointments and offered next-day assessment on demand. The time between the call and receipt of the first service dropped to an average of 2 to 3 days. Furthermore, the percentage of calls that resulted in a competed assessment increased from 50 percent to 70 percent.

Another BHRM principle is establishing a recovery partnership with those we serve. We used the NIATx rapid-change process to make treatment welcoming and engaging. For two women's residential programs, the rate of discharges against medical advice dropped from 30 percent or greater to 11-12 percent.

There is also a "business case" for these changes. For example, in one residential program, earnings increased by $274,000 annually, compared to the baseline period one year earlier.

GREAT LAKES ATTC: One of the comments elicited from presentations on recovery management is, "Nobody will ever fund this. Who's going to pay?" How have you funded the innovations you have described?

MIKE BOYLE: For recovery coaching, we can bill those services either to the Division of Mental Health or to the Division of Alcoholism and Substance Abuse as case management services. Medicaid covers mental health case management services in Illinois. Unfortunately, case management services linked to addiction treatment are not funded in our state by Medicaid. As far as potential funding through insurance is concerned, we haven't approached that yet. I suspect it will be easier to sell this concept to corporations and insurance companies than to the public funders because of the former's experience with new approaches to the management of chronic medical disorders. Our recovery management project was only supposed to be three years in length, but the Division of Alcoholism and Substance Abuse was so impressed with the results that they extended the project for two more years and then converted the grant to a fee-for-service contract two years ago. We funded the recovery coaches by taking some of the former BHRM development money and using it to fund the salaries of the recovery coaches and then billing out those services.

GREAT LAKES ATTC: Do you have a vision of how funding changes will help support this transition from an acute care model to a recovery management model of addiction treatment in the next 10 years?

MIKE BOYLE: I think our first step is to prove that this model is effective and to study the cost implications and potential cost offsets and cost benefits. We need that data to approach the funders, both private and public. At this point in time, all we have is the pilot data that looks very good, but it is weak from a research perspective. We are getting indications that are confirming the value of this approach. These include positive impact on engagement and retention demonstrated through our work with the Network for the Improvement of Addictions Treatment and the well designed studies of the Assertive Continuing Care and the Recovery Management Check-ups that have been conducted by Lighthouse Institute. We need additional studies that confirm the value of post-treatment monitoring, support, and early re-intervention. We need formal studies of recovery coaching and its effects on relapse and recovery rates. We know anecdotally that recovery coaches provide a level of support that can help some people overcome a lapse without having to return to structured treatment. Our traditional response to relapse has been readmission for another treatment episode. Why do we continue to put people back through the same treatment they've been through multiple times and think this time

it's going to work? We need studies that illuminate how to deal with the problem of post-treatment relapse in the client's natural environment.

GREAT LAKES ATTC: What are some of the obstacles you've encountered in implementing the recovery management model, whether that's inside your agency; in the community; or at the federal, state funding, or regulatory levels?

MIKE BOYLE: There were several such obstacles. Let's start with the external ones. We've already referenced issues related to funding and regulatory compliance, but an obstacle we didn't anticipate was the attitudes of our referral sources. It took some time to orient them to what we were doing and why. On the criminal justice side, they like to mandate residential treatment whether people need it or not, and the same is often true of the child welfare system. It took us some time to demonstrate the value of less intensive services such as recovery coaching. As long as a person is staying engaged in a service process, our referral sources are supportive of our new service philosophies.

GREAT LAKES ATTC: Did the recovery management efforts that you've initiated open the doors to other projects and areas of innovation for the agency?

MIKE BOYLE: I believe the Recovery Management project was a key factor, along with our participation in the Network for the Improvement of Addiction Treatment, in our being selected for a United Nations project, the International Network of Drug Treatment Resource Centers. One of the four UN workgroups is focused on sustainable livelihoods for rehabilitation and reintegration, and the workgroup is using the principles of BHRM as well as Cloud and Granfield's concept of recovery capital as a foundation for the manuscript we're developing on how we can support recovery. The other project that ties in with our recovery management work is our involvement in the Innovations for Recovery project being developed by the University of Wisconsin, which involves the application of technology to treatment and recovery support. Its primary focus at the present time is on post-treatment recovery support, so this was a natural complement in the shift toward recovery management. Through this project, Dave Gustafson and his engineers are taking Alan Marlatt's relapse prevention schema and looking at technological applications we can use to help people when they're in various risk situations. For example, GPS technology might be used to identify people entering their high-risk environments and provide support through an avatar counselor on a PDA-type device. Our field is far behind other areas of health care in the use of new technologies to provide treatment. These technologies might make ongoing recovery support and monitoring affordable while providing an efficient means of ongoing outcome monitoring. We are even considering developing a recovery support "island" in a virtual world that can be accessed for support and information 24 hours a day.

GREAT LAKES ATTC: Are there pitfalls that other agency directors should be aware of who may want to consider implementing a recovery management philosophy at their agencies?

MIKE BOYLE: First and foremost is how to counter staff resistance or inertia. Recovery management challenges a lot of traditional service thinking and service practices, so there will be resistance. We worked through that by involving everyone in the process and through our training and supervision activities. An equally difficult challenge is the question of time. Many staff like the concept of recovery management and ongoing support, but they uniformly say, "We don't have time to do it. We'd love to be able to keep in contact with individuals when they leave and know how they're doing and provide them support, but we can't do it. As soon as somebody walks out the door, I've got somebody new on my caseload." That's a big barrier to

overcome. The time problems flow from the fact that funding streams are primarily designed to support the acute-care model.

In regards to funding, I believe providers will have to partner with funding and regulatory agencies to make necessary changes in the rules that control the provision and purchasing of addiction treatment services. This will have to occur on an individual basis with each state, due to the variations among states. Some states are already changing their funding mechanisms to support some aspects of a Recovery Management approach. In Arizona, for example, peer-delivered recovery support services are covered through their Medicaid funding stream.

GREAT LAKES ATTC: It does seem like the financial interests of addiction treatment programs work against providing long-term recovery support.

MIKE BOYLE: There are opportunities to incent service providers for providing such services. Pay-for-performance experiments in Delaware and Philadelphia are focusing on access and keeping people in treatment once they've begun. If we really move toward paying for recovery outcomes, that could change the whole world.

GREAT LAKES ATTC: What do you personally feel best about related to the work you've done in recovery management over the past six years?

MIKE BOYLE: The question probably should be, what do "we" feel best about, as BHRM has been a team effort of folks, obviously including Bill White, as well as folks like David Loveland, Pat Corrigan, and Mark Godley. What I feel best about is changing the entire culture of my organization for clients and staff. If somebody who worked here ten years ago walked in here today, they wouldn't recognize us as the same organization. Now everybody talks about using evidence-based practices. Our staff members' learning plans are based on evidence-based practices. Everybody's looking at recovery. I mean, recovery wasn't even a word we used on the mental health side ten years ago.

On a national level, it has been a thrill to watch more and more providers, states, and federal organizations become interested in Behavioral Health Recovery Management and start to apply RM principles and approaches. I think we are nearing the "tipping point," where we become a movement in making drastic changes to addiction recovery nationally, and even internationally. Recovery Management has been embraced by the United Nations project I've mentioned here.

Finally, I'm excited about the early positive results on research trials on recovery management approaches conducted by Mark and Susan Godley, Mike Dennis, Chris Scott, and others from Lighthouse Institute. The significant impact of Assertive Continuing Care for adolescents and Recovery Management Check-ups are very promising for promoting the outcomes of Recovery Management.

GREAT LAKES ATTC: Mike, what do you see as the next steps for your agency in the coming years?

MIKE BOYLE: I think the recovery concept and the recovery management model are very well ingrained here. I think the next three to five years will entail really finishing the total cross-training of all the staff in evidence-based practices for both mental health and addiction. All staff need to be well versed and well skilled in each of these practices and have their own personal toolboxes of techniques that they can use to support individuals and families in recovery. We're not there yet, even with our supervisors, but we're getting closer every day. I think we will also

be increasing our focus on what the community has to offer people in recovery. Let me give you an example. Our staff have put together a list of upcoming events that are free or that cost less than ten dollars, to encourage clients to become engaged in positive social interactions and entertainment in the community. I was reading some case notes the other day regarding an outpatient addiction treatment client who shared how bored he was all weekend. His whole weekend consisted of being bored, with the exception of going to three 12-Step meetings. Part of recovery management is finding ways to make recovery both fun and fulfilling. To do that, we have to get people into the life of the community.

GREAT LAKES ATTC: Your work with the faith community in recent years would seem to illustrate this.

MIKE BOYLE: We've done a lot the last few years to engage the faith-based community to help people become involved in church sampling. Recently, we've established the Peoria Area Alliance for Recovery, which includes many faith-based organizations providing recovery supports. The chemistry is amazing. For example, many women lack the Social Security card and number needed to obtain employment. The churches said they could provide funds to these women to purchase the birth certificates needed for obtaining their Social Security cards. Others in the group suggested the women could volunteer in church activities in exchange, thus empowering and engaging them in positive behaviors.

GREAT LAKES ATTC: How has your relationship with other local community institutions changed in the move toward recovery management?

There are many local organizations supporting recovery, and we realize we need one another to better assist those we serve. For example, the Peoria Area Alliance for Recovery is composed of representatives of organizations providing housing, employment, education, faith-based supports, community development, and other supports that people may need on their journey to recovery.

GREAT LAKES ATTC: Are you providing more services actually out in the community today than you were 10 years ago?

MIKE BOYLE: Absolutely. On the mental health side, 75 percent of our services are community based. On the addiction side, there's probably been less change. We've had our outreach component going for women involved with child welfare for 20 years now, but the recovery coaches are the major change there, moving toward more community-based services. I would love to have more recovery coaches. We did a focus group with people who are involved in our adult drug court in recovery coaching, asking whether or not they would find this beneficial and what types of services they would like from recovery coaching, and it turned out by chance that two of the people who were in the focus group had already been working with recovery coaches. By the end of the group, people in adult drug court programs were saying, "I hope I can stay in this drug court program long enough to get a recovery coach." To hear comments like that from mandated clients is testimony to the potential power of the recovery management model.

This interview is part of *Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-Oriented System of Care*, the second in a series of monographs on recovery management published by the Great Lakes Addiction Technology Transfer Center (ATTC).

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The Addiction Technology Transfer Center Network
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Peer-based Recovery Support Services: The Connecticut Experience

An Interview with Phillip Valentine
By William L. White, MA

INTRODUCTION

One of the distinctive characteristics of recovery-oriented systems of care is the elevated role of peer-based recovery support services within such systems and the importance of post-treatment monitoring, sustained support, and early re-intervention. Such systems are pioneering new volunteer and paid roles under such titles as recovery coaches, recovery support specialists, personal recovery assistants, peer helpers, etc. These roles are attached to existing addiction treatment organizations or are emerging from newly conceived grassroots, recovery advocacy, and recovery support organizations. Interest in these roles and in the broader arena of non-clinical recovery support services has been spawned by two Federal programs: the Center for Substance Abuse Treatment's Recovery Community Support Program (http://rcsp.samhsa.gov/) and the White House-initiated Access to Recovery program (http://atr.samhsa.gov/). One of the most prominent recovery advocacy and support organizations in the United States is the Connecticut Community for Addiction Recovery (CCAR). In December, 2006, I conducted a wide-ranging interview with Phillip Valentine, the Executive Director of CCAR, on behalf of the Great Lakes Addiction Technology Transfer Center (Great Lakes ATTC). The following interview profiles one of the most successful grassroots recovery support organizations, outlines the kinds of services CCAR provides to support the process of long-term recovery, and describes a new potential component of the addiction treatment service continuum, the recovery community center.

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GREAT LAKES ATTC: Phil, briefly describe how you came to be involved in the New Recovery Advocacy Movement and the delivery of recovery support services.

PHIL VALENTINE: Most of the time I think the movement chose me. I received a call back in the Fall of 1998 from a dear friend of mine, Jim Wuelfing, who told me there was an interesting thing happening that I might want to check out. He was involved with NEAAR, the New England Alliance for Addiction Recovery, and told me about the work Bob Savage was doing with the Connecticut Community for Addiction Recovery (CCAR). Both organizations had just received funding from CSAT, and I applied for positions at NEAAR and CCAR. I was offered the position of Associate Director at CCAR and assumed that position in January, 1999.

GREAT LAKES ATTC: How would you describe CCAR's vision and mission?

PHIL VALENTINE: CCAR envisions a world where the power, hope, and healing of recovery from alcohol and other drug addiction are thoroughly understood and embraced. Our mission is to put a positive face on recovery through advocacy, education, and service, in order to end discrimination surrounding addiction and recovery, open new doors and remove barriers to recovery, and ensure that all people in recovery and people seeking recovery are treated with dignity and respect. When people ask me what I do, my "one-liner" is that CCAR organizes the recovery community to put a face on recovery and to build recovery capital.

GREAT LAKES ATTC: How is CCAR organized?

PHIL VALENTINE: CCAR has a central office and four recovery community centers. They evolved out of our chapters. At one time we had six chapters up and running, and their primary purpose was to put a face on recovery. From their needs and desires, we launched the recovery community centers—recovery-oriented anchors in the hearts of the communities, a place where local communities of recovery can design and deliver the supports they need to initiate and maintain their recoveries. Our CCAR staff members constitute an inner circle, and our task is to support, empower, and train the volunteers who form the next circle. Our "target audience" is our volunteers—people in all stages of recovery, family members, interns, friends, and allies. One of our "ideal" volunteers is a retired person in long-term recovery. Our target audience is not people still actively using, or even those seeking recovery or those in early recovery. They are our secondary target audience, and we reach them through our volunteer force. Staff interacts with people at all stages of need, but we're gradually working to have volunteers handle most of the direct peer support. Currently we have 10 staff and 150 trained volunteers. We use this model to multiply our efforts and get the most value for the federal, state, and local dollars we receive.

GREAT LAKES ATTC: What would you consider to be some of the more important milestones in the history of CCAR?

PHIL VALENTINE: There are so many. Receiving funding from CSAT's Recovery Community Support Program laid a financial foundation that was matched by funding from the Connecticut Department of Mental Health and Addiction Services (DMHAS). Our first "Recovery Walks!" held in 2000 was another early milestone and an idea that came from the recovery community. We had never heard of a walk in support of recovery from alcohol and other drug addiction. We did some internet research and found one walk/run for a treatment center in the DC area, so we decided that, if we held a walk and 50 people showed up, we would be successful. Seven

hundred showed up for that first walk. Last September walks for recovery were held coast to coast. That's an incredible breakthrough. Recovery is truly becoming more visible. We just held our third Legislative Day, and a few legislators revealed for the first time publicly their own personal recoveries.

We produced a couple videos that are still pertinent and powerful today, "Putting a Face on Recovery" and "The Healing Power of Recovery." We wrote the "Recovery Core Values" in collaboration with mental health recovery advocates that became the cornerstone of Tom Kirk's (DMHAS Commissioner) policy on a Recovery-Oriented System of Care, which has become a national model. Opening our first Recovery Community Center in Willimantic was an important milestone. This was in response to a high-profile series of newspaper articles in the state's largest paper, *The Hartford Courant*, labeling Willimantic "Heroin Town." We like to say that a few years later CCAR had a hand in turning Heroin Town into Recovery Town. Another milestone was starting our Recovery Housing Project that inventoried the state's independently owned, privately operated sober houses; established a coalition; wrote standards; and delivered training. The most recent milestones have been the initiation of our Telephone Recovery Support program, which perhaps we can talk about later; and our purchase of a three-story, character-laden Victorian home in Hartford for our fourth recovery community center, which will also contain our administrative offices.

GREAT LAKES ATTC: CCAR has developed a very close relationship with the Connecticut Department of Mental Health and Addiction Services, your state addiction agency. How has that relationship evolved over time?

PHIL VALENTINE: The key is that CCAR places a high emphasis on integrity, honesty, and trust. The DMHAS staff trusts us. We will tell them the truth, even if it might mean some temporary "loss" for ourselves. They know we have the best interests of the recovery community at heart. What we will not do is inflate our numbers or exaggerate what we are doing or minimize our struggles to make ourselves look good.

GREAT LAKES ATTC: How would you describe CCAR's relationship with the treatment community?

PHIL VALENTINE: CCAR has never taken an antagonistic stance with the treatment community. Early on, we were perceived as a threat—a new source of competition for limited dollars. I believe that has changed. Recently, I was meeting with a PhD researcher, and I was talking about working with treatment programs to find better solutions. He was surprised. He wanted to know why I wasn't more angry, or more active, in trying to right ALL the wrongs within the system. I replied that I know a lot of people on the front lines, and have met many counselors with huge hearts trying to move people into recovery, and that I don't have an issue with them. Yeah, there are some bad eggs; there are in every field. But for the most part, we have an incredibly dedicated workforce. Why would I take issue with them? I think it also has to do with another unwritten philosophy that is part of the CCAR culture. I say it this way, "We labor in the light of recovery instead of dwelling in the darkness of addiction." I realize the treatment industry is there; and, yes, there are instances of "harvesting the crop of the addicted for profit"; and, yes, recoverees are usually left to fend for themselves once they're done with their treatment episode. Yet the treatment industry does serve a vital purpose: it is very good at initiating recovery.

GREAT LAKES ATTC: Describe the recovery values and principles that CCAR helped forge for the State of Connecticut.

PHIL VALENTINE: The state had merged the mental health and addiction services under one new agency. CCAR got together with mental health advocates to discuss what we had in common. We agreed that we had a lot in common when we first entered the "system." Our common concerns are centered around being treated with dignity and respect, that we shouldn't be left to navigate the system on our own, and that the system should reward the providers that are the most recovery friendly and produce the best outcomes. We don't care how many people a provider serves; we care if the people they serve get well. Tom Kirk used these to write Policy #83, a defining document in beginning to design the state's Recovery-Oriented System of Care (see http://www.dmhas.state.ct.us/policies/policy83.htm).

GREAT LAKES ATTC: Describe the evolution of CCAR's involvement in peer-based recovery support services.

PHIL VALENTINE: CCAR was first organized as a pure advocacy organization. Those first four-plus years we did all kinds of cool things to put a face on recovery—posters, website, video, presentations, etc. However, when a member asked a very simple but deep question, "what can I do?" we were often stretched to find something meaningful. They could tell their story (well, what does that mean?), or they could attend a Chapter meeting (and then?), etc. You catch the drift. There was also a segment of our membership that wanted to be of service. They wanted to provide support, give rides, lend a listening ear, mentor, etc., and we didn't have those opportunities available. So when the RCSP switched from Support to Services, we resisted at first and then began to see how this could really be of benefit. We started slowly, and as we grew into the delivery of support services, they've become more defined.

GREAT LAKES ATTC: Describe the range of recovery support services being provided through CCAR.

PHIL VALENTINE: Our recovery support services range from telephone-based recovery support to offering peer recovery support groups. We were very hesitant to start the latter on the grounds that people should use existing resources, such as AA and NA meetings. But we found a need for an "all-recovery group." Our all-recovery group in Willimantic draws from 20 to 50 people at each meeting. It welcomes 12-Step, Christian-based, methadone, medication-assisted, co-occurring, family members, and community members, but the main theme is to come in and talk about recovery. Such a simple concept, it's brilliant, and it's helped a lot of people. We also are conducting a lot of family-education and community-education activities, as well as family support groups and groups that mix family members and people in recovery. We have a comprehensive recovery housing database that allows us to know up-to-the-minute bed availability and to link people to sober living. And then there's this whole process in the recovery community centers themselves, where people are hooked into jobs or just get support from one another. We serve a broad spectrum of people, but I think we have a special mission of serving people who don't feel fully accepted in mainstream AA or NA. We don't place judgments on people. We say, "You're in recovery if you say you are. Is there some way that you think you might be able to improve your recovery, and how can we help you do that?"

GREAT LAKES ATTC: How would you describe the relationship between professionally directed treatment services and peer-based recovery support services?

PHIL VALENTINE: I've had a couple knee surgeries that illustrate this relationship. I trusted my doctor to perform these surgeries. They were critically needed, but when he was done he turned me over to a physical therapist. And that's where my recovery would either succeed or

fail. If you go regularly to your physical therapy sessions and do the exercises at home like you're supposed to, you can expect your knee to be stronger than ever. Recovery from addiction is the same process. You might need professional treatment to jump-start the process, but recovery is about what happens after treatment. Recovery support services are the physical therapy of recovery.

GREAT LAKES ATTC: Has your expansion beyond advocacy to providing recovery support services broadened the characteristics of people who volunteer for CCAR?

PHIL VALENTINE: The people who are attracted to CCAR are usually wired one of two ways: they're wired to do advocacy about the big issues—to get out there and speak and fight for the cause—or they're wired for service work with individuals. Recovery support services are a tremendous way for grateful people in recovery to give back. Our advocacy work called for a vanguard of recovering people to offer themselves as living proof that long-term recovery is real. There are many people in recovery who quite frankly aren't comfortable being part of that public vanguard, but who are willing to help offer such testimony to individuals in need. Many of our volunteers know experientially that leaving treatment is like falling off a cliff with no one to catch you. They understand the need for a bridge between treatment and long-term recovery and are willing to serve as that bridge. These are the people who are making the telephone recovery support calls, facilitating groups, facilitating trainings, and getting involved with the recovery housing coalition.

GREAT LAKES ATTC: Describe your efforts to build a network of recovery community centers.

PHIL VALENTINE: As CCAR evolved, we realized that, in order for local communities of recovery to have a realistic shot at providing support services, they'd need an actual physical location. We put together a loose plan and worked it in Willimantic. The plan follows a theme from the movie Field of Dreams, "build it and they will come." Willimantic opened. We looked for a site for over a year before we found one in New London. Bridgeport opened after a long search. Last, we've moved into the world of ownership by purchasing a building in Hartford. Our funds are stretched to the maximum now. We'll need additional funding to open more. We've been welcomed wherever we've opened. There has been no NIMBY ("not in my back yard") experience for us (knock on wood). A lesson learned is that the Center will take on the personality of the lead organizer, and that is a good thing. We call the lead organizer a Senior Peer Services Coordinator, and running a Center is more about community organizing than anything else. I think a lot of Recovery Community Organizations lose the organizing piece; they follow a traditional treatment provider model.

GREAT LAKES ATTC: You have recently started providing telephone-based recovery support services to people leaving Connecticut treatment programs. Could you describe the scope of this and what you're learning from it?

PHIL VALENTINE: The Telephone Recovery Support premise is simple: a new recoveree receives a call once a week for 12 weeks from a trained volunteer (usually a person in recovery) to check up on their recovery. We have found, though, that after 12 weeks when we ask the recoveree if they still want to receive a phone call, most times the answer is "yes." We now have people who have been receiving calls for 50 or more weeks, and they're still in recovery. In our first full year of making these calls, CCAR volunteers and staff have made more than 3,100 outbound phone calls. We piloted the project for 90 days out of Willimantic, after meeting with Dr. Mark Godley from Chestnut Health Systems to refine our procedures (DMHAS supported this consultation through a Center of Excellence project). We tweaked the script a

bit, and the process works amazingly well. Outcomes have been ridiculously good—our last quarterly report indicated that 88 percent of our recoverees were maintaining their recovery. Volunteers love making these calls; it helps them as well. It's a win-win situation. We have trained dozens of people to make these calls out of all our locations. Anyone is eligible to receive a call—all you have to do is ask.

GREAT LAKES ATTC: Are all of your volunteers people in recovery?

PHIL VALENTINE: We thought the telephone recovery support would best be provided by people in recovery, but we have had some interns who weren't in recovery who have done a great job in this role and have gotten the same results as our recovering people. I think it's just the fact that the agency of CCAR, what we represent, is reaching out to them, and as representatives of CCAR, they really feel and understand that somebody cares for them. It may be more the institution and the relationship with the institution than the particular person who's making that call. And I don't even know if it's the institution as much as the purpose. It's the care, compassion, and love behind the call that seem to work.

GREAT LAKES ATTC: It's hard to estimate the power of such contact.

PHIL VALENTINE: Early in my recovery, I was told to get a long list of names and phone numbers of people in recovery, and I did. I was a good boy. I had probably a couple hundred names. Did I ever call anybody? No. The idea of actually using the phone numbers was foreign to me. I couldn't pick up the phone to call somebody, but when somebody called me, I would talk and talk and talk and talk and felt very grateful for the support.

GREAT LAKES ATTC: What keeps the volunteers coming back?

PHIL VALENTINE: It's fulfilling. I sit here, and I listen to volunteers make telephone recovery support calls. I'm not ever sure who's getting the most out of it, the volunteers or those they're calling, but I see volunteers with eyes lit up, energized on the phone, really glad to hear from this person that they're doing well, praising the person for all the good things they're doing, being able to be a small part in maybe moving that person towards a life of recovery. There is nothing more rewarding in a volunteer position than playing a role in moving someone into a life in recovery.

GREAT LAKES ATTC: How would you distinguish between peer-based recovery support services and treatment services?

PHIL VALENTINE: I associate the terms "treatment" and "clinical" with being cold and sterile. I don't know if that's correct, but maybe that's been my experience. I see treatment as more sterile, professional, hospital-like, staff-focused. Treatment can be real effective in initiating recovery, where recovery support services are more focused on maintaining and enriching recovery. Recovery support services aren't bureaucratically bound—at least not yet—by mountains of rules, regulations, and paper. Recovery support services are more free and unencumbered to sustain a focus on whatever it takes to support recovery. We're trying to escape the coldness you feel when you walk into a place that seems only concerned with forms and money—the feeling that you're just one more person in the assembly line, one more of the addicts or alcoholics coming through the system. It's hard to be seen as a person in such coldness. Recovery support services are the warmth that can heat you back up. They're the antidote to people being paid to be your friend. Frontline counselors are often warm and wonderful people, but they are constrained by the burdens placed upon them.

GREAT LAKES ATTC: Are your recovery support services being provided by people in volunteer and paid roles?

PHIL VALENTINE: The vast majority of our recovery support services are provided by volunteers, and that's they way we hope to keep it. That being said, if a director of a center is a very strong, powerful personality and very visible, people will be drawn to that person for recovery coaching. What we try to do is to get such people to train others so that we can expand the pool of recovery support resources.

GREAT LAKES ATTC: Do you see a danger in the trend toward paid recovery coaches? Might we drift toward that same clinical coldness you described earlier?

PHIL VALENTINE: It's always about the heart. There's a real spiritual component. Some recovery coaches can get paid and handle it well, and others cannot. Getting paid in this role elevates the level of authority and responsibility. I worry about the ego. I worry about coaches aspiring to that kind of life-and-death influence over others. That kind of authority can mess with a person's recovery and humility. The longer I'm in recovery, the less I know. When you're a paid recovery coach for a while, you think you're starting to know all the answers, and that's just not true. There's always gonna be clients who are gonna teach you more than you teach them, and I hope we stay open to the lessons of such people. There are new ways to deal with things. The volunteer piece works in part because you have a whole network of other volunteers that you bounce things off of. With volunteers, the individual is served by a community of people—the volunteers being the welcome wagon of that community. What a difference it makes on the soccer fields! I've had six years' experience as a travel soccer coach. I wouldn't dream of getting paid. I love it, and I do it because the kids are so much fun. The sport's great. I have something to contribute. Why do we think that a recovery coach should be any different than that?

GREAT LAKES ATTC: Could you provide more detail on what you're doing with telephone-based recovery support services?

PHIL VALENTINE: Right now, we're making calls out of all four CCAR recovery community centers in Connecticut: Hartford, Bridgeport, New London, and Willimantic. In a recent quarter (July-Sept, 2006), we had 108 individuals we were calling on our rolls; 95 were in stable recovery, and only 13 had relapsed. The group as a whole included people who were 30, 60, or more than 90 days out of treatment. The services are available to anyone who requests them, even if you haven't been in treatment. Our number-one referral source is the Recovery Housing Coalition in Connecticut. The treatment providers are starting to jump more on board, so we're getting 6 to 10 referrals a day from them.

GREAT LAKES ATTC: You mentioned that many people want to keep up the phone contact after the standard 12-week period. How long are telephone-based services provided?

PHIL VALENTINE: We have people we've called now for more than a year who are still sober and still appreciating our calls.

GREAT LAKES ATTC: Describe a typical recovery support call.

PHIL VALENTINE: We have a set script, but the call really starts on this basic premise: "Hi. This is _____ from CCAR, checking in with our regular recovery support call. How are you

doing?" And then the conversation branches from there based on their responses. We use a decision tree to guide those making the calls. "I'm doing well." "What kind of supports are you using for your recovery? Oh great. You're in a 12-step program. Have you had a chance to get a sponsor yet?" That kind of thing. "You're still clean, but you're not going to any support meetings? Is there some reason why you're not going to meetings? Can I help you find a meeting?" If we find that people have relapses, we explore options with them and try to get them re-linked to recovery support. Our complete script is available for anyone who wants it.

GREAT LAKES ATTC: Describe the orientation and training of those staff and volunteers who provide recovery support services through CCAR.

PHIL VALENTINE: We have this inner circle of ten staff people who know that the best way to multiply our efforts and be good stewards of our funding is to recruit and develop a volunteer force that is highly trained. We modeled our volunteer program on those used at the major hospitals in the New Haven area. There is a formal application, an interview, a background check, an orientation that includes the module "CCAR Ambassador 101," and ongoing training. Our basic orientation covers such areas as crisis intervention, confidentiality, ethics, and relationship boundaries. And then we provide specialty training for the kinds of roles people want to fulfill, such as peer support group facilitation or telephone recovery support. We have a formal schedule for volunteers working, and each volunteer is evaluated at six weeks and again after six months. We spend a lot of time acknowledging and rewarding our volunteers—for example, at reward dinners—to let them know how much we appreciate the contributions they're making. Volunteer management is not easy, and it takes a very skilled person running it.

GREAT LAKES ATTC: Describer the ongoing supervision of volunteers.

PHIL VALENTINE: Volunteer supervision is done by our peer services coordinators, with our statewide Volunteer Manger having a hand in the formal evaluations. Each volunteer is given a clear sense of what we're evaluating them on and how they can improve. The volunteers also get together and talk with each other about situations that are coming up in the phone calls or in the peer support groups. There's not a lot of crisis intervention. We do have situations where people referred to us may come in high or intoxicated, but we're pretty good at responding to them. When people show up at the center high, we understand that they're here looking for something—looking for help.

There is a second tier of supervision that's important that involves the staff who work with and supervise the volunteers. There are always risky situations that can arise in this kind of service work. The key is how we manage it. Our staff meetings are a reporting session, in which we explore these areas of risk. We look at, "What kind of scenarios came up that you struggled with? What did you find most difficult?" We're trying to get the coordinators to always be completely truthful, rather than hide areas of potential vulnerability.

GREAT LAKES ATTC: How are the telephone support services provided by CCAR being funded?

PHIL VALENTINE: We were fortunate in that we worked with the State and their federal Access to Recovery grant to establish our first fee-for-service. We've learned to cope with the complexities and the tedious work of the medical billing world. We also established a case-rate, so for every ATR eligible recoveree, we receive $151.20 for the first 12-week block of phone calls.

GREAT LAKES ATTC: What are the major obstacles in implementing peer-based recovery support services?

PHIL VALENTINE: One of the potential obstacles is how the treatment providers respond to this growing recognition of the need for non-clinical recovery support services. There is a question of whether they'll jump in and do these services to expand their own service empires, or whether they're going to help the recovery community enhance its own capacities for support. The question is whether treatment agencies will see an "upstart" young recovery community organization as an ally or as a competitor for funds. We are very fortunate in Connecticut that our state leader, Tom Kirk, has promoted a collaborative relationship between CCAR chapters and local treatment programs.

GREAT LAKES ATTC: What do you see as the future of funding for peer recovery support services? Is there an ideal way to fund these services?

PHIL VALENTINE: Ideally, the funding will come from the recovery community itself, and I think the recovery community centers will be that vehicle through which people can, through their individual financial contributions, support local recovery support services. State and federal agencies can help seed these programs for a number of years to build a base of support, but in the long term, the recovery community itself must take ownership of these service centers. The problem is that it may take eight to ten years of development work for a center to be fully self-sustaining.

GREAT LAKES ATTC: What do you personally feel best about today in terms of CCAR's involvement in recovery support services?

PHIL VALENTINE: I'm a fisherman. I feel good that the recovery support services we provide are a net that's catching a lot of the people who wouldn't have otherwise started and sustained a recovery process. Somebody had to build and maintain that net, and I'm honored and humbled by the enormity of how we have affected people's lives. Counselors in treatment often don't get to see the fruits of their work, but we get to see people and stay involved with people and see how their lives have changed years into the recovery process. We can see how they grow and change. We get to witness the fruits of recovery.

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The National Association of Addiction Treatment Providers: Thirty Years of Leadership and Service

William L. White, MA

Fourteen physicians and lay people met in New York City in November 1870 to found the American Association for the Study and Cure of Inebriety (AASCI)—the first professional association of addiction treatment providers. AASCI nobly represented the new field until the association's collapse in the second decade of the twentieth century amidst the larger closure of inebriate asylums, inebriate homes and private addiction cure institutes. It took the dedication of many recovery advocates and more than five decades of effort to rebirth the modern field of addiction treatment. The resurrected field rapidly became a patchwork of advocacy groups, publicly funded and private treatment organizations, governmental and regulatory bodies, and a wide mix of professional roles—all represented by different state, regional and national associations.

At a time that the emerging field was dominated by the flow of new government funding, a number of private programs began discussing the need for a professional association that represented the particular needs and interests of their organizations and their clients. Those discussions, which began in September of 1976, let to the founding of the National Association for Alcoholism Treatment Programs (NAATP) in January 1978. The founding NAATP leaders included Bob Scott, Len Baltzer, Joan McCrea, Hank Clark, Jim Fulton, Lou Carrier, Jerry Creeden and Burt Knight. From discussions between a dozen programs in California, NAATP membership grew to more than 650 treatment programs in 45 states by 1988. Michael Q. Ford, NAATP's first full time Executive Director, orchestrated this first decade of development, but trouble was on the horizon for NAATP and the whole treatment industry.

The 1990s threatened the character and existence of NAATP and private addiction treatment programs. An aggressive system of managed behavioral health care created a precipitous drop in patient census and sparked the closing of many programs. NAATP membership plummeted,

and many remaining members were unwilling or unable to pay their dues. In the midst of this crisis, NAATP moved its office to Washington and recruited Ron Hunsicker to serve as NAATP's new director. Ron and a small cadre of board members began NAATP's resurrection, growth and return to vibrancy. NAATP survived its near-death experience and now stands again as one of the premier organizations in the field of addiction treatment.

Over the past year, I have had the honor of interviewing NAATP leaders from across the country about NAATP's history and contributions. From these interviews I have drawn several conclusions about NAATP's distinctive niche in the modern history of addiction treatment. First, NAATP, by retaining fidelity to its primary mission of serving its membership, has played a role in enhancing the quality of addiction treatment in the United States. It has done this through the vehicles of information dissemination, professional networking, training, technical assistance, standards development, membership surveys, and through programs that honor professional and organizational excellence. Second, NAATP has represented private programs to the larger field and the larger society through its policy advocacy efforts and through its public service initiatives. The former include legislative advocacy and filing briefs before the Supreme Court on addiction-related cases; the latter include making beds of its members available to persons displaced from treatment in the aftermath of Hurricane Katrina. Contributions to the larger field also include development of new technologies for the field such as the uniform patient placement criteria developed by NAATP and turned over to the American Society of Addiction Medicine.

In the final analysis, professional associations are only as good as their core leadership. NAATP has been blessed by two leaders—Michael Q. Ford and Ron Hunsicker—whose long tenures have provided continuity of representation in the field for 30 years and whose dedication and competence have bestowed gifts to the field that far transcend their contributions to NAATP. And of course, there are the board members who represent some of the finest treatment programs in the world and whose contributions to NAATP's effectiveness and the larger field are immeasurable. I finished my interviews with the NAATP staff and past and present board members with a sense of awe at what their dedication and skill had done for the survival, resilience and renewal of NAATP and the larger field. I also experienced a sense of privilege at having met some of the pioneers of modern treatment who will soon be passing the torch of leadership to a new generation.

The field of addiction treatment is a more capable field because of NAATP's role in it, and the field's future is more secure because of NAATP's commitment to that future.

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Tribute to a Pioneer: Dr. LeClair Bissell

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> *What I can say is that over the years I have found I must speak my own truth and take the consequences if I am to stay comfortable. In my case, that has been saying that I am an atheist who does not believe in a god with ears and that I'm a lesbian in a committed relationship since 1959. I see no need to enter a room and at once declare these facts. Even "Good morning, I'm Jewish" would be out of place…. That has cost me some acquaintances but is a whole lot better than slinking as if there was something to hide.*
> LeClair Bissell, M.D. Sanibel, FL (2004)

On August 20, 2008, the addiction treatment field lost one of its modern pioneers, Dr. LeClair Bissell. In her eightieth year, she had lost none of her wit or wisdom. I was one of many people in our field blessed by her knowledge and her encouragement. It is only proper that we pause and offer tribute to her life's work and legacy and reflect on some of her observations about addiction and recovery.

LeClair received a Masters in Library Science from Columbia University and worked as a librarian for the New York Public Library before returning to Columbia in 1963 for medical school. That decision was prompted by the influences of her life partner, Nancy Palmer, and LeClair's participation in the Yale School of Alcohol Studies. After completing her medical degree, LeClair pursued certification as an addictions counselor on the grounds that physicians needed far more than medical knowledge to effectively treat alcoholism and other addictions.

The remaining decades of LeClair Bissell's service to our field were filled with many roles. She was a leading clinician and administrator at such prestigious institutions as the Smithers Alcoholism Treatment & Training Center at Roosevelt Hospital in New York City. She was a skilled researcher, making landmark contributions to the study of addicted professionals. She was a skilled teacher and lecturer, traveling throughout the world speaking on addiction- and recovery-related issues. She was a distinguished author, writing and co-writing such classic texts as *Alcoholism in the*

Professions, *Ethics for Addiction Professionals* and even a children's book entitled *The Cat Who Drank Too Much*. LeClair was also a prime mover within the addictions field through her leadership roles (e.g., president of the American Society of Addiction Medicine and member of the Carter Mental Health Commission's Task Force on Alcoholism) and through her outspoken advocacy on major issues the field confronted over the past five decades.

LeClair Bissell received wide acknowledgement from the field, including awards from the American Society of Addiction Medicine and the Elizabeth Blackwell Award from the American Medical Women's Association—their highest honor for outstanding contributions to the cause of women and medicine. She was also acknowledged for civic contributions to Zonta; the Democratic Party; the Unitarian Universalist Church; Parents, Families, and Friends of Lesbians & Gays; the Gay, Lesbian, Bisexual & Transgender Coalition; Planned Parenthood; and for her devotion to rescuing dogs. (It is hard to think of LeClair without accompanying images of her beloved Chihuahuas). LeClair was the consummate activist who pursued this role, not from a position of arrogance, but in a spirit of humility and service.

As the material at the close of this article will attest, LeClair was personally and professionally quite open about her involvement in A.A. and what A.A. meant to her as a person in recovery and as a physician, woman, lesbian and atheist. She is part of a generation whose passing marks the last of those who had close relationships with A.A.'s founding pioneers. (Marty Mann was one of LeClair's sponsors and LeClair would occasionally give Bill Wilson as a personal reference to professionals she was recruiting for her research studies.)

This brief biographical sketch fails to convey what LeClair meant to so many of us blessed by her mentorship. She played a significant role in my own career. In my first decade in the field, LeClair introduced herself to me at a conference and praised an article I had written—one of my first—and told me the field needed people who could think and write clearly. Her encouragement marked a turning point for me—the first inkling that I might serve the recovery cause as a writer. Years later, I praised LeClair for her work with James Royce co-authoring *Ethics for Addiction Professionals*. She responded that the field still needed a book of ethical case studies and that I should write it. Her challenge set the stage for my subsequent work on *Critical Incidents: Ethical Issues in the Prevention and Treatment of Addiction*. That was so typical of LeClair—deflecting praise and inviting others to greater levels of service. Many owe their contributions to the addictions field to LeClair's challenges and encouragement.

In discussing with others how to best convey the many faces of this most remarkable woman, it was suggested that perhaps this could best be expressed through her own words. Those words are available through her published books and articles, but the persona of LeClair Bissell is revealed much more candidly through her regular posts on the field's internet discussion groups. Here is a sampling of LeClair's reflections taken from her posts on Add_Med—an online discussion group on addiction medicine and addiction science.

On the Need to Play

I wonder if you/we need to learn new ways to celebrate and to reward ourselves? Work is easy but play....? LeClair Bissell, M.D. Sanibel, FL (1998)

On Stigma

There have been some great comments on this and on chronic disease in general, but we can't forget the difference made by stigma. I have Addison's Disease as well as alcoholism. I also have MENS. That means that endocrine residents enjoy me as a rare find and others read my MedicAlert with interest. The contrast between that and how folks respond to my alcoholism is obvious. I don't have to spell it out for this group, do I? LeClair Bissell, M.D. Sanibel, FL (1998)

On Alcoholism Fads

One advantage of being over 70 and involved in various ways with alcoholism since 1953 is that one sees fads come and go. In the 50's, the treatment of choice among AA's doing 12th Step work was fructose, so shaky newbies had honey spooned into their mouths. Later the cure all was an amino acid. Then it became stylish to do 5 hour GTT's to demonstrate hypoglycemia, then treat it with diet. Then we went into a period of alcoholism being partly caused by inadequate niacin, so there was quite a lot of flushing in AA circles and elsewhere for a time. Then we went back to hypoglycemia and sugar "addiction," but by that time many excessive behaviors were being called process addictions. So it goes. Wonder what the next decade will bring?
LeClair Bissell, M.D. Sanibel, FL (1998)

On the Mann Test for Alcoholism

What we often heard was the so-called Marty Mann test in which one is urged to drink three measured drinks a day, never more, never less, for three months. The idea was that if you could do that you were not alcoholic, since one could have just enough to set the trigger but not enough to satisfy. Most of us flunked it within the first week. Any alcoholic can stay dry for a while, but to be only a wee bit wet....?
LeClair Bissell, M.D. Sanibel, FL (1999)

On Recovery and Dying

My fix on this is a bit different from some. I am currently on chemo for breast cancer. I find I am not the least bit afraid of dying but I am scared of helplessness and falling into the hands of colleagues who are worried about my becoming addicted. I'm careful about addictive drugs but, really, who cares if my last months are spent as a medical addict or not? What I find is that we try to find universally applicable policies when what we really need is horse sense and to individualize treatment. I am a Unitarian and a Hemlock Society member of long standing. We're all different.
LeClair Bissell, M.D. Sanibel, FL (2000)

From A Joint Statement with Dr. Anne Geller following Attacks in the Popular Press on Dr. Alex DeLuca

How many of you were prepared to accept what was said in the Post, a biased report of a brutally edited article, without doing any further research? Is that how you normally get your medical information? This seems to have turned into a religious war without the use of any medical, scientific or even collegial common sense. We are ashamed of all of you who rushed into comment without checking your sources and hope that you will remember this episode when it's your turn to be the recipients of media distortion….It is enormously depressing to us, both now in retirement to witness the same mindless zealotry that so beset our field 30 years ago again raise its head to make us a laughing stock in the medical scientific community. We have repeatedly stated that we wish to be in the medical mainstream, to have addictions treated as any other medical illness, to base our treatments on the science and to examine the data carefully. In your attacks on DeLuca you did none of this. You behaved like a bunch of religious fanatics with Satan in sight. Shame on you.
Anne Geller, M.D. and LeClair Bissell, M.D. (July 2000)

On Undeserved Praise

I appreciate the effort to cast credit to me for Smithers [Alcoholism Treatment & Training Center], *but the truth is that what was good about it came from a whole lot of people…I think we credit the physicians who are at the top of the ladder and tend to forget many of the others....I think that the AA friend who used to keep harping on the notion that one could do all sorts of things if one paid no attention to who got the credit was on the right track. It's nice to be praised and I enjoy it, but there are dozens of unsung Smithers*

staff members who should share it. Happy new year everyone and don't stop writing to Congress about what needs to be done for funding treatment.
LeClair Bissell, M.D. Sanibel, FL/ (2000)

On AA, Atheism and Recovery

As a member of AA since 1953 and still an atheist, I have found that one can avoid a lot of the religiosity by selecting groups to attend and picking out fellow spirits among the members. Yes, I am a Unitarian now and find a non-creedal "religion" works just fine for those of us who'd like community with which to share in doing good works that AA cannot by its traditions undertake….I write this not to get into the same old tired arguments but simply to say that many folks can be comfortable and sober within AA without buying into a particular belief system beyond agreeing that people can help one another and that together we can do what individuals may find impossible.
LeClair Bissell, M.D. Sanibel, FL (2000)

On Meeting People Where They Are

Someone once said that addiction is like a tiny furry animal under a dresser. Sometimes the tail sticks out, sometimes a foot, sometimes only eyes and a whisker. We have to grab whatever we can and pull gently. If that's going to be only telephone or email conversation for a while, that's OK with me. We have to get the patient ready to be a patient. I'm sure we've all had many phone calls at an AA answering service or similar when it took several contacts before the body actually appeared. You make some very good points and I agree that we have to be careful not to let the person think s/he's "in treatment" before that's really the case.
LeClair Bissell, M.D. Sanibel, FL (2001)

On Acknowledgement of Mistakes

I remember that when we first were starting the Smithers rehab unit in the mid 70's, we seriously considered starting up smoke free. Problem was that I needed to attract referrals. I discussed the issue with the delightful man who ran the NY Times EAP. He said that he had quite enough trouble persuading his people into treatment. If I forbade smoking, he'd use another facility. I chickened out and did not do it. Some years later, this man was dying of cancer of the lung. I think I was wrong.
LeClair Bissell, M.D. Sanibel, FL (2003)

On Personal Bias

I'm not saying how many days of residential treatment Rush Limbaugh might need. Can't unless I know the man a whole lot better than I do. My own feeling is that treatment should be individualized. Some folks just need a referral to AA with a follow up to be sure things are going well. Others need a variety of outpatient approaches. Others need residential care, sometimes a very few days, others a lot longer than the 28 day formula. I don't like this guy. I'm a liberal Democrat and one of the "feminazis" he used to yap about, so what I'd recommend for him would be way biased.
LeClair Bissell, M.D. Sanibel, FL (2003)

On Online Recovery Support and Isolation

One of my first experiences with being online was to realize how different it was to know only the persona shown in emails with other members of a dog rescue group. Three examples: one young person who was wheelchair bound from brittle bone disease who mentioned she could have only a very tiny dog as a pet or risk another fracture when picking it up, another who said he'd have to be AFK (away from keyboard) for a few minutes to walk a seeing eye dog and one very insightful man to whom I turned for advice before learning he was only fourteen. If I had met any of them in person before we got to know each other online, I'd have been struck first by the physical attributes and would have had to deal with those barriers. Embarrassing to me as a physician to have to face my own feelings yet again….If I'm not posting a lot right now, it's in part because

I'm primary caretaker of my 90 year old life partner whose dementia is progressing rapidly and whose care keeps me rather isolated.
LeClair Bissell (2006)

Reflections on Dementia

I plan to read the Horton book and, now that my life partner has died, that's possible. The last couple of years were my first hands on experience of being a care taker for someone with severe dementia. I learned a lot, including that time to read without interruptions is a real luxury….Now I find that just about everyone I meet here in a resort/retirement part of Florida has had someone with Alzheimer's in the immediate family. It seems that many of us are being saved for dementia and that scares me. I hate to think about all the boomers and folks my age (I'm 79) who are going to create problems for a medical system ill prepared to deal with us. Addictions are easy to manage compared with what I fear lies ahead.
LeClair Bissell, Sanibel, FL (2007)

On Laziness

I'm overweight and nearly 80. Exercise is not always all that convenient but there are things one can do that require very little time. Anne Geller told me that she works on her balance by standing on one leg while waiting in the grocery queue. How long does that take? One of my tiny dogs can't manage stairs on her own so that's at least 3-4 flights of stairs a day. No, it does not get my heart rate up but it supplements the exercises I do in bed before getting up. So it goes.
LeClair (2007)

On Physician Discomfort

I think that teaching doctors how to identify problem drinkers is not very complicated. In my experience, the difficulty is that they don't want to know because that involves them in conversations that make them uncomfortable.
LeClair Bissell, Sanibel, FL (2008)

I hope these excerpts from LeClair Bissell's casual communications to the field offer a glimmer of the person behind the reputation. John French, a long-time colleague and friend of LeClair, recently lamented that LeClair's contributions to the field could be forgotten because of her own humility and other-serving style. I hope this will be the first of many ongoing tributes to her that will prevent that from happening.

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The Life and Legacy of Lisa Mojer-Torres

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On April 4, 2011, Lisa Mojer-Torres died at the Hospital of the University of Pennsylvania from the ovarian cancer she had so valiantly fought. Lisa seemed so indestructible to those of us who knew her that we were deeply shocked by the news of her death. We were so sure that she would win this battle just as she had prevailed in her battle with addiction and in changing how people viewed addiction treatment and recovery.

After receiving her B.A. from Boston University and her J.D. from the University of New York, Lisa worked as a civil rights attorney licensed in both New York and New Jersey. She also served as the Consumer and Recovery Advocate for the New Jersey Division of Addiction Services. Lisa was a leading figure in the new addiction recovery advocacy movement. She served as a founding member and first chairperson of Faces and Voices of Recovery and was a board member of the National Alliance of Methadone Advocates. Her advocacy activities also included congressional testimony, media interviews, presentations at innumerable conferences, serving on multiple advisory boards—including the National Institute of Medicine and the Center for Substance Abuse Treatment, consulting with countless local treatment and recovery support programs, marching in recovery celebration events and, of course, her professional writing--including the 2010 monograph Recovery-Oriented Methadone Maintenance which I had the privilege of co-authoring with her.

Lisa was the recipient of many national awards for her recovery advocacy work, including the first Public Service Award presented by the National Institute of Drug Abuse, (1996), the Johnson Institute's Award, "America Honors Recovery" (2006) and the Richard Lane and Robert Holden Patient Advocacy Award from the American Association for the Treatment of Opioid Dependence (2010).

Anyone who spent any time with Lisa could not help being struck by her personal integrity and the love she had for her family. She often spoke of her parents, Joseph R. Mojer (who preceded her in death) and Gwendolyn Walters Mojer, her husband,

Rolando Torres Jr., her sons Matthew and Liam, and her siblings and extended family. The brightness of the world we live in is diminished for us all by her absence.

I first met Lisa at the historic 2001 Recovery Summit in St. Paul, Minnesota and had many opportunities to collaborate with her over the subsequent years. I am thinking today of some of the milestones in our work together. They reveal why she had such an important influence on my life and work.

At our first meeting in St. Paul, Lisa and I eyed each other skeptically—feeling that we each represented very different ends of the recovery advocacy continuum. I perceived her solely as a methadone advocate, and she saw me as coming from the mainstream advocacy movement that had in the past so often expressed its discomfort if not hostility towards methadone maintenance. By the end of that meeting, we had both allowed ourselves to get to know each other as persons beyond those categories. We ended that meeting believing that we might have a lot to learn from each other. I was struck by Lisa's toughness in challenging the stereotypes held by others, but I was even more impressed with her openness to confront that same capacity in herself.

In the ensuing years, Lisa and I had the opportunity to sit on numerous committees together, share many podiums and get to know each other as colleagues and friends, but it wasn't until a presentation Lisa made in Illinois that I first heard her full recovery story. My thinking about medication-assisted recovery had been evolving for years from open hostility to ambivalence to tepid support to intellectual advocacy, but the power and eloquence of Lisa's story marks the first time I accepted medication-assisted recovery in my gut. Here was someone who had achieved recovery through the use of medication whose character and quality of living and service matched anything I had witnessed in diverse communities of recovery. Many more such acquaintances would follow, but Lisa was the first person who truly put a face and voice on medication-assisted recovery for me. My deepest feelings about the potential role of medications in recovery were forever changed by that encounter. All of the words I have written and spoken on medication-assisted treatment and recovery are a product of our discussions and Lisa's challenges that I could not be silent on this subject.

I interviewed Lisa in 2007 as part of the series of interview in the Profiles in Recovery Advocacy posted on the Faces and Voices of Recovery web site. The interview itself went very well and I sent a copy of the transcription to Lisa for her to review and refine. The transcript was so "clean" I expected we would complete and post the interview in a matter of days, but the days stretched into weeks with Lisa calling me regularly to discuss the smallest of word choices. Even when she submitted the interview to me, she continued to send changes right up to the moment it was posted. What is most revealing is that this process was not about Lisa's aspirations for perfection, but her belief that words could change the world and thus the words had to be perfect. This was not about ego; it was about using a one's thoughts, words and actions as instruments to change the world. If there is a Rosa Parks of medication-assisted recovery in the United States, her name is Lisa Mojer-Torres.

In 2009, I approached Lisa about working with me on a monograph on medication-assisted treatment and recovery. She readily agreed and expressed her hopes that her continued treatment for ovarian cancer would not inhibit her work on the project. In the span of time in which we worked, there were good periods in which her health and voice were strong, but there were also periods in which the treatments made Lisa very sick and weak. It was during those periods that I told and sometimes pleaded with Lisa that we could take a break in the work until she was feeling better. She always refused. She said simply that the work was too important to postpone and that

she needed what we were doing to take her mind beyond the cancer. I recall times when we would have to pause in our discussions for a moment until a wave of nausea passed, but she came right back to where we had left off and moved forward. She was tenacious.

In the summer of 2010, I sent Lisa a first draft of the monograph that integrated what she and I had separately drafted. It contained a sweeping synthesis of the science of methadone maintenance and quotes from some of the modern clinical pioneers of addiction treatment. She called shortly afterwards to tell me that we had left out the most important voices—the voices of methadone patients! So for many weeks we posted notices at opioid treatment programs and recovery advocacy web sites offering current and former methadone patients an opportunity to weigh in on key issues addressed in the monograph. We were specifically looking for persons for whom methadone had been or currently was a central support for their recovery initiation and/or maintenance. We had no idea what the response would be, but I will never forget Lisa's first calls telling me with bubbling excitement that emails and phone calls were pouring in from many directions and that these messages contained detailed suggestions on how the recovery orientation of methadone maintenance could be enhanced.

Beyond our immediate project, those calls convinced her that there really was a large and hidden population of current and former patients who one day would step forward and put a face and voice on medication-assisted recovery. With Lisa, it was always about the patients and the potential power they could wield if they stood in unison.

Lisa, you touched so many of us in this movement in ways we could never fully express to you. If anyone could ever doubt the power of one person to make a difference—to change the world, your life is that evidence. We hope you are resting easy in the knowledge of how much you achieved and how much you were loved. We will miss you dearly, but we will not let your vision or your legacy die.