

White, W. (2012). Recovery management and recovery-oriented systems of care: The view from Detroit: An Interview with Calvin Trent, Ph.D. Posted at www.williamwhitepapers.com.

Recovery Management and Recovery-oriented Systems of Care: The View from Detroit

**An Interview with Calvin R. Trent, Ph.D
General Manager, Division of Special Population Health Services
Detroit Department of Health and Wellness Promotion**

William L. White

Introduction

Following pioneering work to implement models of recovery management (RM) and recovery-oriented systems of care (ROSC) in the State of Connecticut and the City of Philadelphia, similar efforts were replicated across the United States. What characterized these early replication efforts was a state or local policy leader who came to believe that the adoption of RM and ROSC principles and practices were critical to improved long-term recovery outcomes. That leader for the City of Detroit, Michigan was Dr. Calvin Trent. In the fall of 2011, I had the opportunity to interview Dr. Trent about his career and his recovery-focused systems transformation efforts in Detroit. Please join me in this engaging discussion.

Early Career Perspectives

Bill White: Dr. Trent, you worked as a clinical psychologist before coming to the Detroit Department of Health and Wellness Promotion. How did this early work inform your later work with recovery management and ROSC?

Dr. Trent: Well, as part of my Ph.D. Program in Clinical Psychology, I did an internship at the VA in Detroit and after completing my degree worked as a psychologist at the VA hospital in Battle Creek, MI. Most of my work there was in the addictions area and that work informed the later work in Recovery in significant ways.

I had in my personal and professional life met people who were in recovery from their addiction and had developed a deep interest in the whole process of recovery. What facilitated the change in people in recovery and what the nature of

this dramatic process was captivated me. I had been primarily working with people with schizophrenia and other forms of severe and persistent mental illnesses and, of course, did not see the resolution of those problems in such dramatic ways. But with people with substance use disorders, we at times saw remarkable transformations. In spite of these impressive cases of recovery I had witnessed, I was astounded when I first began working in the addictions field with the attitudes I witnessed within the treatment programs. When I came to work at my first treatment center, I was instructed that patients were manipulative, anti-social personality disorder types and that it was up to them to prove that they wanted treatment. There seemed to be little support for the practical, everyday problems of these patients and little focus on the process of long-term recovery.

I had been interested in the idea of natural recovery and wanted to do my Ph.D. research investigating how people recovered without treatment. I was discouraged from doing that. Later I decided to do my Ph.D. looking at the developmental changes that people went through while in treatment. I postulated that there were developmental stages to the recovery process and that this developmental process would need to be sustained and motivated within a chronic disease framework.

Bill White: Yes, I suspect this focus primed you for the long-term recovery orientation that would be later emphasized in your work.

Dr. Trent: Yes, the treatment that we provided was good and generally effective for the 30 or so days of inpatient care we could provide but the rate of relapse for those completing was high and many returned time and time again.

When I left the VA and was asked to come to Detroit, as a manager of the Bureau of Substance Abuse, one of the first challenges we faced was the Medicaid required elimination of waiting lists for addiction treatment for their recipients. In Detroit, at that time, people seeking services had to arrive at a certain time in the morning. They started gathering about 5:00 o'clock am and our doors opened at 8:00am. By then, there would be a line of people whether rain or snow. We'd let about 40 people into treatment and the rest would go on a waiting list. That was typical for the provision of substance abuse services at the time. Our job was to move our system toward the elimination of these waiting lists and as we began to examine the waiting list policy it became clear that it was a policy that was grounded in the idea that addicts could wait for services and that their disease was not life-threatening. For me that was the beginning of a process within my own thinking that changed everything for me about how we should see the addicts and provide them services. As a consequence, we implemented "Treatment on Demand" in Detroit, where waiting lists have been eliminated.

What happened was we moved from a model of contracting for beds to contracting for services. That was also an amazing change, Bill, because before, providers were getting paid a certain amount of money for a portion of their service capacity, let's say 20 beds. And if those 20 beds were filled up, then we had to find another provider who had an available bed. When we went to a contracting for services system, then we were able to draw on the total capacity of the whole system. Since that time in 1999-2000, we have continued to pursue a Treatment on Demand model. Today, you don't stand in line. You call on the phone and there's a person on the other end of the phone 24/7, Christmas, New Years, every day a person is able to get you into treatment within 24 hours.

Recovery Management Comes to Detroit

Bill White: With that as a backdrop, describe your early introduction to recovery management and ROSC and your first responses to those ideas.

Dr. Trent: The beginnings of my seeing recovery as an overarching concept started when I was encouraged to read your book, *Slaying the Dragon*. For me, understanding the history of the recovery movement was a turning point and then when I had the opportunity to hear you when you came to Detroit as a conference keynote speaker in 2001 or 2002 was pivotal. Your critique of the prevailing treatment system and your vision for moving towards a model of sustained recovery management was an epiphany for me. Like many others, I felt that it was time we stopped kicking people out of addiction treatment. Like many others, I felt we needed to shift from patient pathology to a focus on recovery capital. Like many others, I felt we needed to offer sustained support for these clients, as was done for those with other chronic diseases. But I saw these issues more clearly after your presentation, and the feelings became convictions and I began to see such changes as part of the kind of a paradigm shift in the way that we address addiction.

The other thing that happened was the first of the Center for Substance Abuse Treatment's Recovery Community Support Program applications were announced. Andre Johnson and others in long-term recovery in our community had formed a peer-led recovery committee under the Partnership for A Drug Free Detroit and sought the support of the Bureau to apply for this grant and of course support was given. They applied and designed the grant based on a vision as to how we could better serve clients, drawn from their experiences. That recovery committee also drew on the work that you were doing. Needless to say, our group was awarded in the second round of applicants and continues to provide peer-led services today.

Bill White: Have your ideas about recovery management evolved since you've tried to apply those principles I presented?

Dr. Trent: I've evolved from my early concerns as a clinical psychologist about a focus on the acute care clinical services to a broader more holistic concern for how we can better equip our partners in recovery to "live a life in the community as a drug-free person." As I came to the city and became a manager over an entire network of services, my focus shifted to how the whole system could change to accommodate that goal. There were early steps that turned out to be very important. We recognized that involvement and cooperation of people in long term recovery was essential to our success in changing the paradigm. We surveyed people in long-term recovery to see what their thoughts were about what service elements were most important to recovery initiation and maintenance. We started with a focus on pre-treatment engagement and service access and then began looking at how to improve the quality of those services to improve recovery outcomes. We were fortunate to have a quality treatment system in place but with their cooperation had to begin to focus more on building capital to address what happens after treatment. We had to come to grips with the fact that we were sending our clients into the same environments in which their addictions had flourished. We had to start focusing on how to bridge the worlds of treatment and the natural worlds in which our patients were nested. We had to seriously identify barriers to recovery for our people and work on limiting their impact.

There was also a confluence between our own experience, the ideas you had given us and what we were learning from Dr. Clark and CSAT—messages about "No wrong door to recovery". Let me give you a couple of scenarios of how this played out.

A program that we have become very proud of is called FAIR and stands for Families Achieving Independence through Recovery. Like many urban communities, Detroit has experienced large numbers of families facing abuse and neglect charges with a resulting expansion of foster care cases. After cooperatively determining that most of these cases were the direct result of addiction issues in the family, the Bureau and the Department of Human Services jointly developed Project FAIR. The project brought together and cross-trained human services caseworkers, treatment therapists, and family court personnel to work together to identify addiction related abuse cases early, expedite providing treatment for these families, and demonstrating progress to the courts and consequently having less families broken up. As an integral part of the recovery process for these families they are also enrolled in a Strengthening Families program run by our community recovery support organizations.

We have also had a problem with street prostitution and our Drug Court Judge Leonia Lloyd reached out to us because she recognized that almost one hundred per cent of arrested street prostitutes were addicted. The Judge and Police and Sheriff's Departments were looking for alternative options to the cyclical patterns of arrest, bail and release that these cases typically followed. So we worked with the courts to develop a project called Fresh Start which gave addicted women arrested for prostitution treatment and recovery support services as an alternative to incarceration. It's been a phenomenal success.

Bill White: The focus of most treatment systems for years was on the mechanics of screening, admission, assessment, discharge and treatment in ever shorter periods of time and I'm sure that was the case in Detroit as well. But now it sounds like there is a much greater focus on what happens before treatment and what happens after treatment.

Dr. Trent: I think that's a crucial part of moving forward towards a more complete recovery-oriented system of care. Although we have recognized that the most effective way to address our community's issues with addiction is through a more comprehensive model of recovery, we have been having some success moving in that direction because we have great partners. We have a regional ATTC that has been a champion for Recovery Oriented Systems of Care and has brought the technical support so critical to this effort. We are in a State that has embraced this concept and has been a leader in providing mechanisms for funding recovery support services. We have a County Mental Health system that sees the benefits of Recovery Support and has provided the resources for us to aggressively reach out to the homeless with co-occurring disorders and encourage them to come into care. We have City law enforcement, court, and incarceration systems that are increasingly tiring of the cycle recidivism of addicts in their care and are seeking ways to break the cycles by investing in recovery support. But most importantly we have a treatment provider network who not only see themselves as providing treatment services, they're now seeing themselves as providing recovery management services with the recovery support services that this entails. Providers have shifted and have accepted the idea of recovery support as a legitimate service distinct from, but supportive of, the traditional bio psychosocial stabilization that treatment provides.

Bill White: Was that a difficult transition for many of your programs?

Dr. Trent: Yes, but it's been a 10-year transition. The first thing that we did for providers was how to encourage everybody to support alumni groups of their

clients. We said, “You have to provide a place for clients that you graduate to come back and still participate.” I think that was the beginning of them accepting a different kind of responsibility for the client, not just a responsibility for the treatment, but taking on the responsibility for support for the larger recovery process.

Peer-based Recovery Support Services

Bill White: You have invested considerable resources in the development of peer-based recovery support services. How have these services affected the treatment system?

Dr. Trent: I think the most significant change has been that peers working as recovery coaches and in other roles are now accepted as legitimate partners in the treatment and recovery management process. We have seen our providers and our health care system become increasingly convinced that there is a strong healing quality to the involvement of peers in recovery and their modeling of pro-social behaviors for the newcomers to the recovery process. Additionally, the recovery community and its welcoming of those seeking recovery provides an alternative culture to join and bond with in support of long-term success. In the past, we in the treatment system would provide opportunities for people in recovery to work in our agencies but not really as an integral part of the treatment process. Here in Detroit, and I think throughout the treatment community we now see that the successful formation of peer relationships is essential to the long-term success of our consumers and that the involvement of these peers and the community they represent in every facet of our service provision is key to our success. The treatment system is far stronger as a result of our inclusion of peer-led recovery support organizations as a critical component of long-term recovery management.

Relationship with Recovery Advocacy and Faith Organizations

Bill White: Could you describe the relationship you forged with the Detroit Recovery Project?

Dr. Trent: Well, that was an interesting situation. In fact, the Detroit Recovery Project grew out of a community coalition, the Partnership for a Drug Free Detroit. The Partnership is a community coalition that advocates for sensible policies

involving substance abuse prevention and treatment. The organization was founded by Alberta Tinsley-Talabi, a former County Commissioner, Detroit City Councilwoman, and current State Representative for Detroit. Representative Talabi and I served as co-chairs of the Partnership for the past 12 years. Many of the members of the Partnership were people in long-term recovery. These members were very active and dedicated and felt that, if organized properly; they could bring more people in recovery into active community work. So we formed a subcommittee, *The Recovery Committee*, led by Andre Johnson. Their membership grew quickly and just as quickly they became a voice for the recovery community as well as for individuals seeking treatment. This happened around 2000 about the time that Faces and Voices of Recovery was forming on the national level; and the groups collaborated. As a consequence of the activity of the Recovery Committee, the Partnership allocated \$100,000 of its limited prevention resources to support its work with recovery. And the next year; the Partnership applied for and were awarded the CSAT RCSP grant award for 3 years. After two years, we re-organized the recovery committee as a 501(c) 3 and it became independent of the Partnership. That was the beginning of the Detroit Recovery Project.

For me the Detroit Recovery Project is vindication of the confidence that our community has in the resilience and dedication of our survivors of addiction to promote the reality that people cannot only overcome but that they can lead our community to the self-reliance we all desire. So it was no surprise to me DRP quickly grew in scope and effectiveness. The organization brought new possibilities to our community. One of the first contracts they received was with the county jails to address the goal of reducing the recidivism cycle. The jails had a terrible time with individuals coming into the jail, leaving the jail 30-90 days later, only to come back again and again due to problems of addiction. The Detroit Recovery Project went into the jails to work with these individuals before they left county jail and to provide recovery support to them following their release from jail with great success. They have continued to expand their range of agency partnerships and the range of recovery support services they are offering to the Detroit community and they serve as a model for many.

Bill White: Have there also been opportunities to work with your faith communities to expand recovery support services?

Dr. Trent: We have been actively involved with and supported by our faith communities. Detroit is 85% African American and our community is very faithful to the faith community and the leadership that it has historically provided. Some of our most visible advocates for recovery come from our faith community. Rev. John Marks was a founding member of the Partnership for a Drug Free Detroit and is a

leader in developing prevention and treatment services in our churches and mosques. Imam Abdulla El Amin the leader of the Muslim Center in Detroit has been a consistent supporter of recovery in Detroit and internationally. And as Pastors in long-term recovery, Rev. Benjamin Jones, Director of NCADD and Pastor Christian Adams of Hartford Memorial Baptist Church reminds us on a daily basis that the spiritual dimension of recovery has to be included in our support services. Of course our faith-based treatment service providers have been a fundamental key to any success that we have experienced and Dr. Chad Audi and the Detroit Rescue Mission Ministries has not only been an innovator in the development and provision of recovery support services but has been a key collaborator bringing many more institutional players to our system of care. One of our most significant projects with the faith community has been with an organization called the Council of Baptist Pastors. This organization includes about 300 churches and they have provided leadership for an annual city-wide revival and conference focusing on substance abuse prevention, treatment and recovery. This activity happens the week preceding Easter and although there are educational activities the heart of the revival/conference is a focus on the mutuality of recovery and the celebration of rebirth and redemption associated with this period. This event has been very successful and has drawn the attention of many to our issue and has changed how many in the religious community view recovery and potential of people in recovery. No other institutional partner has been more important to our movement than the faith community.

We have a well-known R & B artist named Kem who is very popular here in Detroit. He was a homeless addict who found recovery through our faith-based treatment providers and has decided to give back by sponsoring a yearly benefit concert for people in recovery and the homeless with the proceeds going to local community-based service providers. That's the kind of visibility we have been able to bring to the recovery issue.

This past summer, Kem's concert and the recovery celebration event drew 30,000 people. The Bank of America and other major corporations were involved. The open air concert was held, right in the heart of the Cass corridor where many of Detroit's homeless addicts frequent. All of the benefit proceeds went to support the prevention, treatment and recovery support services in the community. And in the midst of all this we had city council members, community leaders and local ministers talking about how addiction had affected their families. We have more and more people going public with their recovery stories.

Recovery Management and Harm Reduction

Bill White: In many communities, there is great polarization between supporters of recovery and supporters of harm reduction. You have supported both and integrated these strategies. Has integrating harm reduction into your recovery management and ROSC services been an important part of what you've accomplished?

Dr. Trent: Oh yes. Somebody once told me, "We can't treat a dead person" and that not providing support for the health of persons not yet ready for treatment results in dead people. So we support keeping our potential consumers healthy and that means needle exchange as one strategy. We support it and our community supports it. I believe our aggressive outreach on the front end, our dedication to the idea that everybody who needs treatment, needs to get it the day that they reach out for it. That is harm reduction, but it is also part of our approach to creating a recovery-oriented system of care. When you're recovery-oriented, you believe that recovery is real and recovery is possible. And so you can't ethically sit back and wait for the person to hit rock bottom and then make a decision for treatment. We have aggressive outreach in every area of the community, letting addicts know that help is available and welcoming. We are, in cooperation with peers in recovery taking the recovery message and health related prevention services to the most drug-infested areas of our city. As long as an addict is living recovery is possible.

Bill White: From our past conversations, I have the impression that you've also tried to increase the recovery orientation of your methadone programs. .

Dr. Trent: We have. First, we accept the idea that people on methadone are in recovery and they need to be afforded the same recovery support services we provide people in other treatment modalities. One of the important principles of recovery is that there are many pathways to it and that people deserve support on the path they have chosen. The rejection of some in the recovery community of people who find recovery through methadone is something that we discourage in our system and attitudes are changing for the good. Many of our methadone patients have some stability in their lives and need different types of recovery support services however, many in the early days of methadone treatment are homeless and so we are able to provide them with recovery support that includes housing. The housing programs were reluctant at first to accept consumers on methadone because they thought that they would somehow undermine the recovery of those in recovery without pharmaceuticals. Reluctantly at first, the methadone consumers were accepted with no negative impact on other consumers and now it is normal procedure.

The Role of Outreach Services

Bill White: You've mentioned the importance of outreach services. Could you describe in more detail the Helping Hands Project to reach the homeless with addiction-related problems?

Dr. Trent: Bill, there is such a unique relationship between our community mental health agency and our addiction agency. It started when we had the Super bowl in Detroit and the community and organizers had to face the question, "What are we going to do about the homeless people when the Super bowl comes to downtown Detroit?" Now this was not unique to Detroit. Whenever the Super bowl or NCAA finals come to a city, it seems there is always that conversation. We were fortunate to be asked to head a subcommittee and work with local law enforcement and the NFL committee around providing the opportunity for the homeless in Detroit to participate in the Super bowl activities. We worked with the shelters, faith-based providers and treatment providers to make sure that there would be extended hours of service and that the consumers would be able to have places where they could not only see the game but receive outreach services and opportunities for treatment.

This was new. Usually people go into the shelters at 6:00 o'clock in the evening and they are put out 6:00 in the morning—regardless of their circumstances. We decided to have the shelter open all day and provided services all day. It turned out to be such a good experience that everybody, particularly the sheriff and the police department, were interested in continuing this broader array of services. The shelters and particularly the Detroit Rescue Mission Ministries, created a program with Mitch Albom (our local sports columnist and philanthropist) called, "SAY," Services All Year. So, let's just don't do this for Super bowl. If we can do it for Super bowl, we can do it every day.

And so, out of that, Wayne County Community Mental Health Agency allocated funding for a joint outreach project with the Bureau of Substance Abuse where vehicles canvass the downtown area responding to businesses, responding to individual problems and going out and reaching out to people who are homeless in the community; most of those individuals also have problems with mental illness and/or addiction.

We hired people who were formerly homeless and people who were in long-term recovery. This project has been running three years now and it's funded again for the next year. It does a phenomenal job. Even the hospitals call *Helping Hands* now to help persons they are discharging from the ER. *Helping Hands* also serves the jails. If a person is leaving the jail and they don't have a place to go, they can call *Helping Hands*. We'll pick the person up and we'll take them and get

them in a shelter. *Helping Hands* exemplifies the kind of partnerships that are crucial to recovery management and ROSC.

Community Recovery

Bill White: I've talked a great deal recently about the idea of community recovery—the idea that whole communities have been wounded by addiction and that the whole community may need a recovery process. Is that what is happening in Detroit?

Dr. Trent: Well, I do think that a process of community recovery or rebuilding is sorely needed in my community and that the example presented by the recovery community has the potential to be the model. As we in the broader community see the success of the recovery movement we see that a major part of what's making a difference is the whole set of relationships and shared values that is growing outward from the recovery community. These values of having a spiritual life, of having a welcoming attitude toward others, of striving to be self-improving and of being committed to giving back are things that are opposite to the addict attitude and culture they live in. Yes, in a community wounded by addiction we have adopted many of the misguided life styles of the addict, selfishness, exploitation, fear, distrust and we need recovery.

We have something in Detroit we call neighborhood development that we use to try to revitalize neighborhoods and that means refurbishing that physical community. But you have to revitalize people, because a neighborhood is not just about policing and renovating physical structures. You have to renovate the connections between people who live in that neighborhood. A community really is about the interaction of the people in that community and the way that urban communities and rural communities affected by addictions have dissolved is that there's a loss of positive interaction between people. I often talk about my grandparents coming to Detroit at the turn of the century when Henry Ford created many jobs. A lot of black people were leaving the south and coming up north. When my grandparents arrived, they got 12 people together and they formed a little church. Everybody in that community started coming to that church and the community associated at the church and got to know each other and began to work together. There was a powerful sense of community—even in the poorest of neighborhoods.

It was the kind that if you did something, your parents would know about it before you got home. I think in some ways the mission of this ROSC movement, and I'm not talking only for people in recovery, is to recreate that kind of community. To the recovery community, I say, "We need you to help us learn

how to have community again”. We all watch Andre and the young men and women in recovery. They call each other. They lean on each other. They give back. We as a society need to learn some lessons from them.

International Work

Bill White: You’ve been asked by the Great Lakes Addiction Technology Transfer Center to assist the Republic of Tanzania in the development of recovery support services. Could you describe that experience for us?

Dr. Trent: Well, it’s been a very interesting and exciting experience. Because of the work that Dr. Nathan Linsk, of University of Illinois at Chicago was doing in East Africa, an opportunity was presented to Lonnetta Albright, Executive Director of Great Lakes ATTC to form a team to assist with a substance abuse intervention in Tanzania. She then asked us to be involved and we jumped at the chance. We were commissioned originally to go to Zanzibar, which is a part of Tanzania and work with them to help reduce drug-related HIV/AIDS. We did an assessment of what was going on and the first thing we discovered was that there was no addiction treatment available in Tanzania, in fact there was only one treatment center in all of East Africa and it was in the neighboring country of Kenya.

There is a growing drug problem in East Africa since it is becoming a major transit point between the heroin growers in the Middle East and the markets in Europe and America. With the increased availability come more use and injecting drug use is a significant problem, especially among the youth. Faced with the reality that treatment was not an option it was decided that they would attempt to replicate and adapt what we had done in Detroit around recovery support in Zanzibar. We formed a Recovery Committee of some people that were in recovery and we supported them in locating others. They were able to then recruit about 30 individuals who they knew in recovery. We trained them on how to do 12-step work, how to conduct an NA meeting and they were astounded to see people in recovery 10 years. The only dollars we had to work with was the funding for us to travel there, so we created a drop-in center that was run by people in recovery. When we returned the second time, we found that a lot of people were coming to the center.

Now, I should explain that addiction is relatively new in this culture. They haven’t had as much of a history as we have with heroin and injection drug use. It’s affected a lot of young people and their families, and everybody is very confused about how to best deal with it.

When we came back, we found that people were coming but that they needed more than the drop-in center. They asked us if we could help them create a sober house where people could stay during their early recovery. So 4 of us who were there consulting each contributed \$200 and they went out and bought a few mattresses and rented a house. You can do things with a lot less money there. And so they created this recovery house. Since that time the one Sober House has increased to ten and there is also a Sober House for women. These recovery houses are totally peer-led and peer-owned. They are self-supporting. Hundreds of men and women have been cared for by the Sober Houses. Now, the mainland government has decided to support this project, too. And the project is actually called, Recovery-Oriented System of Care.

And so recovery-oriented care has started in Tanzania. It is people in recovery helping each other. Now the government wants to get in on the deal and help provide resources. You know, Zanzibar is primarily Muslim, and I met with the one of the Muslim leaders who told me the story of his cousin who had died from addiction and how the religious community and the government is now mounting a response to addiction. They are looking to establish sober houses in every community in the mainland. It is all being created within their culture. Those of us from the U.S. are standing on the sidelines helping out, but they created their own NGO 501(c) 3 to launch a recovery project that they call, “Drug-Free Zanzibar.” I’ve been thinking it would be a great diplomatic move for the U.S. to offer greater assistance in organizing recovery projects to more countries because so many of these countries see us as not friendly to them. We could offer a helping hand to address addiction that would, like in Tanzania, be seen as very helpful and deeply appreciated.

Personal Reflections and Legacy

Bill White: Dr. Trent, when you look back over these 10 years of work applying principles of RM and ROSC, what are you most proud of?

Dr. Trent: Well, for me it’s personal. I had an aunt who was an addict. She never found recovery. She lived a very confusing, painful life and she died in her addiction. What has meant the most to me is seeing men and women like my aunt find recovery and to see their families come back together. When I walk in the grocery store, people come up to me and tell me their story or the story of their family member and they thank me for helping make that possible. I’m really grateful that people are being helped and that we are discovering something in this recovery experience that can help us all—not just people in addiction.

Bill White: Dr. Trent, thank you for your willingness to do this interview and for all you have done for people in recovery in the city of Detroit and beyond.