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ROSC in Western Michigan: An Interview with Mark Witte and Kevin McLaughlin

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Introduction



Interest in recovery management (RM) and recovery-oriented systems of care (ROSC) is increasing within behavioral health care systems throughout the United States and in other

countries. Much of the early publications on RM and ROSC focused on the RM/ROSC systems transformation efforts in Connecticut and Philadelphia that began more than a decade ago. While these early initiatives have been well documented, many questions remain about how such systems transformation efforts are unfolding in other states and local communities. The Great Lakes Addiction Technology Transfer Center and other ATTCs have been both supporting these efforts and trying to extract



lessons from them that will be of value to other communities. The following interview, conducted in June of 2014 with Mark Witte and Kevin McLaughlin, is part of a series of three interviews exploring the ROSC work in Michigan, with a particular focus on the work that has been underway in Western Michigan.

ROSC in Western Michigan

Bill White: Mark and Kevin, could you each introduce yourself to our readers?

Kevin McLaughlin: I am the Executive Director of Recovery Allies of West Michigan. We are a recovery community organization that serves the West Michigan area. I'm also a CCAR Recovery Coach Trainer and have conducted fifteen such trainings.

Mark Witte: I work for Network 180 as the Planning Director for the Substance Use Disorder division. I've been here for about ten years. Before that, I spent about nineteen years in child welfare, working in various clinical and administrative capacities

in an agency that served children and families. Network 180 is an integrated mental health and substance abuse services agency. A lot of our work has been focused on developing capacity to serve individuals with co-occurring disorders. I am presently involved with the process of transitioning our system to a regional entity that will manage public mental health and substance abuse services for a seven-county region. I also serve as Vice President of our statewide association for substance use coordinating agencies and, in that role, do a fair amount of coordination and advocacy work across the state.

Bill White: Tell me from both of your perspectives how the ROSC efforts began in Western Michigan?

Mark Witte: At Network 180, we had started to hear about the movement to increase the recovery orientation of addiction treatment in the U.S. in the early 2000s. We had begun developing long-term case management services in 2005 and, as we got into that experience, it became clear to us that we needed to bring our community and our county service providers together to talk about the barriers people were experiencing in their efforts to achieve long-term recovery. So we held a summit in March of 2009 and invited service consumers and service providers to talk about this long-term recovery perspective and what it meant to them. It was a wonderful sharing and listening exercise. Our state staff were in attendance and they then launched a series of such summits throughout the state that they referred to as ROSC Symposia. That process launched our ROSC work in West Michigan. We just recently had a second local ROSC symposia to evaluate our progress to date.

Kevin McLaughlin: The roots of our ROSC efforts can also be traced to the development of recovery community organizations in Michigan, beginning with Project Vox in Flint under the leadership of Tom McHale. Our efforts in West Michigan began four or five years ago. We started with

five or six people being present at a table every first Tuesday of the month hoping to attract people and to really get things going. At the same time, the CCAR Recovery Coach Training was brought to Michigan. Then an individual who attended the first CCAR training that I conducted who was a twenty-two-year die-hard A.A. pound-the-table guy went back to the recovery community and said, "Boy, this recovery coaching's where it's at." One of the key characteristics of West Michigan is that we have an incredibly strong recovery community. We suddenly got the buy-in of a huge portion of that community, which was very momentous and spurred our subsequent ROSC work.

Bill White: Were there other outside influences on your early commitment to ROSC as an organizing model?

Mark Witte: Eyes were opened in our community by witnessing changes that have occurred elsewhere. I spent some time visiting with Andre Johnson at the Detroit Recovery Project as we began our early forays into recovery supports. Andre's operations at the Detroit Recovery Project were very inspiring to me, and I appreciated his hospitality in showing me the kind of energy and excitement that could be elicited by this increased recovery orientation. That was very instrumental for me in opening my eyes to the possibilities for the future.

Kevin McLaughlin: In addition to Tom McHale's influence, there were others pursuing this work, such as Jane Pressly in Greenville, South Carolina. She helped me understand that an RCO's initial mandates are: be visible, be visible, be visible. CCAR influenced us a great deal, as did our subsequent involvement in the Association of Recovery Community Organizations (ARCO). And I would be remiss if I did not mention your presentation at the statewide addictions conference here in Michigan in 2005. For many of us, that was the detonation point for ROSC in Michigan.

ROSC Planning Process

Bill White: When you first began to come together, was there a structure that you used for ROSC planning that brought together professionals and recovery advocates?

Mark Witte: Network 180 used a clinical work group consultation model in which Network180 served as the planning body and brought together those from whom we purchase services and other stakeholders. It's been sort of an organic process in which we just simply emphasized the role of partnership across the spectrum in helping develop services that responded to service recipient needs and addressed systems issues that inadvertently created obstacles to long-term recovery. We started with clinicians and case managers and added recovery coaches to that model very early. Then we added ROSC-oriented training for everyone.

Bill White: And was this set up kind of as a city, county, or regional initiative?

Mark Witte: This was and is a county-wide initiative. The county is structured such that Grand Rapids, which is the metropolitan center of the county, has about 250,000 of a total county population of 600,000 residents. The area is fairly urbanized, but there is also a lot of rural area as well, with most of our providers located within Grand Rapids.

Bill White: Who've been the major partners involved in the ROSC planning process?

Mark Witte: The four primary service agencies we selected to provide recovery management services were Pine Rest Christian Mental Health Services, Arbor Circle Corporation, Family Outreach Center, and an agency now called Cherry Street Health Services that was earlier known as Project Rehab.

Bill White: And Kevin, from your vantage point, what organizations in addition to Recovery Allies of West Michigan were part of this?

Kevin McLaughlin: I think a major reason we are experiencing such incredible momentum right now is that the organizations Mark noted have staff members who are very, very dedicated and willing to say that they are in recovery and that they support the idea of a peer-run organization. Having those individuals who shared the vision and understood the concepts was a great help to our efforts. We have tried to adhere to what you have written about the importance of authentic recovery representation. This became an opportunity for our whole community to come together.

ROSC and Community Awakening

Bill White: Since beginning this process in 2009, how has this ROSC initiative changed frontline service practices?

Mark Witte: We started by reemphasizing that the people who come to our door for services are at different stages and have different needs. There's an old social work adage about starting where your client is, but programs oftentimes didn't do that. Clients were too often forced to start where the program was. We helped establish an expectation that you really must start where your client is and support them to achieve recovery even when that may be a very long journey for some. There was also a move in our addiction services to understand the brain chemistry underlying addiction and the potential role of medications as a recovery support. We moved the care of addiction much closer to how other medical disorders are treated—things like the emphasis on screening and early intervention and providing ongoing care following the acute phase of illness. We broadened the focus from how to get into recovery to how to sustain and live a life in long-term recovery and on supporting the person through this process. I think this is starting to gel and that our field is becoming much more responsive to people's needs.

Bill White: Kevin, how has the ROSC initiative affected the recovery community

and its perception of treatment and recovery support services?

Kevin McLaughlin: One of the things that makes Grand Rapids unique is that we have a lot of clinicians and program directors who are involved personally in Twelve-Step programs. Because of their influence, people here are more likely to say “Sometimes, medication is necessary,” where in other places you’ll hear, “If there was a pill that’d cure alcoholism, I’d never take it.” You have this very forward-thinking recovery community as a result of the influence of professionals in recovery. The same is true for recovery support services. In Kent County, organizations were approached about their willingness to hire a recovery coach, and almost all responded in the affirmative. So we trained recovery coaches and did all kinds of training to facilitate integration of this new role into service organizations and to make sure the recovery community understood this role. And, what’s really neat is that the organizations involved use the coaches in different ways so that there wasn’t just a cookie cutter approach to recovery support services. Some used them for outreach and engagement, some used them to serve people on the waiting list, and some used them for long-term follow-up.

Bill White: One of the tenets of ROSC is respect for diverse pathways of recovery. Have you seen an increase in such respect in your area as a result of your efforts?

Kevin McLaughlin: It’s an interesting evolution. My partner, Clyde Sims, and I have trained about 250 individuals in the CCAR model of recovery coaching. Many of those individuals never intended to be coaches but were there to learn. Most were members of the Twelve-Step community, and they take that information back. Part of what they have taken back is this theme of respect for diverse recovery pathways. We started holding the trainings at one of the Alano Clubs in the community. So, here were all the trainers and trainees, Monday through Friday, coming upstairs in the cafeteria for lunch and mingling with the

people who were there. This idea of multiple pathways of recovery was difficult at first, but people are embracing it. The Alano Club actually changed their bylaws and is now allowing SMART Recovery in the building. They have adopted your quote, “There are many pathways to recovery and ALL are cause for celebration.”

Bill White: That’s remarkable.

Mark Witte: It really is something. Back in 2006, we launched “RecoveryPalooza” as an annual recovery celebration and recovery advocacy event. This year will be our ninth version of it, and it was always timed to coincide with the National Recovery Month. It’s an all-day celebration in September with food, music, and lots of information. This year, the Detroit area Recovery Walk and Rally is relocating its event to Grand Rapids in conjunction with RecoveryPalooza, and for the first time, the event will be in the downtown location on the banks of the Grand River, right in full view of the city proper and in front of the resting place of Gerald and Betty Ford. That event has become a true celebration of the growth and diversity of people in recovery.

Kevin McLaughlin: It’s a huge event. The park that we’re holding it in is named Ah-Nab-Awen Park, and the Native American community will be doing smudgings and participating at a greater level than they’ve ever done before. Typically, we have between eight hundred and thirteen hundred people come to this event. It has been strictly celebratory, but with the state-wide Celebrate Recovery Rally and Walk, we’re going to do more advocacy. And, of course, there’s the great food. My greatest catering feat ever was to serve thirteen hundred people fresh chicken on beds of lettuce, Caesar salads with mixed greens, and pasta salads. No soda and hotdogs. It was fabulous.

Mark Witte: I should say, too, Bill, that the Ah-Nab-Awen Park is a sacred space. There are three Indian tribes in our region and back in the lumber baron era, the gravesites of the

Native American community were scraped for fill dirt. In 1979, the three tribes came together in what they refer to as the “Three Fires Pow-Wow” and named this park Ah-Nab-Awen, which means “Resting Place.” It has since become an important community gathering spot and a most fitting site for our recovery celebration events, especially so because of Betty Ford’s legacy.

Peer Recovery Support Services

Bill White: Could you elaborate on the role of peer recovery support services in your ROSC initiative and the variety of ways peers are being used?

Mark Witte: We started out having recovery coaches joined with masters’ level clinicians in serving people in case management-type services. Since that time, as more people have become trained, we’ve progressed more in our thinking about where peer support can be best used. Now, trained recovery coaches serve as treatment support staff in residential treatment programs. We have a number of recovery residences that operate according to the National Association of Recovery Residence Standards, and we offer training of their house managers so they can be recovery coaches. We have recovery coaches in our Access Center where people can first come when seeking help. We have peer coaches deployed in the Methadone Program to enhance recovery support within medication-assisted treatment, and we are in the frontier right now of making recovery coaching an optional adjunct to our outpatient programs. And then in the frontier, we’ve also got a very close relationship with our drug court locally, and I want to talk with them about deploying a recovery coach within their setting with our funding support.

Resistance to ROSC

Bill White: When you went through the early implementation stages of your ROSC efforts, how would you describe the major sources of resistance you encountered?

Mark Witte: In our community, we’ve been very blessed by the fact that there have been so many providers of different levels of service, including many residential treatment providers. The difficulty with that is like they say, “If your only solution is a hammer, then every problem is a nail.” We were probably over-utilizing residential treatment at the very beginning. I remember sitting with one of our recovery housing operators who has now passed who invited me to participate in a session that he held at a local residential treatment program. He asked people to raise their hand about how many times they’d been in treatment. So he’d say, “How many have been here before? How many people have been here five times before? How many people ten times before?” He kept going. There was one guy in the room who had been in treatment twenty-three times. My question was, what do you expect to get out of treatment the twenty-third time that you didn’t already get in the previous 22 episodes?

It dawned on us that what most people need is crisis intervention services and then more intense and sustained support in the community. We shifted some of the resources that we were spending in residential treatment to community-based care—recovery management services, recovery coaching supports, helping people sustain recovery in the communities where the challenge really hits. That is the philosophy now. There was some resistance among residential programs who feared the loss of funding and potential closing of their units. And we did lose some and shortened the length of stay significantly for others, which had the benefit of reducing waiting lists. People who have never been in treatment before can get a full course of care, while others get quick re-stabilization and more long-term support in the community. The resistance came in the unknowns as we moved through this transition.

Bill White: Kevin, was there concern about the effects of ROSC and peer support services on the recovery community?

Kevin McLaughlin: There certainly was, but not nearly as much as has been the case in other communities I am aware of. We have a fortunate situation here in that key recovery leaders recognized early on the potential of this shift and became some of its strongest advocates. When people have a paradigm shift and they have a transformation and approach, they are excited and they share it. That's what happened here, and that's what happened to me. I decided to become a recovery coach, and I didn't know how to do it. I went to recovery coach training in Iowa and listened to your 2009 ROSC symposium in Atlanta five times. As a result of becoming a trainer, we were offered contracts to go to northern Michigan and then to southern Michigan. All this happened very quickly in the first year. Most of the early resistance we encountered came from administrators and clinicians rather than the recovery community. I called you one time about this and your message to me was the importance of collaboration. So, I focused on the idea that getting everybody to think along the same lines could turbo-charge a person's recovery by helping the person become engaged in treatment. Suddenly, the clinicians love us, and you know the rest of the story.

Mark Witte: Bill, another element for us was that we came to see the community rather than ourselves as the center of the universe and that our role was to supplement the natural support of the community. And we saw prevention and recovery support as linked services in that process. Our contract with Kevin in the community is much like our contract for the prevention coordinator in the community. The center of the recovery universe is not in our organization, it is in the community. That's really key. We conceptualize all of these activities as a giant circle, moving from primary prevention to screening and early intervention, followed by acute and ongoing treatment efforts and finally by recovery supports and community advocacy. It turns out that the community we want for people in recovery is exactly the same as the community we seek to promote

in prevention. Prevention and recovery support touch at ends of the circle.

Major Achievements to Date

Bill White: What would you define as your major achievements to date through the ROSC initiative?

Mark Witte: I think the engagement with the recovery community, the ongoing partnership with the treatment providers, the effectiveness of our prevention services, and the breadth of partners we have in the community on the prevention side would be high on that list.

Kevin McLaughlin: Today, the recovery community believes it has a voice and is heard. We bring the recovery coaches together every month from all over the state, and this provides a crucial forum for collective reflection and input into policy forums.

Financing

Bill White: Were additional financial resources required to support the ROSC initiative?

Mark Witte: The largest part of the funding came from the reallocation of funds that would have otherwise gone into the extended residential stays. Ninety-day stays became a thing of the past, and we focused more on two- to four-week stabilization episodes and then the differences were spent on recovery support services. I think we've also looked for federal grants to help support some of the work that we've done. I'll also give credit to my organization, which serves as both the mental health and addiction services authority. The addiction treatment system had long been underfunded here compared to our mental health services, so our leaders committed excess revenue to enhancing the addiction treatment service system. There's been a gradual effort to increase resources to help support the recovery community efforts.

Bill White: You know, one of the things that some of our early pilots discovered was when you saturate these recovery support services, you can slow if not stop the revolving door of addiction treatment. Did you experience cost-savings from that process?

Mark Witte: Absolutely. It's more economical and more effective in terms of long-term recovery outcomes. People certainly need to be safe, and we certainly need to have options for when they're in crisis, but you initiate recovery in such programs but must learn to maintain recovery in the community. So we've said, "We really need to be out in the community where people must learn to live in recovery."

Bill White: And Kevin, from the recovery community perspective, do you have a sense that some people who were once castigated with labels such as "frequent flyers" and "retreads" are now actually achieving stable long-term recovery?

Kevin McLaughlin: Yes, absolutely. We are recognizing that maintaining recovery is a quite different process than initiating recovery. Maintaining recovery has been the missing piece.

Future Directions

Bill White: What do you see as the future directions for ROSC in Western Michigan?

Mark Witte: Well, there's a trend nationally and in our community to increase the integration of not just mental health and substance abuse services, but also behavioral health care with physical health care. I think we conceptually understand the relationship between how excess healthcare dollars are spent on people whose needs really come from their behavioral health challenges. The difficulty we're having is that the behavioral health world is being asked more than the physical health world to fund this integration. One of the frontiers is figuring out how to integrate what we do in an optimal way with the healthcare industry.

The other thing we are on the frontier of is an era in which medication and physician services are going to need to be more closely connected. I'm not talking about the traditional medical services; I'm talking about the use of addictionologists and the addiction psychiatrists in addiction treatment services, which will have an attached cost. I'm concerned about making sure that we're able to provide the best possible care we can and yet not do it by having to cut the number of people we serve in half. When we talk about the future, I envision new structures, new resources, and frankly, new systems of care.

Lessons Learned

Bill White: What lessons have you learned or suggestions would you make to other communities who are considering embarking on an ROSC transformation process?

Mark Witte: Nothing can be done without a solid partnership with the recovery community. That's probably the most important benefit and blessing that we've had—this tight partnership with the recovery community.

Kevin McLaughlin: Absolutely. And nothing can be done without the support of the treatment community. I think two things have to happen initially. First is mobilization of the recovery community, even if initially that is no more than a recovery community organization starting with five or six people sitting around a table. The second thing is educating clinicians on the difference between recovery initiation and recovery maintenance and their role in both.

Mark Witte: I don't know if it's possible to recommend an approach, but I'm so thankful that we built our initial efforts with the recovery community by celebrating the reality of recovering people's lives. That gratitude for that gift to our community has been at the center of what we are doing here.

Personal Reflections

Bill White: Let me ask both of you a final question: What has your involvement in this ROSC initiative meant to you personally or professionally?

Mark Witte: Bill, I'm a guy who grew up in the country only interested in working with people and that's about as refined as it got when I left my hometown to go to college. All along the way, I feel like I've been guided to opportunities that have brought meaning to my personal life as well as opportunities to be of use to others. I'm a person of faith who pretty much gives credit for what I've done to a divine presence guiding my life to get me where I am. And I feel a certain obligation to continue to follow that guiding force so that I can continue to be of use to people. I've not been personally affected by addiction and no one in my immediate family has been affected by addiction, but there have been very close friends of mine who've lost kids, and there are so many out there whose struggles with addiction continue. It has been meaningful to me to be of some value in helping to support a system that meets the needs of people so affected. I feel like I've done a good thing. So, on a personal level, it's very, very satisfying to be a part of a system that has exerted such a dramatic influence on helping people live healthier lives. I feel like I'm doing what I should be doing and am being faithful to the gifts I've been given.

Kevin McLaughlin: I get to do a lot of neat stuff without having had to go to twelve years

of school to get a masters or a doctorate, and that is a dream come true. You party like a rock star for a long time and you surface and you know you have some talents, you know you have some gifts and some things to offer. You know that making sense of your suffering is part of your recovery and suddenly, you find yourself trusted with a whole lot of responsibility and, today, because of recovery, I believe I'm worthy of that responsibility. I absolutely love the opportunity to do what I am doing today to give back to others. And I regularly think about a quote from one of Tom Hill's papers on servant leadership: "If we allow ourselves to sustain a large enough and bold enough vision, the recovery community can radically alter the social order of society." That's an incredible vision.

Bill White: Mark and Kevin, thank you for a most interesting discussion of the story of ROSC in Western Michigan.

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