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# Innovations in Recovery Management in Hancock County, Ohio: An Interview with Precia Stuby

William L. White

## Introduction

Efforts to extend acute care models of intervention for substance use and mental health disorders to models of sustained recovery management (RM) and recovery-oriented systems of care (ROSC) are continuing throughout the U.S. and in other countries. One of the bright spots of such innovation is in Hancock County, Ohio. I recently (May 2015) had the opportunity to interview Precia Stuby, Executive Director of Hancock County Board of Alcohol, Drug Addiction, and Mental Health Services (ADAMHS), about the history their RM and ROSC efforts. Please join us in this discussion.

## Background

**Bill White:** Precia, perhaps we could start by having you describe your background before coming to the Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) Board.

**Precia Stuby:** I'm a masters' level trained social worker from Ohio State University where I received my associates, bachelors, and a masters' degree, the latter with a concentration in planning and administration. Prior to coming to the Board, I spent five years doing hospital social work in such areas as pediatrics, obstetrics, and neurology. From there, I worked in child welfare for two years before moving to the Board.

**Bill White:** How did the opportunity to come to work for the Board occur?

**Precia Stuby:** I was finding work in child welfare very frustrating. At about that same time, Ohio had just passed the Mental Health Act and local boards in Ohio were expanding to hire people to do planning and evaluation. A psychologist I knew said to me, "I think you would be really ideal for this position." I ended up submitting my resume and was hired by Phyllis Putnam, the person who was then the director.

**Bill White:** How would you describe Hancock County, Ohio?

**Precia Stuby:** People like to describe Hancock County as a micropolitan area. We are in Northwest Ohio. We have a population of about 75,000. The county seat is Findlay, Ohio, which was founded during the gas boom. We are home of the worldwide headquarters of Marathon Petroleum. There are several corporate headquarters located in our area. So there's this mix of a business community and a local university nested within a large rural farming community. As a result, we have tremendous resources that we can tap from diverse aspects of the community.

## The ADAMHS Board

**Bill White:** Tell me a about the history and primary functions of the Hancock County ADAMHS Board.

**Precia Stuby:** The ADAMHS Boards were established by state statute in 1968. Every county in the state of Ohio is represented by an ADAMHS Board. Some boards represent more than one county. We only serve Hancock County. By statute, we are charged with the responsibility of serving as the safety net for mental health and substance abuse services. We have the responsibility for planning, funding, and evaluating a continuum of care in relationship to mental health and substance abuse services. Any public funds that are earmarked for mental health or substance abuse, whether it comes from federal block grant funds or comes from the state revenue budget, flow through these local boards, who then decide where the funds should be invested in the community. In addition to those public funds, we also have a local property tax levy, as many boards do in the state of Ohio. We also leverage funds from private sources and grants. We are similar to a United Way in that money flows through our office and contracts are put in place to meet local needs, but no direct services are provided. I started here in 1990 and became the Director in 1997.

**The Hancock County ROSC Initiative**

**Bill White:** How did the ROSC Initiative begin in Hancock County?

**Precia Stuby:** As I mentioned, we have a property tax levy and it's on the ballot about every five years. In 2007, we made a conscious decision to increase the millage of our levy and in doing so we met with stakeholders all across the community. They prioritized the development of a residential treatment facility to serve individuals struggling with substance use disorders. That levy passed, which was really unusual. When a new or increased levy is proposed in the state of Ohio, you have less than a 20% chance of it passing. So this was quite a milestone for us. The earmarked money began to flow in January of 2008, but then in July of 2008, when the economy started to go south, there were huge cuts made--about 1.2 million dollars in local service dollars. Instead of building new services, we made the decision to backfill the existing service. At the same time, the opiate epidemic hit our county, and the demand for residential treatment services grew. I kept writing grants to anywhere I could to try and backfill the loss of funds and to fund the development of a residential treatment facility.

We ended up getting a large prevention grant, and I used some of the money to go to the National Addictions Conference. While there, I tried to identify residential treatment programs across the country that I thought would be really good for us to model. I ended up contacting someone in Minnesota and asking them for help and the gentleman suggested, "I think what you really should do is work with the Addiction Technology Transfer Center." I had heard of them but I had never worked with Addiction Technology Transfer Center (ATTC). I contacted Lonnetta Albright at the Great Lakes ATTC and I explained what I was trying to do. She helped locate a consultant, Dr. Michael Flaherty, who agreed to help us. He said he would only do it on the condition that any program development is done within the context of ROSC. That was the first time I really ever heard of the concept of ROSC. He explained that we would not be successful if we did not nest our proposed residential program within a larger ROSC model. So, our Board agreed to hire him. I went to the Technical Assistance Training offered by the ATTC with Dr. Ijeoma Achara to develop a framework for ROSC. We ended up with this perfect storm.

The opiate epidemic helped to increase the sense of urgency and put a less anonymous face to the issue of addiction. Medicaid expansion passed in Ohio and that allowed us to shift some of our resources that we were paying for primary treatment into recovery support, and then we had access to people like Dr. Flaherty at the right time. We were also able to capitalize on grant funding and mobilization that had already occurred in our community around the opiate task force.

**The ROSC Development Process**

**Bill White:** Could you talk about constituency involvement in the actual development of your ROSC concept?

**Precia Stuby:** I certainly can. It was built into our process from day one; all we've done has flowed from constituency involvement. We're governed by an eighteen-member volunteer board and have always had multiple local committees. It was intuitive for us to expand such involvement through our ROSC planning. At Dr. Flaherty's recommendation, we started with the development of a preamble for our ROSC initiative. We then mobilized what we called the ten P's (policymakers, providers, payers, purchasers, philanthropy, professors, pastors, patients and families, police, and press) to participate. They helped us design the preamble and from that, we sponsored a community wide ROSC kick-off in September 2013 which was facilitated by Lonnetta and Dr. Flaherty. We had about 70 people who participated in that event. From there, we established a ROSC Leadership Committee made up of different segments of the community to oversee the implementation of the entire ROSC initiative.

**Bill White:** Could you elaborate on the role of the preamble?

**Precia Stuby:** The intent was that we would have a document that would guide all of our work. We wanted to make sure we had such a preamble to make sure that everything we did was consistent with our philosophy. We started with the 2012 SAMHSA definition of recovery as the process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their potential is delineated over four major dimensions: health, home, purpose, and community. We went on to define our ROSC vision: Our community, defined as providers, leaders, and citizens, will use our shared resources to assure that all those who need them will be provided with opportunities for wellness and recovery when and where they need them and that the ADAMHS Board is the coordinator of those shared resources.

**Bill White:** How were peer-based service developed as part of this process?

**Precia Stuby:** Peer services increased and are still growing. I should mention that peer services are not reimbursed in Ohio under our Medicaid program. We initiated peer support services in our community in early 2000 and have had peer support in our housing program and in our adult mental health and substance use treatment programs for years. As we have gotten deeper into ROSC, we've expanded peer services exponentially. We hosted a local peer support summit. Dr. Flaherty helped us get in contact with Bev Haberle, who had championed peer services in Philadelphia, and she led the summit for us. About seventy people attended, and it really helped to energize individuals in the recovery community to want to become more involved.

We have been able to take advantage of various grants to add peer services. For example, when we got a criminal justice grant, we added peer support into our work with the Justice Center. We are adding people in peer support roles to serve as house parents in our recovery housing. We are transforming our current drop-in center into a recovery support center with expanded peer services.

One of the things that we really have worked on is creating opportunities for peers to become involved as non-paid volunteers. We came up with the idea of doing a recovery guide program. Most people understand what a hospice volunteer is: it's generally somebody who's been through a family hospice experience who supports other families going through such an experience. They might just relieve them so somebody can go shopping; they might just play cards. They do whatever they can to provide help and assist during someone's hospice experience. They aren't a primary treatment provider; they don't replace anything; they're additive. We came up with that same kind of concept for recovery guides. We hired a consultant to help us develop a curriculum. We've actually had our first class and have graduated six recovery guides who we are matching with people in our residential treatment facility and in our recovery housing. Everyone deserves to have somebody in their lives for support that is not paid to be there. We see our recovery guide program as an opportunity to do that. I know there are some systems that are really trying to find a way for all of the peer services to be reimbursed. We're more looking at it like a career ladder where we can have an opportunity for recovery guides who are not paid to participate in recovery for others and then if they really like that, they might want to go on to become a paid peer support person and from there, might be interested in moving on into other areas into the field.

**Bill White:** Have peer recovery support roles been well-accepted in both the professional and lay communities in your area?

**Precia Stuby:** Early on, it was very difficult and I'm certainly glad that we had had years of experience with paid peer support before we did this. The typical things that we heard were concerns that we were going to replace primary treatment and questions about how the guide role was different from the roles of a case manager or therapist. We went through a lot of those hurdles. When our adult agency first started hiring peers, we did not take a step back and really look at how the infrastructure needed to change to make sure we had adequate supervision, adequate policies and procedures, and adequate discussions with other members of the agency about boundaries and roles and responsibilities. Our past years of going through all of those challenges helped prepare us for a better process of implementing the use of volunteer recovery guides.

**Bill White:** And I'm assuming from what you're saying that this is something you'd recommend other communities do as a foundation for peer support services.

**Precia Stuby:** Absolutely. There is a lot of that work has been done on this in other communities. I would really encourage people to take advantage of that work. I think the most significant pieces are providing adequate supervision and having a champion within the agency who promotes peer services and their benefit to the clients.

**Bill White:** Could you describe the development of the recovery center and the services it offers?

**Precia Stuby:** In 2003 we were able to get a consumer-run drop-in center in place. It has been challenging over the years. Participation has been relatively flat and the number of hours of service hasn't been able to grow. As we got more involved with ROSC and could see the power and the absolute necessity to mobilize and increase the involvement of peers and the recovery community, we wanted to transform our existing drop-in center into a recovery support center. We've nearly tripled the budget. We've gone from a part-time director to a full-time director. Our recovery guide program is housed there, the house parents for our recovery homes will be employed there, and we're offering SMART Recovery programs and recreational opportunities there. We're integrating addiction recovery support services while trying to be sensitive to the fact that the facility has a long history of working with individuals with severe and persistent mental illness. We need to sustain parallel programming as well as some integrated programming to serve both populations.

**Bill White:** You mentioned earlier the epidemic of opioid addiction that had hit Hancock County was part of the impetus for the ROSC initiative. How did the treatment of opiate addiction change through the process of developing the ROSC model?

**Precia Stuby:** One of the most significant things we were able to do was bring all of our treatment providers in this community together who were working with individuals with opiate addiction. We came up with a singular protocol for our approach to working with individuals that have opiate addiction. The protocol is based on our understanding that there are many pathways to recovery and that when an individual comes to any of our doors, we will outline the scope of services available for primary treatment of opiate addiction, even if it's something we don't provide as an organization. We let the individual in need identify the best match for themselves and their family. We wanted everyone seeking help to know what all of the options were before deciding which avenue to take. We want the client to have what he or she needs to make an informed decision about what would work best for them. That protocol was ratified in November of 2014 across all of our providers, and it included the willingness to participate in reviews of cases when there has been a death from overdose or suicide. We want to do a root cause analysis in such cases so we can see if there are things that should inform what we could do to prevent such incidents in the future.

**Bill White:** In many communities, the medication-assisted providers and the traditional drug-free treatment providers have been very polarized, so I'm very impressed that you were able to bring those poles together and create this integrated vision and collaboration.

**Precia Stuby:** It did not come easy. I think there were about eight revisions before we got to the point where everybody agreed. It has been very helpful to us. The one struggle that we've had really has not been anything about the philosophy or the different range of treatments. The problem that we've had is that our protocol calls for anyone diagnosed with addiction to receive a prescription for Naloxone. Our providers are all willing to do it but we're having terrible difficulty getting access to Naloxone in this community and having our pharmacies stock it and

make it readily available to families. Other than that, services for opioid addiction have improved. Work on the protocol forced soul-searching by our providers in defining their level of expertise and their service capacity. This process helped our agencies and our community identify centers of excellence where particular services could best be offered.

**Bill White:** ROSC models emphasize the need for sustained post-treatment recovery support. I'm wondering in Hancock County what you've done to extend such support beyond traditional primary treatment.

**Precia Stuby:** We are still working on making this shift. We have much work to do. We are changing our thinking. If you compare our system to a human skeleton, treatment is like an appendage; it's an arm, but it is not in any way the totality of what needs to occur to sustain recovery. There is the intensive care piece (treatment) that needs to occur but all of the other appendages and the rest of the skeleton need to work together for the whole to function. You have to have employment, you have to have recreational support, you have to have pro-social activities, you have to find meaning in your life, and so on.

When we talk about treatment now, we often compare it to cancer treatment. A treatment agency that's providing treatment for substance use disorders is like the chemotherapy or radiation of cancer. Once you get through that intensive care piece, you still need to sustain your health through diet and exercise and all the other work that is involved to restore your health over time. If you had cancer, the provider would bring you in once a quarter, then every six months, then once a year until a five-year period has lapsed and they can say, 'you can consider yourself to be cancer-free.' That's how we're viewing the role of the primary treatment agency. After they do their primary treatment, which would be like that radiation or chemo, the agency then needs to continue to do those recovery check-ups and sustained recovery support for an extended period.

**Bill White:** One of the things that you did as part of that continuing support was to try to expand recovery housing support services in Hancock County for men and women in recovery. Could you talk about that effort?

**Precia Stuby:** That has been unsuccessful, and I think we have been able to identify some of the reasons. We clearly underestimated the level of stigma and the level of fear that people have related to addiction. We are so used to working with people and involving people—being surrounded by like-mindedness--that we misread the level of stigma we would encounter and the tremendous push-back that would follow the purchase of our first recovery home. We actually sold the home back to the community as we realized that our planning and communication efforts had not been significant enough for the home to be successful. We followed the dollars when they became available for recovery housing without using a good planning sequence and it caught up to us in the form of a backlash. The good news is it initiated an unprecedented level of dialogue in this community about addiction. The other big thing that we learned is that there is a much higher level of fear associated with drug problems, particularly opiate addiction, than with alcohol problems. We face more challenges today because of fear of opiate addiction than we

would have fifteen years ago if we had proposed recovery housing and the primary population had been individuals addicted to alcohol.

**Bill White:** If you had it to do over again, is there a different strategy you would employ to prepare the soil for recovery housing in your county?

**Precia Stuby:** If we had it to do over, I would communicate, communicate, communicate. Dr. Achara, in our ROSC training, told us, "You will talk about ROSC so much that it will make you sick. You'll just think. 'How could someone possibly not know what we're talking about?'" She kept saying, "You have to do it over and over and over again." I heard those words and still underestimated the need for communication at the community level and the need to focus on recovery rather than addiction within those communications. People's perception of addiction and what they see and hear in the media do not include the picture of recovery. So, to do it over again, we would focus on the positive stories of recovery, positive faces of recovery, and put forth story after story after story and spell out how the community can support such recoveries.

**Reflections-to-Date on the Hancock County ROSC Initiative**

**Bill White:** Since you've taken over the leadership role with the board, what accomplishments do you feel best about?

**Precia Stuby:** I think the ROSC initiative has been the best opportunity we have had to provide a framework for this community; showing how all of the pieces and parts fit together. When we put things out from our Board, it's like, oh, the Board's doing mental health first aid or the Board's doing something about trauma or the Board's doing something about criminal justice. The danger is that these can become the flavor of the day kind of thing without people seeing how it all fits together. The ROSC framework has allowed us to actually describe in print how all those pieces fit. We're able to diagram where we are going and have a very good conversation with people about it. It's been very helpful for our Board members and very helpful for the general community.

I am also really proud of the fact that we are finding a way for anyone and everyone to get involved, no matter what system they're from or what they do in their personal or professional life. If they want to be part of the solution, we're able to link them. For example, our local university is now looking at a certificate program with a specialization in substance use. Our local courts have developed our first drug court. We've got twenty-two organizations in this community to be a part of a trauma-informed learning community. It's like everywhere you turn now, people and organizations are making changes that are going to be of support to people recovering from mental illness or addiction. Some days, it feels chaotic and overwhelming, and some days, you can sit back and just say, "Oh my goodness! Look at all of these wonderful things that are going on."

**Bill White:** As you reflect back on this experience, is there any additional guidance you would offer other communities that are just beginning to explore using this ROSC framework?

**Precia Stuby:** Several. I know we're all in the position where we need to chase money because this is how it is: a grant comes out and you try and figure out how you could fit that into what you are doing. This is both an opportunity and a danger, like we experienced with our first effort at recovery housing. We put recovery housing ahead of our communications plan. I could have been better prepared with communication tools directly around recovery housing and that may have helped our situation.

I think we have been able to get a lot of local organizations involved, but if we're really going to be successful, we have to find a way to really ignite the community at large. That's going to require finding a way to generate a feeling of empathy within the larger community so we can generate a collective call to action out there. Let me, again, talk about cancer. When somebody we know is diagnosed with cancer, we have an immediate reaction of, "Oh, I'm so sorry. What can I do to help?" We can intuitively list five or ten things to help: I can take them to the doctor's office, I can mow their yard, I can watch their kids, and so forth. We need to create that kind of reaction when somebody is diagnosed with a mental illness or a substance use disorder; one where our reaction is not of fleeing but of empathy and desire to assist. When Bev Haberle was here, she shared with us the concept of warrior down. That really stuck with me and I've used it a lot in this community to help people understand the mental image of warrior down and going to people's rescue and how we do not have that yet with mental illness and substance use disorders. Somebody brighter than me needs to do an autopsy of how the people involved in the disease of cancer were so effective at gaining that empathy. It's what we need to do for people that have a mental illness and addiction.

The lack of empathy and the resulting stigma are keys to the isolation that so many people with mental illness and addiction experience. Isolation should be a choice, not a consequence of one's illness. We need to get back to the fact that we are a community, we are people, and nobody should be alone unless that's what they have chosen. It should never be a consequence of disability or disease. We need to energize people to action to eliminate forced isolation.

**Bill White:** As a final question, what are your thoughts about the future of this work in Hancock County?

**Precia Stuby:** I think it is this concept of communication and trying to build empathy and a call to action. We're trying to get some interest through the ATTC and hopefully from some larger funders to help us design and implement such an effort. There's a science to public relations and marketing that I don't possess, and we need to bring some of that science and merge it with our medical science so we can be more successful.

I think the other challenge that lies ahead is to sustain the initiatives that have gotten started. We need to sustain our efforts with trauma-informed care. We need to sustain what we're doing with the courts and so on. We have adopted outcomes for our ROSC model related to engagement, access, and clinical outcomes, which will help us evaluate and refine our efforts. I think we just need to continue to secure resources and find ways to get momentum for ROSC, not just here, but across the whole state and then, state by state across the country.

**Bill White:** Precia, thank you for taking this time to share your experience promoting ROSC in Hancock County. Your pioneer efforts there are deeply appreciated.

**Precia Stuby:** Thank you, Bill.

**Note to the Reader**: Several key ROSC planning documents from Hancock County, Ohio are posted at http://www.williamwhitepapers.com/rm_rosc_library/

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