

Against All Odds:

A Peer-Supported Recovery Partnership



PSA Behavioral Health Agency

- History
- Programs



Odds Against: Mental Illness

- In 2012 it is estimated that 9.6 million adults aged 18 or older in the United States had been diagnosed with a Serious Mental Illness *(SAMHSA: Prevention of Substance Abuse and Mental Illness, 2014)*
- Additionally, 23.1 million persons in the United States age 12 and older have required treatment services for Substance Use disorders *(SAMHSA: Prevention of Substance Abuse and Mental Illness, 2014)*

Odds Against: Bureau of Justice Statistics

- **Mental Health Problems of Prison and Jail Inmates: Special Report** *(September 2006 NCJ 213600)*
 1. Mental Health problems defined by recent history or symptoms of a mental health problem
 2. Must have occurred in the last 12 months
 3. Clinical diagnosis or treatment by a behavioral health professional
 4. Symptoms were diagnosed based upon criteria specified in DSM IV

Odds Against: Bureau of Justice Statistics

- Approximately 25% of inmates in either local jails or prisons with mental illness had been incarcerated 3 or more times
- Between 74% and 76% of State prisoners and those in local jails met criteria for substance dependence or abuse
- Approximately 63% of State prisoners with a mental health disorder had used drugs in the month prior to their arrests

Odds Against: Bureau of Justice Statistics

- 13% of state prisoners who had a mental health diagnoses prior to incarceration were homeless within the year prior to their arrest
- 24% of jail inmates with a mental health diagnosis reported physical or sexual abuse in their past
- 20% of state prisoners who had a mental health diagnosis were likely to have been in a fight since their incarceration

Odds Against: Homelessness

- 20 to 25% of the homeless population in the United States suffers from mental illness according to SAMHSA (*National Institute of Mental Health, 2009*)
- In a 2008 survey by the US Conference of Mayors the 3rd largest cause of homelessness was mental illness.
- In New York one review of homeless persons with mental illness (2001) indicated that the average cost of publicly funded services was \$40,449—this included emergency room, hospital stays, shelters, and **incarcerations** (*Kupersanin, E., "Getting Homes for Homeless is Cost-effective," Psychiatric News, (June 1, 2001)*)

Odds Against: Additional Factors

- Family Trauma
- Abuse
- Instilled Core Beliefs
- Negative perception from others in the community
- Lack of support from others
- Rumination
- Hopelessness
- Lack of Recovery understanding

Recovery: SAMHSA's Definition

- SAMHSA has defined Recovery as *“a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations.”* (SAMHSA, *Recovery and Support*, October 2014)

Recovery: 4 Dimensions that Support a Life in Recovery

- **Health**—overcoming or managing one’s disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being
- **Home**—having a stable and safe place to live
- **Purpose**—conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- **Community**—having relationships and social networks that provide support, friendship, love, and hope

(SAMHSA, Recovery and Support, October 2014)

Recovery: Hope

- *“Hope, the belief that these challenges and conditions can be overcome, is the foundation of recovery. A person’s recovery is built on his or her strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person and their community, and is supported by peers, friends, and family members.”*

(SAMHSA, Recovery and Support, October 2014)

Recovery: In Addiction

- *“Recovery is the process through which severe alcohol and other drug problems (here defined as those problems meeting DSM-5* criteria for substance use disorder) are resolved in tandem with the development of physical, emotional, ontological (spirituality, life meaning), relational and occupational health.”*

(White, W. & Kurtz, E. (2005). “The Varieties of Recovery Experience”. Chicago, IL. Great Lakes Addiction Technology Transfer Center. Posted at <http://www.glattc.org>) (Updated to reflect DSM-5)*

Recovery: In Addiction

- *“The immediate goal of reducing alcohol and drug use is necessary but rarely sufficient for the achievement of the longer-term goals of improved personal health and social function and reduced threats to public health and safety.”*

(McLellan A.T., McKay J.R., Forman R., Cacciola J., Kemp J. (2005) Reconsidering the evaluation of addiction treatment: from retrospective follow-up to concurrent recovery monitoring. Page 448 Addiction 100:447-458.)

Recovery: Evidence-Based Practices

- David Mee-Lee, M.D. *“Recovery in Co-Occurring Disorders: What Does It Mean? Walking the Talk About Recovery,”*
(10th Annual Mental Health and Substance Abuse Services Training Conference, October 28, 2014)
- Guidelines for the redesign of health care were published in “Crossing the Quality Chasm: A New Health System for the 21st Century” (2001) and “Improving the Quality of Health Care for Mental and Substance-Use Conditions” (2005) – both reports from the Institute of Medicine.
- Of the 10 rules originally published to guide the redesign of the health care system, at least 5 involve “patient-centered care”

Recovery: Evidence-Based Practices

- The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.
- Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.

Recovery: Evidence-Based Practices

- Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information
- The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.

Recovery: Evidence-Based Practices

- The health system should anticipate patient needs, rather than simply reacting to events.

PSA: Collaboration

- Probation Department
- Clinical Teams in the community
- Hospital personnel
- Family members and Friends
- Community Resources
- Community Supports

PSA: Engagement

- Substance use/abuse treatment/coaching/counseling
- Symptom management of SMI/substance abuse
- Coordination of care with clinical teams, PO's, PCP's, pharmacies, guardians, advocates, attorneys, MMIC, courts, housing providers, family members and other stakeholders
- Navigation of mental health system, mental health court, etc
- Individual counseling (trauma informed care)

PSA: Engagement

- Peer support
- Art Awakenings
- Recovery/Wellness (whole person health promotion)
- Pre-job skills
- Employment support
- Family support
- Independent living skills/survival skills
- Community integration/reintegration

PSA: Engagement

- 7am-9:30pm 365 days a year
- Overnight staff are available by phone and provide limited oversight of the properties after hours when assistance is needed

Traditional vs. Recovery Focus

Person's Attitudes and Behavior	Recovery Process in 12 Step Programs and other Recovery Groups	Traditional Addiction Treatment Attitudes and Practice
1. Ambivalent about abstinence and recovery	1. "Keep coming back" – do the research; you don't have to get the program; it will get you; stages of change and cognitive behavioral approach (SMART Recovery)	1. Client must agree to abstinence as a precondition of admission into treatment; or "come back when you are ready"
2. Reluctant to attend recovery meetings and groups	2. Outreach with 12-Step calls; offer to be a sponsor; assist with transportation; welcoming and "attraction not promotion"	2. Access to care is difficult; long waiting lists; recorded messages and complicated intake procedures
3. Shows up to a meeting after a few drinks	3. "Keep coming back" – "There but for the grace of God go I"; a good "remember when"	3. Leave and come back when you are sober. Sign a contract that you will not come to treatment if you have used
4. Feels will power will fix addiction and trouble accepting suggestions	4. "Powerlessness" and helping people understand the paradox of surrender and power; unmanageability and making amends	4. Counselors act as if powerful and able to confront and coerce recovery; work harder for recovery than client
5. Involves family and significant others in a web of pain and loss	5. "Detachment" – Al-Anon, Alateen; Naranon; help the family develop serenity and their personal recovery	5. Act as if we will stop addiction; work as hard as the family did to stop addiction; compassion fatigue and staff burnout

Traditional vs. Recovery Focus

Person's Attitudes and Behavior	Physical and Mental Health Recovery Approach	Addiction Treatment Recovery Approach
1. Relapse or re-occurrence of signs and symptoms of disorder	1. Viewed as a poor outcome or crisis requiring a timely response; assessment and treatment plan change	1. Viewed as willful misconduct with exclusion from treatment that day and possible discharge from treatment. "Punitively discharge clients for becoming symptomatic" (W.White, 2005)
2. Psychosocial crisis; treatment adherence problems; acute exacerbation of the disorder	2. Discussed as lack of progress and a poor outcome requiring a change in treatment strategies e.g., individual, group, family therapy, pharmacotherapy, case management	2. Discussed as the need for "consequences", sanctions and possible discharge or transfer to another treatment team and setting
3. Persistent treatment adherence problems	3. Variety of proactive strategies – Assertive Community Treatment (ACT teams); Intensive Case Management (ICM); supported housing and employment; variety of "wet", "damp" and "dry" shelters; mental health crisis teams to enhance natural and community supports	3. Blacklist client from readmission to the facility; discharge and send notice of case closed; refer to extended residential and inpatient care away from the person's community with poor continuing care and reintegration into the community; invoke legal sanctions and remove from treatment
4. Severe and chronic illness	4. Utilize levels of care including acute hospitalization; day treatment; outpatient and community-based services; group and independent housing options. No fixed length of stay. Illness, disease and recovery management model.	4. Utilize predominantly fixed length of stay residential programs for those who can pay. Utilize predominantly low intensity outpatient services in the public sector. "Serial episodes of self-contained, unlinked interventions....Relegate post-treatment continuing care services to an afterthought" (W.White, 2005) Repeated episodes of acute care for detox; stabilization; discrete fixed program stay; "treatment completion"; "graduation"
5. Poor outcomes	5. Viewed as the need for more intensive case and care management and community outreach	5. Blame the client for denial and "stinking thinking"; non-compliance; stubbornness to take suggestions

Recovery: SAMHSA Results

“Integrated treatment or treatment that addresses mental and substance use conditions at the same time is associated with lower costs and better outcomes such as:

- Reduced substance use
- Improved psychiatric symptoms and functioning
- Decreased hospitalization
- Increased housing stability
- Fewer arrests
- Improved quality of life”

(Behavioral Health Treatments and Services, October 2014)

Against All Odds: Corrections

- Inmates who were placed in supportive housing in one program experienced an 85% reduction in days incarcerated *(Culhane, D. P., Metraux, S. and Hadley, T. "Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing, Housing Policy Debate, 2002)*

Against All Odds: Homelessness

- Following active placement in supportive housing, an 86% drop in shelter days, a 60% drop in state hospital use, and an 80% drop in public hospital inpatient days. *(Kupersanin, E., "Getting Homes for Homeless is Cost-effective," Psychiatric News, (June 1, 2001)*
- Housing cut incarceration rates in half for homeless persons living with mental illness *(Kupersanin, E., "Getting Homes for Homeless is Cost-effective," Psychiatric News, (June 1, 2001)*

THANK YOU