

Provider Approaches to Recovery-Oriented Systems of Care: Four Case Studies

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Office of Program Analysis and Coordination, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

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Background

The concept of recovery lies at the core of the Substance Abuse and Mental Health Services Administration's (SAMHSA) mission, and fostering the development of recovery-oriented systems of care is a Center for Substance Abuse Treatment (CSAT) priority. In support of that commitment, in 2005, SAMHSA/CSAT convened a National Summit on Recovery. Participants at the Summit represented a broad population of stakeholders, policymakers, advocates, consumers, clinicians and administrators from diverse ethnic and professional backgrounds. Although the substance use disorder treatment and recovery field has discussed and lived recovery for decades, the Summit represented the first broad-based, national effort to reach a common understanding of recovery guiding principles, elements of recovery-oriented systems of care, and a definition of recovery.

Through a multi-stage process, key stakeholders formulated guiding principles of recovery and key elements of a recovery-oriented system of care. Summit participants then further refined the guiding principles and key elements in response to two questions: 1) What principles of recovery should guide the field in the future? and 2) What ideas could help make the field more recovery oriented?

A working definition of recovery, 12 guiding principles of recovery, and 17 elements of recovery-oriented systems of care emerged from the Summit process. These principles and elements can now provide a philosophical and

conceptual framework to guide SAMHSA/CSAT and other stakeholder groups, and offer a shared language for dialogue among stakeholders.

Summit participants agreed on the following working definition of recovery:

Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life.

The guiding principles that emerged from the Summit are broad and overarching; they are intended to give general direction to SAMHSA/CSAT and other stakeholder groups as the treatment and recovery field moves toward operationalizing recovery-oriented systems of care and developing core measures, promising approaches, and evidence-based practices. The principles also helped Summit participants define the elements of recovery-oriented systems of care and served as a foundation for the recommendations to the field contained in Part III of the *National Summit on Recovery Conference Report*.

Following are the 12 guiding principles identified by participants (for a complete definition of each of the guiding principles, see the *National Summit on Recovery Conference Report*):

- There are many pathways to recovery;
- Recovery is self-directed and empowering;

- Recovery involves a personal recognition of the need for change and transformation;
- Recovery is holistic;
- Recovery has cultural dimensions;
- Recovery exists on a continuum of improved health and wellness;
- Recovery emerges from hope and gratitude;
- Recovery involves a process of healing and self-redefinition;
- Recovery involves addressing discrimination and transcending shame and stigma;
- Recovery is supported by peers and allies;
- Recovery involves (re)joining and (re)building a life in the community; and
- Recovery is a reality.

Participants at the Summit agreed that recovery-oriented systems of care are as complex and dynamic as the process of recovery itself. Recovery-oriented systems of care are designed to support individuals seeking to overcome substance use disorders across the lifespan. Participants at the Summit declared, “There will be no wrong door to recovery” and also recognized that recovery-oriented systems of care need to provide “genuine, free and independent choice” (SAMHSA, 2004) among an array of treatment and recovery support options. Services should optimally be provided in flexible, unbundled packages that evolve over time to meet the changing needs of recovering individuals. Individuals should also be able to access a comprehensive array of services that are

fully coordinated to support individuals throughout their unique journeys to sustained recovery.

Participants identified the following 17 elements as what recovery-oriented systems of care should be (for a complete definition of each of the elements, see the *National Summit on Recovery Conference Report*):

- Person-centered;
- Family and other ally involvement;
- Individualized and comprehensive services across the lifespan;
- Systems anchored in the community;
- Continuity of care;
- Partnership-consultant relationships;
- Strength-based;
- Culturally responsive;
- Responsiveness to personal belief systems;
- Commitment to peer recovery support services;
- Inclusion of the voices and experiences of recovering individuals and their families;
- Integrated services;
- System-wide education and training;
- Ongoing monitoring and outreach;
- Outcomes driven;
- Research based; and
- Adequately and flexibly financed.

Purpose Statement

This white paper has been developed as a resource for States, organizations, and communities embarking on or strengthening systems change efforts to develop recovery-oriented systems of care. Each State, organization, and community will create a unique design and implementation strategy for recovery-oriented systems of care. The lessons learned by several organizations that have already begun this process are captured in this paper and can serve as an invaluable resource throughout the design and implementation phase.

Developing and implementing recovery-oriented systems of care are a rewarding, difficult and complex process. This process is relatively new to the addictions treatment and recovery field and minimal information is available to guide States, communities, and organizations wishing to develop recovery-oriented systems of care. The case studies presented in this document provide examples, of recovery-oriented approaches within several communities/settings for diverse populations. By providing a range of examples, States and communities can explore approaches best suited to their circumstance. None provides a complete template or roadmap, since each State and community is unique, and since the development of recovery-oriented systems of care is a continuous process of systems and services improvement.

Using the principles and elements as the framework, this white paper will highlight the activities and operations of provider organizations that have taken steps toward the

development of such systems. This paper will present four case studies describing:

- The approach used;
- Funding mechanisms used or developed that support the recovery-oriented system;
- Workforce and training issues encountered;
- Research used to inform the structure and programmatic requirements;
- Motivating factors contributing to systems change;
- Challenges or barriers to systems-change efforts; and
- Other elements critical to each agency's implementation of a recovery-oriented system of care.

Agencies used as case studies are Fayette Companies (Peoria, Illinois), and the Behavioral Health Recovery Management Project; White Bison, Inc. and the Wellbriety Movement; the Sheridan Correctional Center Drug Treatment Prison and Re-entry Program and TASC Illinois' role in the project; and the Citizens Planning and Housing Association (CPHA) of Baltimore, Maryland, and their efforts to expand supportive housing in Baltimore.

Behavioral Health Recovery Management Project

Background

The Behavioral Health Recovery Management (BHRM) Project was born out of the recognition that treating substance use and mental health disorders, which are often chronic conditions, with an acute care model is an ineffective and costly method. An acute care model treats intense, sudden onset, short-term afflictions with short-term, time-limited intensive care, and results in discharge with minimal to no follow up or ongoing support. However, substance use disorders and mental illness are not sudden onset conditions like a broken leg that can simply be treated and healed. Instead, they manifest as chronic and relapsing illnesses, much like other chronic diseases such as diabetes, coronary heart disease, and arthritis that require ongoing, long-term care and management. “These [chronic] diseases are often characterized by alternating episodes of stabilization and symptom activation that require long-term strategies of disease management.”¹ Unlike the treat and release practice for acute illnesses, when treating a chronic illness, a physician will employ disease management strategies in

Recovery management uses the same principles of disease management but shifts the focus from the disease to the individual and from symptom management to building a life in recovery. Recovery management approaches also place greater emphasis on family and community supports that can be capitalized on to enhance recovery initiation and maintenance.

which the patient becomes a partner in managing the disease. In a disease management setting, the physician is responsible for providing relevant evidence-based medical advice and care including self-care management techniques, patient education, and provider training. Disease management utilizes individualized care plans based on clinical guidelines to manage individuals with treatable chronic diseases. The patient/physician partnership allows the individual to engage actively in his or her care and to live a full and participatory life.

Despite a growing acceptance of the disease management model in the treatment of chronic primary health conditions, reliance on “traditional” acute care models continues in the behavioral health arena. To provide for the piloting of disease management approaches in the addictions treatment field, Fayette Companies, based in Peoria, Illinois, secured support for legislation funding the development of such models. The legislation, supporting a three-year pilot project, passed the General Assembly in 1999.

Michael Boyle, President of Fayette Companies, serves as project director; William White of Chestnut Health Systems and David Loveland, Ph.D., of Fayette Companies serve as associate directors; and Patrick Corrigan, Psy.D., director of the University of Chicago, Center for Psychiatric Rehabilitation, also partnered on the project. Initially developed to create a system change within one organization, the concept of recovery management would eventually influence system change efforts at the State level. The knowledge gathered through this pilot program influenced the revision of the State of

Illinois Administrative Rule 2060 to include recovery planning. The recovery management concept would also come to influence systems change efforts in organizations and State systems across the country.

Behavioral Health Recovery Management Project

The idea of recovery management flowed logically from the disease management concept. Recovery management uses the same principles of disease management but shifts the

Behavioral Health Recovery Management is the stewardship of personal, family, and community resources to achieve the highest level of global health and functioning of individuals and families impacted by severe behavioral health disorders. It is a time-sustained, recovery-focused collaboration between consumers and traditional and non-traditional service providers toward the goal of stabilizing, and then actively managing the ebb and flow of severe behavioral health disorders until full remission and recovery has been achieved, or until they can be effectively self-managed by the individual and his or her family (White et al., 2007).

focus from the disease to the individual and from symptom management to building a life in recovery. Recovery management approaches also place greater emphasis on supports within the family and community that can be capitalized on to enhance recovery initiation and maintenance. Because it focuses on the life of an individual and not just the disease, recovery management is broader in scope than the treatment

approaches that are most prevalent today. It encompasses social and recreational activities, employment, education, housing, and life meaning and purpose. In a recovery management approach, recovery should strive to be an enjoyable and positive experience.

The BHRM model recognizes that recovery is an incremental process in which an individual moves through a series of five zones of personal experience and that there is an “ebb and flow” through and across each of the five zones. The zones of personal experience are physical, psychological, relational, lifestyle,

and spiritual. The recovery management model uses “progress in one zone to prime improvement in other zones.”² Additionally, recovery management recognizes three stages in the recovery process: 1) engagement and recovery priming (pre-recovery/treatment), 2) recovery initiation and stabilization (recovery activities/treatment), and 3) recovery maintenance (post-treatment recovery support services).³

Within a BHRM model, treatment becomes one of many ways in which an individual can achieve recovery. When treatment is necessary, particularly in cases where an individual is experiencing highly severe, multiple co-occurring problems, evidence-based treatment practices are used.⁴

According to the BHRM project staff, recovery management differs from traditional treatment by:

1. Lowering the threshold of service entry for individuals and families impacted by behavioral health disorders, such as working with the existing level and sources of motivation for change, even if the individual or family is not ready to engage in services the clinician would otherwise recommend;
2. Redefining the role of the person in recovery from “patient” to full partner in the recovery management process;
3. Redefining the role of the professional from expert who treats behavioral health disorders to consultant and ally who remains engaged with the individual or family over an extended period of time;
4. Viewing treatment as a multi-tiered intervention designed, operated, and evaluated in collaboration with individuals and families in recovery that also addresses stigma and destructive stereotypes that constitute barriers to treatment and community integration;
5. Shifting the service emphasis from crisis stabilization to promoting the identification and achievement of goals consistent with the developmental needs of the individual and the family;
6. Re-engineering assessment to achieve a process that is global rather than categorical, and continual rather than a service intake function;
7. Emphasizing sustained monitoring, self-management, stage-appropriate recovery education and recovery support services, linkage to the natural resources of communities of recovery, and, if necessary, early re-intervention;
8. Assessing recovery as a multi-dimensional process of personal growth, self-management, empowerment, and self-determination that transcends the biomedical dimensions of recovery;
9. Evaluating service events based not on their short-term effects but on their combined effects on the course of the individual and family’s recovery career; and
10. Evaluating recovery programs in terms of a dynamic interaction among persons and families in recovery, service providers, and the community over time.⁵

Implementation of Recovery Management at Fayette Companies: A Shift in Philosophy and Practice

For clinicians who had been trained in and practiced acute care treatment models, the shift to a recovery management approach required training and a conscious effort to accept a significant philosophical change. To facilitate adoption of the approach, Fayette project staff initiated a series of “brown bag” lunch discussions designed to elicit dialogue among project staff and clinicians in the addictions and mental health programs. Many of the discussion topics addressed ingrained philosophies stemming from treatment approaches modeled after acute care interventions. Discussions focused on the chronic and relapsing nature of addictions and psychiatric disorders; others addressed the “power-control” scenarios that are often present in an acute care model. Project leaders outlined the project expectations, core attitudes, values, knowledge and skills in written documents, and also made it very clear to staff that the system and philosophies were going to change. Staff could accept the change and remain with the organization or move on to an organization in which they were more comfortable. Most staff accepted the change.

A comprehensive training plan also played a key role in the cultural shift within the organization. Ken Minkoff conducted a one-day training designed to motivate the staff on treating co-occurring disorders. His training was followed by a series of evidence-based trainings on both substance use disorders and mental health. Training on motivational interviewing resulted in the most significant

cultural shift within the organization for both substance abuse and mental health practitioners. Motivational interviewing changed the culture of confrontation and blame that had previously existed in the service units, to one of acceptance, respect, and understanding. It became acceptable for individuals to be ambivalent about their treatment and honest about why they were there -- for example, whether it was because they were court-mandated to treatment or because a child welfare worker said they needed to go to treatment if they hoped to get their children back.

Staff was also trained in the community reinforcement approach, contingency management, strengths-based approaches, illness management and recovery, and supportive employment by experts in these areas including, Bob Myers, Nancy Petry, Leigh Steiner, Kim Mueser, and Pat Corrigan and Associates. Collectively, these trainings moved the organization and its staff toward evidence-based practices and a stronger orientation to recovery. They also helped to move the organization toward a person-centered approach in which clinical staff relinquished control over decision-making in the treatment and recovery process, recognizing that the individual or family serve as the ultimate experts and decision-makers in the recovery process. Individuals therefore became partners and active collaborators in the pursuit of recovery, rather than passive responders.

Recovery partnerships became a cornerstone of the recovery management model and reflected the strength-based approach advocated by researchers in the mental health field. The message conveyed to individuals is that the

clinician is a partner in the process and is there to help the individual achieve his or her life goals beyond any treatment goals that may exist.

The BHRM project made significant changes in what has traditionally been called discharge and treatment planning. Historically, individuals were discharged because they violated rules or because clinicians determined they were not ready for change.

In the context of residential treatment, Fayette eliminated rules that had little to do with recovery. These included prohibitions on using the telephone or having visitors for a period of time at the beginning of treatment. This blackout period was implemented out of fear that an individual would get homesick, or hear the “call of the streets” and leave. Once the blackout period was eliminated and individuals were able to have contact with their support network outside of the facility, they remained in the program, and the number of people leaving against medical advice declined. Today, when individuals for whom residential treatment would otherwise be recommended decline admission or are unable to participate, they are offered services at a lower level of care. This supports the philosophy of client choice that is so important to recovery-oriented approaches.

The BHRM project found a way to eliminate discharge plans, replacing them with personal recovery plans. In the beginning, Fayette project staff requested a rule exception to replace discharge planning with treatment planning and personal recovery plans. The State later changed the administrative rule permitting treatment planning and personal

recovery planning, eliminating the need for a rule exception. Fayette staff started with a treatment plan that transitioned to a personal recovery plan as an individual neared completion of structured treatment and began the transition to community support. Recently, the Fayette staff has developed recovery planning guidelines that can be used from the time of initial intake. They believe these plans meet all administrative rule requirements while still supporting a recovery-oriented system of care. They are awaiting confirmation of this from the State.

Integrated Services

A key principle of recovery-oriented approaches is integrated services. Many individuals served in addictions treatment have co-occurring physical health problems and needs. Many of the addictions treatment clients test positive for hepatitis or HIV. Some are diagnosed with AIDS. The BHRM project works closely with a Federally qualified health center (FQHC) in the Peoria area. Individuals in the addictions program are connected with the FQHC or are linked with other primary health care providers. Facilitating connections to primary health care services as a part of the recovery planning process ensures that the whole person is treated, decreasing potential for relapse that can be triggered by challenges associated with physical health. Recovery support services play an important role in ensuring connections to primary health care and other critical services in the community.

Recovery Support

BHRM is piloting providing recovery support services utilizing recovery coaches to assist women leaving the residential addictions

treatment program. Four to six weeks prior to treatment completion, women are offered an opportunity to work with a recovery coach who will assist them in developing a personalized recovery plan. Recovery coaches provide ongoing post-discharge support in eight domains:

1. Recovery from substance abuse;
2. Living and financial independence;
3. Employment and education;
4. Relationships and social supports;
5. Medical and physical health;
6. Leisure and recreation;
7. Independence from legal problems and institutions; and
8. Mental wellness, spirituality and meaning in life.

The recovery plan is developed prior to discharge. Recovery coaches are available to women even if they leave treatment against medical advice. Recovery coaches assist women with their transition to the community and provide support related to the recovery plan. They also assist women in locating safe shelter or housing conducive to recovery, attending to primary health care needs, and support them in working toward a variety of goals, including education and employment.

Financing Recovery Management

The BHRM project continues to receive the majority of its funding from the Illinois Department of Human Services (DHS). Once the initial three years of the project were completed, DHS extended the project for two years and then moved the project from the

grant mechanism that had sustained it to the standard fee-for-service contract between the State Department of Human Services and Fayette Companies. Recovery coach services are now billed to either the Division of Alcoholism and Substance Abuse or the Division of Mental Health as case management services. (Medicaid in Illinois covers case management for mental health services but not for substance abuse. Thus, when billed to the Division of Mental Health, recovery coach services are Medicaid reimbursable, whereas when billed to the Division of Alcoholism and Substance Abuse, they are reimbursed using State or Federal block grant funding.) Project staff believe that future funding will rely heavily on demonstrating the effectiveness of recovery management through ongoing data collection. Initial data appear very positive, and the anecdotal evidence also supports the effectiveness of BHRM.

Barriers and Challenges

Initial challenges included rule and financing issues that were resolved through State changes. However, separate funding streams at the State and Federal levels, and the absence of funding streams that support recovery-oriented services remain ongoing challenges. Internal challenges included staff ambivalence and organizational inertia, as well as a belief that staff time was too limited to provide ongoing monitoring and support after discharge.

An unexpected external challenge arose in the form of the attitudes among referral sources for the BHRM project. For example, judges wanted to mandate residential treatment for

all referred offenders, regardless of assessed need. Other commonly encountered external challenges of organizations attempting to implement this approach may include:

- The lack of capacity to provide a holistic intervention that treats people, not diseases;
- The resistance to providing services in the community, rather than in traditional addictions treatment programs;
- The lack of systems to blend treatment with services outside the traditional realm of addictions treatment (e.g., vocational, housing, and educational services);
- The lack of coordination between systems, particularly the criminal justice system and mental health; and
- The ongoing problem of getting families and allies involved in the treatment and recovery process.

Two other challenges were raised in providing holistic services. They are addressing trauma concurrently with substance use disorders and viewing substance use disorders from a public health perspective. Viewing substance use disorders from a public health perspective would involve taking a total health approach, providing preventative services, early intervention, and treatment for not only the substance use disorders, but for other health conditions.

Lessons Learned

Based on experience gained in implementing recovery management, the BHRM staff believes the following recommendations will support the Movement toward recovery-oriented systems of care:

- Collect data on the cost of the current system and the cost of diverting individuals to less expensive forms of treatment and recovery supports;
- Track people rather than episodes of treatment and see what factors contribute to recovery and recidivism;
- Promote the benefits of integrated substance use treatment (promote addictions treatment the way education is promoted; for example, it takes a village to raise a child, and it takes a community to help an individual recover);
- Modify State and local policies, rules, and practices that are not congruent with the development of recovery-oriented systems of care (including evidence-based programs);
- Modify addictions training programs at local community colleges and universities to include recovery-oriented approaches and to emphasize compatible evidence-based practices, such as motivational interviewing and community reinforcement approach;
- Integrate criminal justice and behavioral health services (e.g., promote jail diversion policies and continuity of care);

- Promote community-based programs and services that can reduce the need for detoxification, hospitalization, and residential treatment;
- Mandate assessment for trauma in all behavioral health programs and modify treatment programs that lead to high dropout rates for individuals with trauma;
- Connect funding to improving treatment processes and outcomes;
- Track and report outcomes that promote recovery over time (employment, education, stable housing); and
- Promote the growth of housing programs rather than residential treatment (help clients access affordable housing, child-care services, vocational and educational services while receiving outpatient treatment).

Summary

The BHRM project is an example of an innovative recovery-oriented systems of care change effort within an organization. This project is based on the implementation of a specific approach called Recovery Management.

The BHRM project generally reflects several of the elements of recovery-oriented systems of care developed through the National Summit on Recovery. However, there are areas where the convergence between the project's work and the Summit's elements is particularly marked. They include:

- **Person-centered** through a focus on individual goals and plans for recovery. In recovery management, individuals are supported in making decisions that best meet their own recovery goals.
- **Family and other ally involvement** through family and other support from the beginning of formalized treatment/recovery planning. Family and ally supports are an important part of recovery planning.
- **Individualized and comprehensive services across the lifespan** through the configuration of systems and services to flexibly respond to the needs of the individual. Traditionally, the individual was expected to adapt to the norms, requirements, and expectations of the program.
- **Systems anchored in the community** through recovery coaches and other community organizations, BHRM provides ongoing support for the individual in recovery.
- **Continuity of care** through the development of a recovery plan and the assignment of a recovery coach who will support continuity of care for women post-discharge.
- **Partnership-consultant relationships** through the development of the recovery plan. The recovery coach serves as a consultant who partners with the individual in treatment and following treatment to clarify goals and strategies related to the recovery plan.
- **Strength-based** because recovery management focuses on the strengths

and resources individuals can bring to bear on their own recovery, not on the deficits of the disease.

- **Integrated services** by providing an approach for integrated treatment of co-occurring substance use and mental health services disorders and by integrating behavioral health and primary health care. Recovery planning also reflects integrated services by looking at the needs of the whole person and linking with a variety of community-based services in support of recovery.
- **System-wide education and training** by conducting comprehensive strength-based training for the staff at the outset of the systems change effort.
- **Ongoing monitoring and outreach** through support over time and continuity from initial engagement through treatment completion through the transition and integration within the community.
- **Research based** through the ongoing involvement of some of the field's leading researchers in recovery management and through the adoption of evidence-based practices such as Motivational Interviewing, Community Reinforcement Approach and contingency management. Research is also ongoing and continues to inform the evolution of the system.

The Wellbriety Movement: A Natural Evolution of the Recovery Process

Background

Native American elders point to the years following World War II and the return of Native American soldiers to the reservations as the turning point for the rise of alcoholism in their communities. The elders believe this trend was strengthened in the early 1950s, when policies moved a significant number of Indians from the reservations to major cities to find work.⁶ The move often resulted in isolation and loss of cultural connection, contributing to the increase in alcoholism in Native American communities.

In response to this rise in alcoholism rates, as well as a rebirth of Native pride across the United States in the 1960s and 1970s, the Indian sobriety movement gained momentum. The sobriety movement capitalized on the Native American history of resistance to the dangers of alcoholism, dating back to the first recorded Native American in recovery, Handsome Lake, a Seneca religious leader (1735-1815). By the late 1980s, the sobriety movement that had begun in the 60s and 70s had become visible, and the groundwork for the Wellbriety Movement was laid.

The Native American population recognized the importance of health and healing, as well as the need to address sobriety and wellness through a “holistic way of life involving the family and the community as well as the individual.”⁷ While some Native Americans

did follow the traditional 12-step Alcoholics Anonymous (AA) model, many found the 12-step process culturally inappropriate.

However, Don Coyhis, Mohican Nation, the founder of White Bison, Inc., and one of the founders of the Wellbriety Movement, knew from his own AA recovery experience that there was great benefit to be gained from 12-step programs. He became determined to combine his own healing experience in the 12-step process with Native American cultural and spiritual ways to reach his own people more effectively than 12-step programs alone.⁸ By the mid-90s, with the Native American recovery movement fully active, Coyhis and his staff at White Bison recognized that many Native Americans who were seeking healing and wellness “wanted to find sobriety and recovery from alcohol and drugs, and then go on to live lives of wellness and wholeness rooted both in their own tribal cultures and in the mainstream world.”⁹ It was at this point that White Bison helped to initiate the transition from the sobriety movement to the Wellbriety Movement.

What is Wellbriety?

The term Wellbriety means to be both sober and well. For the American Indian and Native Alaskan populations, the term Wellbriety describes a natural evolution of the recovery process¹⁰ and combines Native American cultural values with the traditional 12-step programs of AA.

Wellbriety is a state of well-being in which the nations can be well only if the tribes and groups are well. Tribes and groups recover only when the families are well. Families can be well only when each individual person is physically, mentally, and spiritually fit.

“Wellbriety means to have come through recovery from chemical dependency and to be a recovered person who is going beyond survival to thriving in his or her life and in the life of the community. To be well is to live the healthy parts of the principles, laws, and values of traditional culture. It means to heal from dysfunctional behaviors other than chemical dependency, as well as chemical dependency itself. This includes co-dependency [adult child of alcoholics] behavior, domestic or family violence, gambling, and other shortcomings of character.”¹¹ Wellbriety is a state of well-being in which the nations can be well, only if the tribes and groups are well. Tribes and groups recover only when the families are well. Families can be well only when each

individual person is physically, mentally, and spiritually fit.¹²

Wellbriety: A Recovery-Oriented Approach

Relying largely on the cultural teachings of the Native American elders, Wellbriety is based in the Four Laws of Change for Native American community development. The Four Laws involve family and other allies in a person-centered approach to recovery and are a vital part of every Wellbriety event, resource, and program. The Four Laws are strongly anchored in the community, ensuring that the community remains a centerpiece and ongoing support network for individuals and families seeking recovery. They also demand a level of community accountability, recognizing that the community as a whole cannot disassociate itself from one of its own who is not healthy.

The First Law, “change is from within,”

“means that human beings must change their thinking, values, beliefs and attitudes before the community can gain lasting healing and a positive direction.”¹³

The Second Law, “development must be preceded by a vision,”

“means that community self-determination is most effective when the community participates in a visioning process to guide its own future.”

The visioning process asks the question, “what would the community look like if it were healthy and working?”¹⁴

The Third Law, “A great learning must take place,”

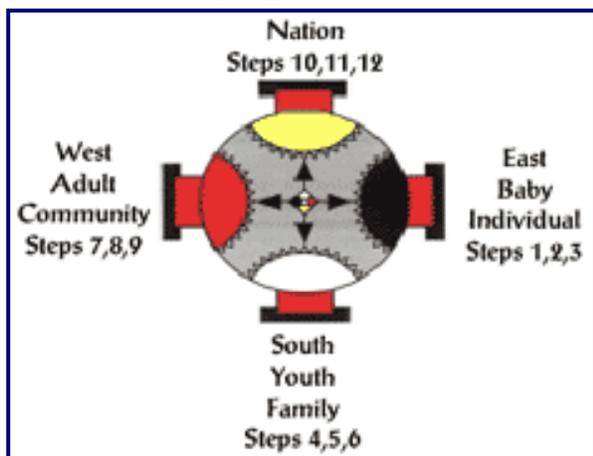
“means that all parts of the cycle of life—baby, youth, adults, and elder—in a community must participate in a

simultaneous learning experience for the community to get well.”¹⁵

The Fourth Law, “You must create a healthy forest,” “means that the entire community needs to be part of the healing process from alcohol and drug problems so that the community itself may recover and individuals may become well persons.”¹⁶

The Four Laws of Change provide a culturally-specific view of healing and recovery that is expressed in the American Indian Medicine Wheel. For the very spiritual Native American population, the Medicine Wheel represents the wheel of life which is forever evolving and bringing new lessons and truths to those walking the path. The Earthwalk is based on the understanding that at one point or another, everyone must stand many times on every spoke of the great wheel of life. Until one has walked the path of another or stood on his spoke of the wheel, one cannot truly know another’s heart. The medicine wheel teaches that all lessons are equal, as are all talents and abilities. It is a pathway to truth, peace, and harmony, and the circle is never ending, life without end. Within the Medicine Wheel are

The Medicine Wheel and the 12-step programs



(Source: White Bison 2007)

the Four Cardinal Directions. Each of the four directions represents something different, in the east is success and triumph, in the north is defeat and trouble, in the west is death, and in the south is peace and happiness.

In Coyhis’ own recovery, he combined the traditional teachings of AA and 12-step programs with the cultural teachings of the Medicine Wheel. Coyhis placed what he identified as the key principles of 12-step programs on the Medicine Wheel—in the East is healing, in the North is the power to forgive the unforgivable, in the West is unity, and in the South is hope. As can be seen in the Medicine Wheel graphic, 3 of the 12-steps of Alcoholics Anonymous are associated with each of the four directions. Steps one through three, which mark the beginning of the recovery journey through 12-step programs are in the East, which coincides with the dawn and early childhood. The recovery process, the journey around the Medicine Wheel, begins in the East with the first three steps. This helped to provide a culturally appropriate, spiritually familiar context for the 12-step process. A principle of the Medicine Wheel is interconnectedness—all aspects of life are connected, related and involved with other aspects. This reflects the teachings of the Native American culture. “Time and again our Elders have said that the 12-step programs of AA are just the same as the principles that our ancestors lived with one change. When placed in a circle then they come into alignment with the circle teachings we know from many of our tribal ways. When we think of them in a circle and use them a little differently then the words will be more familiar to us.”¹⁷

The Medicine Wheel Teachings:

- **Harmony**
- **Balance**
- **Polarity**
- **Conflict precedes clarity**
- **The Seen and the Unseen worlds**
- **All things are interconnected**
- **The honor of one is the honor of all (White Bison, 2007)**

This idea of using the Medicine Wheel teachings to communicate the 12-step concepts eventually evolved into the Medicine Wheel and 12-step program that was piloted in an Idaho prison with incarcerated males in the early 90s. This approach allowed incarcerated Native Americans males an opportunity to benefit from the effectiveness of 12-step programs expressed in a culturally familiar context. The Medicine Wheel and 12-step programs developed for men gave rise to the Medicine Wheel and 12-step programs for women which were also effectively piloted in an Idaho women’s prison.

Between 1999 and 2003, Wellbriety supporters traveled across the United States a total of four times, carrying the teachings of the Medicine Wheel and 12-step programs, and the concept of the Wellbriety Movement to tribes, tribal colleges, and Native American communities. In 1999, the Firestarters program was introduced, becoming a cornerstone for the Native American grassroots recovery movement. Firestarters are trained to work the Medicine Wheel and 12-step programs and commit to continue with the program for four years. Once Firestarters are far enough along in their own recovery, many go on to facilitate

their own peer support services, ensuring that the voices and experiences of recovering individuals are included in helping others in their recovery.

Many other programs have evolved from the Wellbriety Movement in response to the needs of different populations within the Native American community. These additional programs are individualized and provide comprehensive services across the lifespan.

The Creator designed the universe Mother Earth to function as a system of circles and cycles. Therefore, to heal we must understand and live by the cycle and circle system in every area of our lives.

spring	summer	fall	winter
baby	youth	adult	elder
individual	family	community	nation
recognize	acknowledge	forgive	change

In order to heal, we must follow the natural order of healing (White Bison, 2007).

The Wellbriety for prisons program has grown to serve incarcerated Native American populations in several State and Federal prisons. Additionally, two programs, a series of trainings and the Coalition Building program, have arisen out of the feedback from individuals who are familiar with the Medicine Wheel and 12-step program and other Wellbriety Movement initiatives. The trainings series brings together in one place several target populations. The trainings are conducted simultaneously and address the needs of every member of a tribe that is impacted by alcoholism. The trainings and target populations are:

- Firestarters (The Medicine Wheel and 12-step programs) for men and women;
- Firestarters (The Medicine Wheel and 12-step programs) for spouses;
- Sons of Tradition and Daughters of Tradition programs (gender-specific substance abuse prevention programs for youth ages 13-17);
- Strengthening our Families (for family healing); and
- Children of Alcoholics (for youth whose families are affected by alcohol abuse).¹⁸

The Coalition Building, conducted by Community Anti-Drug Coalitions of America (CADCA), teaches Native American tribes how to build coalitions. What the tribe members discovered, however, was that they already understood the idea of coalitions, but for them coalitions were called clans. Tribe members would attend the CADCA trainings during the day, but then in the evening would sit together and transfer the CADCA coalition information to ideas and concepts more readily understood by the clans. The coalition building training program ensures that the system is anchored in the community by teaching, “communities in healing have to band together as coalitions in order to be more effective in accessing healing resources for their communities. It teaches them how to act in unity for the benefit of all.”¹⁹

The most recent addition to the Wellbriety list of program services is called Warrior Down. Warrior Down is a relapse prevention program targeting individuals returning to the community from

incarceration or treatment. Warrior Down creates and trains a network of healthy people to support individuals returning home at a critical and often very difficult time in their recovery.

The Movement and its ideas have also begun to spread to other cultures. An African American group is working on their own culturally specific book inspired by the *Red Road to Wellbriety*, the Native American version of the Big Book. The *Red Road* is also being translated into Spanish. The Daughters of Tradition material is being translated into Spanish and Spanish Braille. A sign-language version of the video for the Medicine Wheel and 12-step programs has been recorded. The Medicine Wheel and 12-step programs are also being taught overseas in Australia and other foreign countries.

Barriers

Initially, the barriers were internal and existed within Native American communities that were resistant to change. But now a greater barrier exists in the fact that the Wellbriety Movement is not grounded in evidence-based science. This has precluded Wellbriety followers from receiving grants from funders that restrict funding to evidence-based practices. Additionally, continued cultural differences plague communications between the Movement’s supporters and local, State, and Federal agencies.

Lessons Learned

The most important lesson learned by the founders of the Wellbriety Movement is the need for evaluation from the start of the

Movement. White Bison was initially funded by a Center for Substance Abuse Treatment (CSAT) Recovery Community Services Program (RCSP) grant. The organizers chose to spend their grant funds in the communities rather than on evaluation. Now, several years later, the Movement is just beginning to collect the data that can demonstrate, scientifically, that the work they are doing has been effective.

Summary

The Wellbriety Movement is an example of a culturally responsive, culturally literate, recovery-oriented approach. Wellbriety Movement founders saw a need to adapt a culturally inappropriate and ineffective approach to recovery support into something that met the cultural and spiritual needs of the Native American population, demonstrating the flexibility of recovery-oriented approaches to meet the needs of very diverse populations.

The Wellbriety Movement generally reflects several of the elements of recovery-oriented systems of care developed through the National Summit on Recovery. However, there are areas where the convergence between the Movement's work and the Summit's elements is particularly marked. They include:

- **Person-centered** by providing stage and age-appropriate support services for individuals.
- **Family and other ally involvement** by recognizing that recovery requires healing the community including the family, other support networks, and the tribal elders.
- **Individualized and comprehensive services across the lifespan** by addressing the needs of the entire life cycle from birth to elder. The Wellbriety programs have evolved since their inception to meet the needs of all members of the community.
- **Systems anchored in the community** through the Four Laws of Change and the Coalition Building trainings. The Wellbriety Movement anchors recovery in the community and also holds the community accountable for healing itself and its members.
- **Continuity of care** through support for those coming out of treatment, as well as addressing the needs of the family and the community. The Wellbriety Movement offers services appropriate to every stage of the recovery process, including new efforts to spiritually prepare individuals in need of treatment for methamphetamine addictions prior to their participation in a treatment program. Wellbriety does not provide direct treatment services, though individuals can receive assistance in locating treatment resources.
- **Partnership-consultant relationships** by encouraging individuals and families to seek their own spiritual pathways to recovery and by offering the support services necessary to help them do that.
- **Culturally responsive** through the evolution of the entire Wellbriety Movement. In response to cultural needs, Wellbriety has developed

training materials in Spanish, Braille, and sign language.

- **Responsiveness to personal belief systems** through the inclusion of Native American spiritual culture into the 12-step concept to create the Medicine Wheel and 12-step program.
- **Commitment to peer recovery support services** through Firestarter groups that are peer-led.
- **Inclusion of the voices and experiences of recovering individuals and their families** through peer and community supports as well as Firestarter groups.
- **System-wide education and training** through annual Wellbriety conferences that bring together the Movement's supporters from tribes all over the United States. Ongoing training for Firestarters also ensures that those involved in the program are able to continue to provide peer support.
- **Ongoing monitoring and outreach** by making the community accountable. Individuals publicly commit to their recovery in a variety of Native American ceremonies. The community also commits to taking care of one of its own and will return an individual to treatment or to a group if he or she relapses.

The Sheridan Correctional Center: A Drug Treatment Prison and Re-entry Program

Background

In 2004, the Illinois criminal recidivism rate was 54 percent, the highest in the State's history.²⁰ To address this historic rate, Illinois Governor Rod Blagojevich proposed to expand the Sheridan Correctional Center to "a national model drug treatment prison and re-entry program."²¹ In response to the Governor's proposal, a working group that included community-based providers, representatives from Illinois executive branch agencies, TASC, Inc.,²² and members of the Governor's staff began to design a system that would address the needs of addicted and incarcerated individuals while they were in prison and provide services in the community upon release. Continuity of care through case management and linkage to community supports for individuals released from Sheridan Correctional Center were intended to sustain and reinforce the treatment and recovery experience. What evolved is a system of care that serves the criminal justice population utilizing recovery-oriented approaches.

In order to fully support re-entry and the recovery process, services must be designed to holistically address the needs of the entire person including mental health and primary healthcare services, and education and employment goals.

The Design

Identification of individuals appropriate for the Sheridan program takes place at the

Illinois Department of Corrections (IDOC) Reception and Classification Center. Participation in the drug prison program is based on security classification, a willingness to volunteer, and an assessment of dependence or abuse. The treatment environment within Sheridan is a modified therapeutic community (TC). However, what sets Sheridan apart from other correctional TC settings is the focus on re-entry that begins on the first day of an individual's incarceration. Sheridan emphasizes a

seamless continuum of care that begins with incarceration and continues through release to the community. Clients are connected to services and programs in and outside the Institution that are designed to help them manage and maintain recovery and restore citizenship. The focus on restoring citizenship

requires that the services within the Sheridan system go beyond substance use disorder treatment. To fully support re-entry and the recovery process, services must be designed to holistically address the needs of the entire person including mental health and primary healthcare services, and education and employment goals.

The Sheridan program is also committed to peer recovery support services. These are

offered in the prison through a peer-led support group known as the Inner Circle. Inner Circle is intended to support incarcerated individuals who wish to enter recovery and to stay crime free following their release. This group meets weekly inside Sheridan and provides opportunities for individuals to share concerns and support and to help each other develop plans for returning to the community. Upon release, Inner Circle participants join a Winners' Circle group, which serves a similar function in the community. This ongoing peer recovery support is a critical component of the Sheridan model.

Winners' Circle is a peer-led, peer-driven support group designed to address the special needs of formerly incarcerated individuals. Membership is open to formerly incarcerated individuals, as well as their families, friends, and allies. Participants must express a desire to participate in their own healing and recovery. They must also be committed to assisting others through encouragement and support. Winners' Circle events provide a positive, social setting in which participants can explore and develop new life skills in a relaxed and non-judgmental setting.²³

Return to the Community: The Need for Linkages and Community Supports

Because individuals take part in treatment for six to nine months, over half return to the community and are able to "step-down" into a supportive living arrangement. This can include transitional housing, halfway houses, or recovery homes. Many parolees require employment and education support services

as a part of their re-entry plan. The continuity of care from incarceration to release allows continued access to services that will help them meet their employment and education goals.

TASC and the parole system work closely together to support an individual's re-entry into the community. TASC provides clinical re-entry case management, intensive case management services specially designed for offenders returning to the community,²⁴ and the parole system provides supervision and enforcement. Unique to the parole system, TASC and the parole staff devise creative strategies to provide incentives and sanctions in support of the parolee recovery and successful re-entry. Historically, when a releasee relapsed or stopped attending mandated treatment, he or she would be deemed in violation of parole and sent back to the correctional system. This resulted in high recidivism rates and reflected a failure to recognize the chronic and relapsing nature of addictions. With clinical re-entry case management, sanctions do not include an automatic return to prison for an individual. When relapse occurs or potential relapse issues are identified, a group consisting of the parolee, family members, TASC, a member of parole, other community-service providers, and the treatment provider develop a plan to address the relapse and to respond to factors that may have contributed to the relapse episode, such as continued unemployment, lack of adequate housing, or lack of child care. Then together, in a client-centered, community support process, the group identifies strategies to resolve those issues. However, while case management and creative sanctions and incentives play an

important role in decreasing recidivism and supporting individuals seeking recovery, the parolee's return to family and community is stressful and may lead to relapse.

Multiple studies suggest that the point of return to family and/or community is a critical juncture of vulnerability to relapse and consequently, re-incarceration.

Communities often reject individuals returning from incarceration out of mistrust

Financing Re-entry and Recovery Following Incarceration

A critical system element of recovery-oriented systems of care is that they be adequately and flexibly financed. The Sheridan project is funded through IDOC, which has woven together a creative funding strategy that has been essential to the success of the program. A blended funding stream

A blended funding stream pays for the services provided post-release through the Sheridan Project. Multiple funding sources allow individuals to access a range of services critical to their successful re-entry and recovery.

and fear that the parolee will re-offend.

Key stakeholders in the Sheridan project brainstormed a way to address this juncture of vulnerability in a manner that built support capacity in the community. Their solution was to create Community Support Advisory Councils (CSACs), which are intended to assist recovering parolees in (re)joining the community and (re)building a life in it. CSACs are composed of individuals who live and work in high-impact communities and include community service providers, employers, and faith-based organizations of a variety of denominations. They engage offenders prior to release to ensure continuity of support. CSACs adopt a client-centered approach and strive to serve as the face of re-entry for the recovering parolees returning to the community. CSACs also serve as a buffer between an often unsupportive or hostile community and the parolee.

pays for most of the services that an individual receives upon release from incarceration, including mental health care and housing. The multiple funding streams afford parolees access to a variety of services critical to successful re-entry and recovery.

However, the flexible funding comes with its own set of challenges. Each of the blended funding streams entails separate reporting requirements, application processes, and timelines, making record keeping, reporting, and fiscal management challenging, though not insurmountable.

Other Challenges

Collaborations, though highly effective, are difficult to maintain. The collaboration essential to Sheridan's success experienced a number of challenges, many of which had to do with conflicting regulations, procedures, and priorities across systems. However, strong leadership from the Governor's staff helped to overcome many of the cross-system challenges. In addition, giving key

staff from each participating State agency a voice in the process helped ensure that there was buy-in to the project across agencies. This created an environment where conflict resolution was feasible. An example of a situation in which conflict was engendered by cross-systems collaboration emerged in the Sheridan TC. Typically, within an IDOC Institution, the treatment staff schedule the entire day for inmates participating in the TC. In the Sheridan project, however, a variety of services competed with the traditional TC activities. These included academic and job training classes, clinical interdisciplinary case staffings, and Inner Circle meetings. Negotiating room in the schedule for all of the support services created an unexpected challenge.

Other challenges included securing immediate employment for individuals returning to the community. A related challenge is that an individual recently released from a drug treatment prison may be tempted to use substances again with the money from his first paycheck. Finally, overcoming many of the historical philosophical beliefs and practices within the parole system posed challenges. For example, individuals released from prison cannot move from the address to which they were released until parole makes contact. This could take three days or more. If the individual has a treatment appointment the day of or the day following release, this poses a challenge for the TASC staff member who wants to get that person into community-based treatment immediately. TASC could not move the individual or he would be in violation of his parole.

None of the challenges were insurmountable. Addressing them, however, required strong leadership, and timely communication, collaboration, and trust among all parties, including the offender and his or her family.

Lessons Learned

Designing the right evaluation from the inception of the project is important. This requires articulating goals, benchmarks, and thresholds during the planning process. Strong leadership is essential to the success of the project. Leadership must be able to bring the right individuals and systems to the table to frankly discuss systems change issues before, during, and after implementation. In designing a recovery-oriented system that works with individuals whose relapse could hinge on split second decisions or responses, rapid and real time communication is essential. Trust, openness, and a willingness to take risks are also essential in creating systems change. To be effective, everybody has to share common goals. In a recovery-oriented system of care for offenders, there also must be a focus on community capacity building, restorative justice, and reintegration of returning offenders into families and communities. This requires changes in communities, not just the individual.

Summary

The Sheridan Correctional Center drug treatment prison and re-entry initiative is an example of a systems-change effort intended to develop recovery-oriented systems of care serving offenders returning to the community from prison. Because of the high rates of drug use and related recidivism for the non-violent, incarcerated population, creating a

recovery-oriented approach to support incarcerated individuals is an important step towards eliminating the continuing cycle of drug related offenses. Building recovery-oriented systems of care for parolees has the potential to reduce recidivism, saving tax payers money. It also contributes to the health and safety of the community.

The Sheridan Project generally reflects several of the elements of recovery-oriented systems of care developed through the National Summit on Recovery. However, there are areas where the convergence between the Project's work and the Summit's elements is particularly marked. They include:

- **Family and other ally involvement** through support services offered for both the family and the parolee in coordination with the CSACs, TASC and parole.
- **Systems anchored in the community** through the ongoing community advocacy work of the CSACs. The CSACs provide an anchor to community support services for returning individuals and their families. TASC and other support providers also connect individuals to community-based support services including treatment, and education and employment programs.
- **Continuity of care** through case management services that begin prior to release from incarceration as well as through the work of the CSACs that reach into the Institution and connect with individuals prior to their release.
- **Commitment to peer recovery support services** through Inner Circles inside the Institution and Winners' Circles within the community following release. Both of these groups rely on peers to support individuals throughout the incarceration, release, and recovery process.
- **Inclusion of the voices and experiences of recovering individuals and their families** through the use of Winners' Circles and CSACs in supporting individuals in their recovery.
- **Integrated services** through an array of community support services. The needs of individuals returning to the community are broad and include housing, employment, education, transportation, and child care. These services are integrated through the ongoing communication and advocacy of the CSACs and community support providers.
- **Ongoing monitoring and outreach** through continued and coordinated case management services provided by TASC.
- **Adequately and flexibly financed** by creatively blending multiple funding streams to access services that traditionally have not been financed by the Department of Corrections.

Building Support for Supportive Recovery Housing: The Citizens Planning and Housing Association of Baltimore

Background

Facilitating and sustaining recovery efforts in many communities across the country is dependent upon safe and secure housing. Upon completion of substance use treatment, many individuals need supportive housing and have few available housing options. Like many cities, the City of Baltimore lacked safe affordable housing. For those without housing, the primary housing alternative was often living in crowded community shelters or returning to their former living environments that contributed to their addiction, thus starting the cycle of addiction all over again. In 2005, a small group of community organizers working at the Citizens Planning and Housing Association (CPHA) of Baltimore launched a plan to address the housing situation for recovering individuals.

CPHA is a community organizing citizen action organization with a sixty year history of facilitating citizen action around neighborhood stabilization, leadership development, public transportation, and capacity building. They also helped craft some of the first fair housing legislation in the country. CPHA assists grass-roots neighborhood organizations, fostering collaboration and coordinated action to achieve shared goals. Composed of an executive director, a lead organizer, five special interest organizers, two support staff

and student interns from the University of Maryland School of Social Work, CPHA spearheaded their supportive housing recovery initiative.

Supportive Housing

These group living arrangements provide residents with housing and support commonly found in a family unit. Residents adhere to house rules and participate in similar activities, e.g., meal preparation, house and property maintenance and gainful employment when possible. The supportive housing model also serves as a bridge for family reunification, encouraging residents to address past problems that have been neglected, e.g., children in foster care, unpaid child support, and damaged family relationships. Utilizing the Twelve-Step model, residents of supportive housing programs begin repairing relationships with family and significant others. Most supportive houses have designated times (usually weekends) for family visits. Supportive housing is not subject to State licensure or certification, because services which require licensure are not provided.²⁵

In Baltimore, Maryland, supportive housing was needed to support the recovery process where there was a scarcity of affordable housing and insufficient residential treatment beds in the City's existing addictions continuum of care. Preliminary research estimated 18,000-20,000 treatment admissions

annually in Baltimore with only 450 available city residential treatment beds. Historically, there had been widespread community-level opposition to the placement of supportive housing and addictions treatment facilities in neighborhoods. Frequently, such dwellings were denied building permits or forced out of communities where they were already operating.

The Process of Building Support

While the addictions treatment system in Baltimore had begun to recognize the need for more recovery-oriented approaches to care, widespread stigma remained an obstacle to the development of services in the community, including housing. Aware of misperceptions and stigma associated with supportive housing in the City, CPHA decided to address the communication gap and the resistance to placement of supportive housing and treatment programs in local neighborhoods. The lack of communication and collaboration among treatment providers, supportive housing operators, and community stakeholders was having a detrimental affect on the community, and CPHA hoped to bridge the communication disconnect that divided these groups.

Multiple issues needed to be addressed for collaboration to occur. Community residents were concerned about the lack of State and local regulatory oversight of certain kinds, “unlicensed recovery homes” of supportive housing. Reports circulated about overcrowding, inappropriate activities, and public incidents/disturbances involving supportive housing residents.

As was stated, supportive housing is not licensed in Maryland, and staff who work in the homes are not credentialed. This created a belief by many treatment providers that supportive housing did not effectively support recovering individuals. Finally, there was the perceived unwillingness of the supportive housing operators, who embraced an abstinence-based philosophy, to accommodate individuals receiving methadone or participating in other medically-assisted treatment approaches. Many of the supportive housing operators were in recovery themselves and at odds with different pathways to recovery.

Initiating Dialogue

Beginning in July 2004, the CPHA Drug Treatment Committee began a series of “Hot Topics” educational forums targeting treatment and zoning reform. Treatment providers, community stakeholders, supportive housing operators, and key city officials were invited as guest speakers to these forums.

Participants represented the Mayor’s Office of Neighborhoods, the City Planning Department, Baltimore Substance Abuse Systems (BSAS), the University of Maryland Drug Policy Clinic, members of The Baltimore City Council and Community Housing Association members. Over 80 participants attended the initial meeting held at the University of Maryland Law School. While the agenda included bills before the City Council regarding licensed group homes and outpatient treatment facilities, unlicensed group “recovery homes” (as they were called at the time) dominated the discussions. The outgrowth of the forums was the creation of a more

common vision among the various stakeholder groups regarding the value of group recovery homes and their designation as supportive housing. For purposes of this report, we will refer to supportive homes for residents in recovery as “supportive recovery homes/housing.”

In late 2004, Baltimore City Council adopted Bill 04-1555 for the purpose of establishing a Supportive Housing Task Force to study the operations and code enforcement of the homes to ensure safe conditions for supportive housing residents and the neighborhoods that surrounded them. Composed of four subcommittees, legal, funding, best practices, operations and enforcement, the Task Force met regularly from December 2004, through February 2005, and developed an increased understanding related to supportive “recovery” homes.

Another important outcome was a proposal with three core recommendations:

- Development and dissemination of educational materials pertaining to supportive housing;
- Development of a one-stop system for “problem” properties;
- Funding for an organizer to create an umbrella organization of supportive recovery homes.

In 2003, the Common Ground Process was also created by CPHA in collaboration with neighborhood leaders and treatment providers. The process was a tool for promoting positive dialogue, interactions, and accountability among communities and treatment providers. The tool assisted with creating a memorandum of understanding (MOU), or “good neighbor

agreement” between the community and providers, and was subsequently utilized by CPHA in garnering support for the supportive recovery housing initiative in Baltimore.

The Baltimore City Drug Court, also aware of the longstanding housing needs of drug offenders, informally advocated for an investigation of supportive housing conditions and the identification of reputable, safe supportive houses in local neighborhoods. The CPHA Director of Drug Treatment and Community Outreach assisted in this process.

In response to a growing need for safe housing, CPHA submitted an application to the Abell Foundation for a grant to fund an organizer and the development of voluntary standards and a peer review process. The Abell Foundation funds non-profit organizations located in Maryland with over 95 percent of their grants awarded to Baltimore metropolitan area organizations.

Through its efforts, the CPHA and partners had successfully created a forum for dialogue among all stakeholders. At the same time, the supportive recovery housing operators demonstrated a desire to be part of the addictions continuum within the community. Some examples include:

- Joining neighborhood associations;
- Modeling for supportive housing residents the role of a good neighbor, e.g., keeping their houses and yards in good order;
- Creating opportunities for neighborhood residents to become involved with the supportive houses; and

- Participating in the Hot Topics forums and the Supportive Housing Task Force with other stakeholders.

Supportive recovery housing residents also played a role in helping break down some of the barriers, stereotypes, and stigma associated with existing supportive houses by volunteering to shovel snow during the winter months, and mowing grass and painting houses in the summer months. By increasing involvement in the community, residents and housing operators helped change how they were perceived by stakeholders.

Bridging the Gap: Setting Standards for Supportive Housing

In 2005, CPHA was awarded an \$80,000 Abell Foundation grant that funded an organizer who developed voluntary standards and guidelines for management of supportive recovery housing. Additionally, based on the recommendation of the Task Force, CPHA created the Baltimore Area Association for Supportive Housing (BAASH). BAASH is an association of supportive housing operators who work together to conduct peer reviews of housing programs and monitor supportive recovery housing standards.

The standards do not address day-to-day operations of the supportive recovery homes, but outline basic life safety codes and other standards modeled closely on the State of Maryland's treatment program regulations. The creation and monitoring of these standards served to enhance the overall reputations of supportive recovery homes.

Supportive Housing: Holistically Addressing the Needs of Residents

Because of the sheer volume of people seeking treatment in the City, there is often minimal case management or follow up once an individual completes treatment and moves into a supportive recovery home. Out of necessity, housing operators have taken on the role of case managers, helping residents maintain their recovery. Operators have encouraged residents to seek employment and provided informal assistance to residents in their job search. Many house operators have familiarized themselves with local employment offices, credit bureaus, child welfare offices, and other local services important to residents. Many are also familiar with local case managers and help residents' access services when feasible. Thus, supportive housing operators, through informal networks, are often able to assist with a wide variety of recovery support resources needed by residents. In addition BAASH has successfully utilized the Common Ground process by establishing MOU's with groups such as the Jericho Ex-offender program increasing referrals to BAASH members.

To further the effectiveness of supportive recovery housing, CPHA has provided clinical training focusing on relapse risk identification and relapse prevention. CPHA also coordinated a day-long training that brought together methadone providers and supportive housing operators in a successful effort to break down the barriers for individuals participating in methadone maintenance treatment. CPHA continues to provide or coordinate training on a variety of topics for

BAASH and neighborhood stakeholders. Discussion and training topics are determined during monthly BAASH meetings. Examples of training sessions include: “Supportive Housing Operators 101” and “A Legal Framework for Supportive Housing.”

Barriers

Funding continues to be a barrier for the supportive recovery housing programs in Baltimore primarily because most operators prefer their autonomy and remain reticent about becoming licensed facilities. Licensure is required for many funding sources. However, 15 -20 percent of supportive recovery housing operators are licensed half-way house operators. The primary difference between half-way houses and supportive homes are that treatment is customary in half-way houses. Operators who are certified addictions counselors or licensed social workers were more likely to pursue half-way house licensure and can provide counseling services to residents. Some operators believed that licensure would facilitate access to BSAS funding as well as strengthen support for grant applications. To date, however, foundations have provided most of the funding for supportive recovery housing initiatives in the City of Baltimore.

The lack of data on the efficacy of supportive housing is a limitation in receiving additional funding. The City is currently developing a plan for evaluating the supportive recovery housing programs. Lastly, although progress has been made, stigma associated with addictions continues to be a barrier.

Lessons Learned

By bringing key stakeholders to the table for frank and open discussions, CPHA and its partners have successfully changed perceptions about supportive recovery housing. Supportive housing is an essential element for many individuals completing treatment and in need of safe living environments in which to continue their recovery. Engaging recovery housing operators and residents in the

Changing attitudes is a process that takes time. The experience CPHA has had with the supportive recovery housing process is a testament to the fact that attitudes can be changed.

community is critical to overcoming fear and decreasing mistrust of neighborhood residents. Finally, data are needed to substantiate supportive recovery housing as a viable housing alternative, as well as critical to supporting those in recovery.

Summary

The work of CPHA in assisting supportive recovery housing gained credence in the community and is an example of how a community resource can support recovery-oriented systems of care. Though there is still work to be done in the supportive housing community and in the larger system, the work of CPHA on this issue has helped to initiate systems change. Outcomes include:

- Decreased community opposition toward supportive recovery housing in neighborhoods;

- Increased interest and buy-in from supportive recovery housing operators (e.g., membership in BAASH increased from 15 members to nearly 50 members) and neighborhood residents;
- Increased accountability with voluntary standards and submission to peer review inspections that are criteria for membership in BAASH;
- Increased credibility of supportive recovery housing programs and funding opportunities, and community support;
- Increased collaborations, (e.g., among BAASH and Baltimore City Drug Court and the Jericho Ex-offender program) through MOU's resulting also in increased referrals to BAASH members.

The work of CPHA generally reflects several of the elements of recovery-oriented systems of care developed through the National Summit on Recovery. However, there are areas where the convergence between the Association's work and the Summit's elements is particularly marked. They include:

- **Family and other ally involvement** through BAASH family reunification efforts, resident counseling, and regular family visits that help mend damaged relationships with spouses and children.
- **Systems anchored in the community** through the provision of community-based housing. Supportive recovery homes are located within local neighborhoods providing residents with safe housing and access to community

services. Community reintegration provides individuals an opportunity to recover and "give back" to the community.

- **Continuity of care** by providing essential recovery support following discharge from treatment and through linkages with available community resources and networks.
- **Strength-based** by building on the natural qualities of the residents, and their family and friends. Additionally, the housing operators (BAASH) demonstrate resilience by modeling successful recovery for their residents.
- **Commitment to peer recovery support** through employing peers as supportive housing operators in supportive recovery homes.
- **Inclusion of the voices and experiences of recovering individuals and their families** by gaining buy-in from stakeholders, including people in recovery (e.g., BAASH), and supportive housing residents and their families/significant others.

Conclusion

The four case studies presented in this document reflect innovative strategies for developing recovery-oriented systems of care anchored in diverse communities and targeting a range of populations.

Each organization approached systems-change differently, some as a part of a larger coalition, others as the lead organization creating internal change. Moreover, the motivating factors influencing systems-change varied. For example, Fayette Companies was motivated to develop and pilot the Behavioral Health Recovery Management project because the staff observed that the organization's clinical and business practices were not only ineffective but potentially damaging to the long-term recovery prospects of those they served. The State of Illinois, through the Sheridan Treatment and Re-entry Program, responded to unprecedented recidivism rates that were clearly linked to drug and alcohol use and ineffective approaches to re-entry. White Bison on the other hand, saw that an existing recovery support service, AA, while effective in some cultural settings, was of much more limited value in the Native American cultural context. In response, the Wellbriety Movement was created, integrating key elements of AA and Native American culture. Lastly, CPHA brought together a coalition to provide a critical recovery support service (housing) and community resource. In doing so, they addressed issues of stigma, funding,

and housing standards in response to individual and community needs.

Several key themes emerge from each of the case studies. The need for strong leadership was consistently found to be a critical element in successful systems change efforts. Articulating a clear vision and the goals of the systems change process, as well as an effective strategy for communicating them to all parties involved, was also important. Serious consideration must also be given to which key stakeholders from the community or State are included in systems-change planning and implementation. Once the key players are identified, ongoing communication is essential. Evaluation was identified as an important element that should be included from the beginning of the process. Benchmarks, outcomes, and evaluation guidelines must be established at the outset to effectively monitor performance and to demonstrate program/organizational effectiveness to potential funding sources. Finally, providers consistently stated that systems change efforts are far from easy and must be undertaken with an understanding that the process requires a long-term commitment on the part of all stakeholders involved.

In conclusion, the providers stressed that systems change is an effort that must be undertaken to improve the current weaknesses in the systems, thereby providing quality services and maximizing limited resources. The providers believe that efforts towards

systems change will ultimately benefit policymakers, advocates, clinicians, the community, and most importantly, the individuals with substance use disorders and their families.

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- ²² Treatment Alternatives for Safe Communities, Inc. (TASC) is an Illinois-based, not-for-profit organization providing behavioral health recovery management services for individuals with substance use and mental health disorders.
- ²³ TASC, Inc. website located at <http://www.tasc.org/preview/corrections.html#rcsp>.
- ²⁴ Clinical re-entry case management is intensive case management for people leaving prison. TASC case managers provide a referral to treatment, place individuals in treatment, and provide ongoing case management services while individuals are under parole supervision. Clinical re-entry case managers begin meeting with clients prior to their release from prison.
- ²⁵ "Supportive Housing in Baltimore City," Task Force Report. March 14, 2005.

Appendix

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Don Coyhis, Founder and President of White Bison, Inc.—The Wellbriety Movement

Pam Rodriguez, M.A., Executive Vice President of TASC, Inc.—Sheridan Drug Treatment Prison and Re-entry Program

Carlos Hardy, M.H.S., Executive Director of NCADD-Maryland Affiliate—The Citizens Planning and Housing Association of Baltimore

