BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Peer-Centered Programming:
Building Recovery Capital

Welcome and Introductions

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Welcome

- Timothy Jeffries, Senior Policy Advisor, BJA
- Elizabeth Burden, Technical Assistance Director, Altarum
- Erin Etwaroo, LPC, Analyst, Altarum

Guest Presenter – Susan Broderick

- Susan is the founder and CEO of Building Bridges to Recovery (www.bb2recovery.com) and Senior Attorney with the National District Attorney's Association
- She was formerly an assistant research professor at Georgetown University, as well as the Deputy Bureau Chief with the Manhattan District Attorney's Office
- Susan also serves as an Advisory Board member with the Recovery Research Institute (www.recoveryanswers.org) and as a board member with The Phoenix (www.thephoenix.org)

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Guest Presenter – George Braucht

- George holds a master's degree in experimental/physiological psychology. He has more than 14,000 hours of psychotherapy supervision experience as a licensed professional counselor and a certified professional counselor supervisor and worked for 27 years with the Department of Community Supervision at the Georgia State Board of Pardons and Parole Board
- George is the cofounder and lead facilitator of the Certified Addiction Recovery Empowerment Specialist (CARES) Academy with the Georgia Council on Substance Abuse and a forensic peer mentor with Ready4Reentry. He is a lead faculty member of the Recovery Residence Manager Training and Recovery Navigation Support for the REC-CAP Assessment and Recovery Tool Training
- George is also a charter board member of National Alliance for Recovery Residences, a Level II trainer in the Partners for Change Outcome Management System (PCOMS), and a recovery consultant with SAMHSA's Opioid Response Network (ORN)

Guest Presenter – David Whitesock

- David is Chief Innovation Officer for Face It TOGETHER (www.wefaceittogether.org). He leads the development and execution of Face It TOGETHER's digital, technology, and data strategies. He developed and designed Face It TOGETHER's peer-based addiction coaching program and is the architect of the Recovery Capital Index®, the tool used to demonstrate outcomes and drive the change process with Face It TOGETHER peer coaching members
- David is licensed to practice law in the state of South Dakota, and is a former chair of the state bar's Lawyers Assistance Committee

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Learning Objectives

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After this session, you will be able to . . .

- Recognize the difference between the medical model for acute care of SUD and the social model of recovery
- Differentiate recovery capital from social capital
- Identify ways to implement recovery-oriented principles within criminal justice settings
- Recognize recovery capital assessment tools
- Describe three steps necessary for building your organization's capacity to support person-centered recovery and building recovery capital

Medical Model to Recovery Model

Susan Broderick, J.D., Senior Attorney at NDAA

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2020: Unique Moment in Time

- The current addiction epidemic has raised awareness across the nation of the problems associated with addiction

The Silver Lining: Turning Point for Our Country

- Research over the past 20 years has led to a much greater understanding of addiction as a chronic, yet treatable and preventable, condition
- Paradigm shift—from medical model to recovery model (ROSC)
  - Addiction and recovery do not just happen inside the body
  - Social and community aspects to both

The Silver Lining:
Truly a Turning Point for Our Country

- Prognosis for substance use disorders is quite good—the majority of people who seek help do achieve sobriety
- Criminal justice reform is happening across the country. This is one issue everyone can agree on

Perfect Storm:
Recovery Oriented Systems of Care (ROSC) and CJ Reform

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The links between substance use disorders and criminal offending are well-documented.

An arrest can be a window of opportunity – creates willingness to change.

“Love, Hope, and Random Drug Testing”

Using the leverage of the justice system to turn lives around in a positive way

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Dr. David Best

- Recovery from addiction parallels desistance from offending:
  - Both involve changing inside and out

Recovery Capital

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What Is Recovery Capital?

Granfield and Cloud (2001) define recovery capital as

> *"the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from AOD [alcohol and other drug] problems"*

White and Cloud (2008): Stable recovery best predicted on the basis of recovery **assets, not pathologies**

Best and Laudet (2010)

Recovery Capital

Personal: skills, traits, resilience

Social: networks, connections, mentors

Collective: community, housing, jobs, recovery support

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Maintaining and enhancing recovery outcomes can have broad implications across the entire justice system continuum

- From diversion through to re-entry, recovery capital can be measured and strengthened.

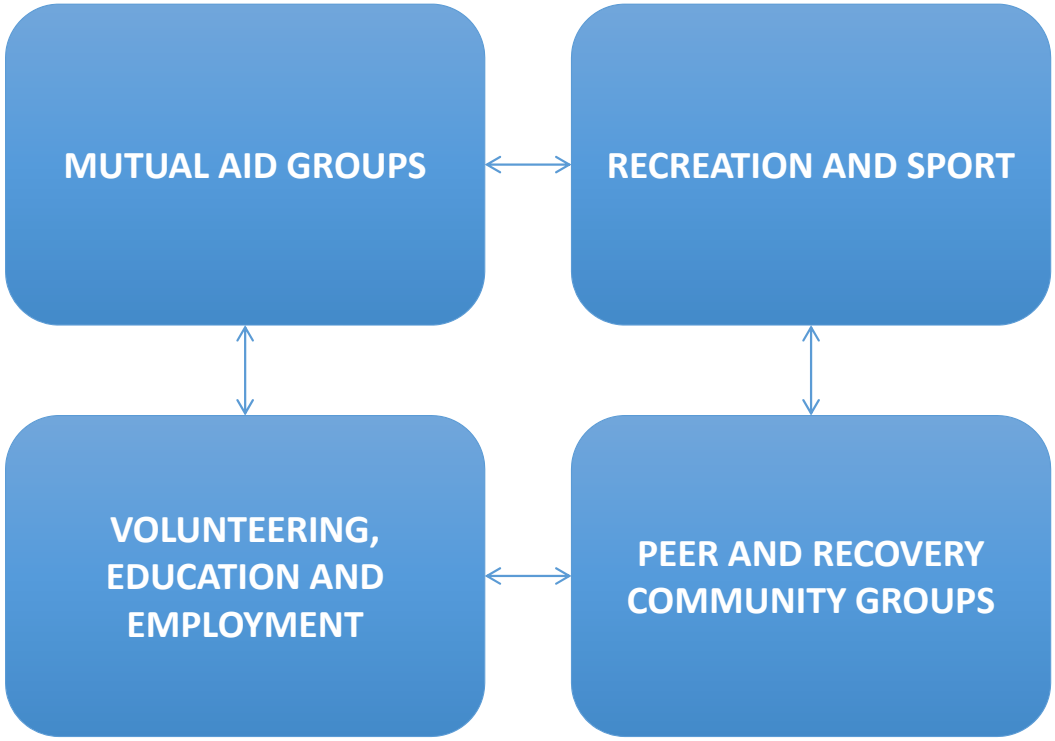
Different tools can be used at different interception points:

- ARC – Assessment of Recovery Capital (ARC): 52 questions (drug court, probation, re-entry)
- BARC – Brief Assessment of Recovery Capital: 10 questions (diversion)
- REC-CAP – Assessment and Recovery planning and monitoring (probation and re-entry)
- RCAM – Recovery Capital for Adolescents Model (juvenile justice systems)

Recovery Capital: Linking Personal, Social, and Community Assets

- Two things we know for sure: individuals cannot do it alone, and recovery is **an intrinsically social process**
- Personal capital grows through the support of the groups we belong to and the nurturance of the context and environment
- Supporting recovery growth requires engaging the positive components of the social networks and the broader community
- The more you use, the more you gain

What to Link



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Best and Laudet (2010)

"We are also increasingly confident that recovery is **contagious** and that it is a powerful force not only in **transforming** the lives of individuals blighted by addiction but in impacting on their families and communities as well"

Promoting Recovery and Offense Desistance: Where's the Sociocultural Beef?

George S. Braucht, LPC, CPCS and CARES
Brauchtworks Consulting

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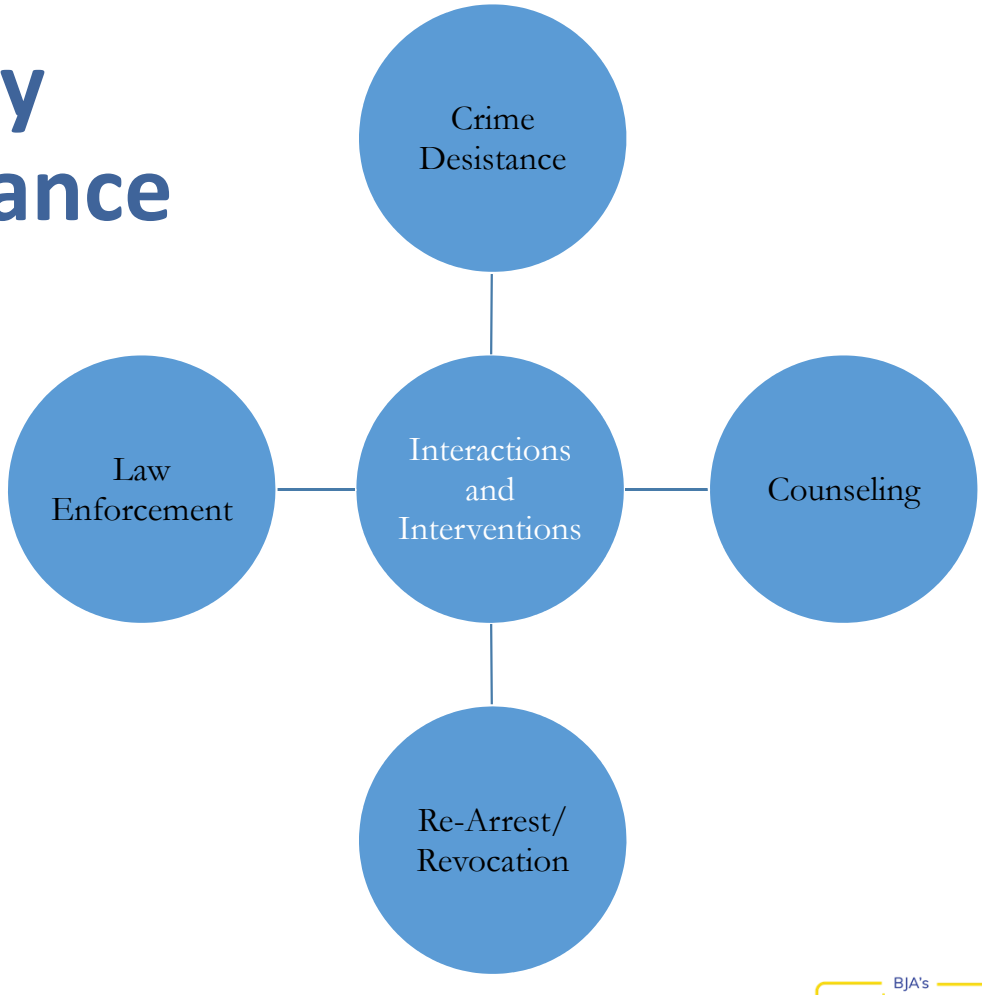
Promoting Recovery and Offense Desistance (PROD)



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Solution A: Listen for the Benefits of Sustained Connections in Recovery Stories

- **30 seconds: List people you know who . . .**

Recidivated (new crime within 5+ years)	Desisted (no crime within 5+ years)
1.	1.
2.	2.
3.	3.

"Until lions have historians, tales of hunting will always glorify the hunter"

—African proverb

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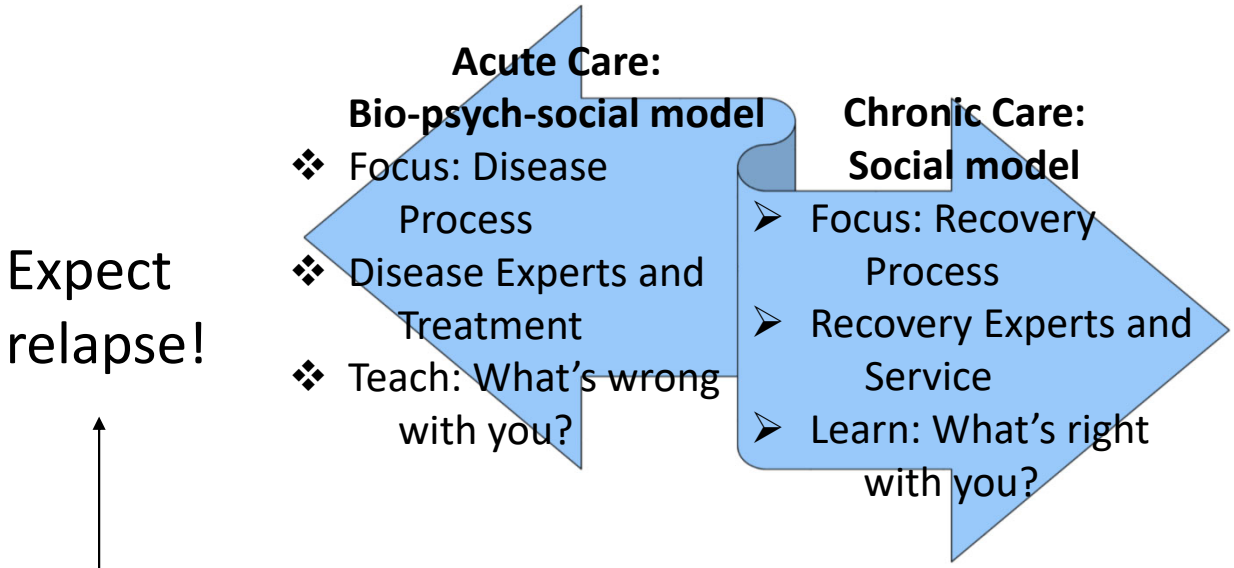
Solution B: Develop ROSC

Paradigm Shift of Enhancing Acute Care With Chronic Peer Support and **Social Model Recovery Programs**



Expect relapse!

Expect recovery/ resilience!

Stigma and discrimination

Contagious hope and redemption

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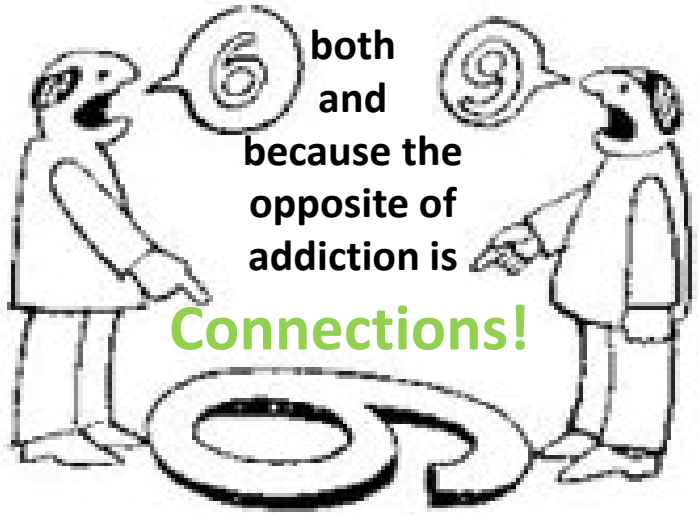
Solution B: Develop ROSC

Paradigm Shift: Enhancing Acute Care With Chronic Peer Support and **Social Model Recovery Programs**

ROSCs involve

- **both**
- **and**
- **because the opposite of addiction is**

Connections!



Expect relapse!

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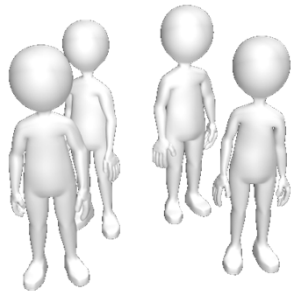
Solution B: Develop a ROSC



A Social Model of Recovery

1. Emphasizes social and interpersonal connections as the foundation of sustainable recovery
2. Values experiential knowledge
3. Promotes peer-to-peer, mutual aid, and other recovery supportive environments in which progressive well-being is the common bond
4. Requires active work in an individualized recovery program
5. Emphasizes peer-to-peer AND practitioner-client relationships that blend to mutually enhance treatment and recovery/wellness objectives and key results

Borkman, Kaskutas, Rooms, Bryan, & Barrows. (1998). An historical and developmental analysis of social model programs. *Journal of Substance Abuse Treatment*, *15* (1), 7–17.

Solution C: Enhance Recovery Capital (Connections) Within Recovery-Oriented Systems of Care

"To travel fast, go alone. To go far, travel with many"

—African proverb

Promoting Recovery and Offense Desistance (PROD) Overview

Adapted from:

1) McNeill, F., Farrall, S. Lightowler, C. & Maruna, S. (2014). Desistance as a framework for supervision. In G. Bruinsma and D. Weisburd (Eds.), *Encyclopedia of criminology and criminal justice*. New York: Springer-Verlag.

2) *Fergus McNeill: Desistance, identity and belonging*. 26 minutes: https://www.youtube.com/watch?v=9OAZ0huxpz0.

3) Maruna, S. (2012). Elements of successful desistance signaling. *Criminology and Public Policy*. (*11*) 1, 73-86.

1. Desistance: 1) the absence of repeated behavior among those who had established a pattern of such behavior, 2) how and why people stop offending and move on with their lives

   "Desistance is not in the gift of criminal justice agencies working alone, it depends on connectivity with other sectors that can provide important supports and functions."

2. Interplay of three sets of desistance factors
   - 2.1. Physical: Physical and psychological changes associated with maturation or aging
   - 2.2. Social: Connections and bonding including social institutions; School, work, marriage, etc. – those relationships shift and affect behavior; Mentor – help in re-imagining who I am, bridging social capital
   - 2.3. Identity: How you see or label yourself and how others label you and with what consequences and effects

3. Three domains of desistance
   - 3.1. Primary: behavioral
   - 3.2. Secondary: labeling and identity
   - 3.3. Tertiary: belonging; to whom am I affiliated

4. Factors to track showing that we are supporting desistance
   - 4.1. Track shifts in identity and belonging (secondary and tertiary) and other intermediate outcomes
   - 4.2. Focus on strengths and challenges (who do I think I want to become): why do I think what I propose to do to help will bring about the result I expect? Leads to forming a theory of change.

5. Potential metrics and methods to assist in assessing an individual's theory of change
   - 5.1. Outcome "star": help the individual rate where s/he stands on each point or dimension and collaboratively chart progress over time

Promoting Recovery and Offense Desistance (PROD) Overview

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   - 5.2. Journaling or diaries: reflect the extent to which the person feels s/he is shifting identity, changing or moving on, recovery or quality of life, social cognitive, networks, connections, etc.

6. Four forms of rehabilitation to simultaneously peruse.
   - 6.1. Personal or psychological: develops the skills, capacities, attributes and motivation of the individual to change
   - 6.2. Social: de- or re-labeling in the community and a willingness to graph people back into the social body
   - 6.3. Moral: the state and the community owe a retributive debt to end punishment
   - 6.4. Judicial: record restriction, occupational disqualification, etc. to fully restore citizenship

See your handout

Brauchtworks: Applying science to practice

Risk-Need-Responsivity and Other Evidenced-Based Principles and Practices in Community Corrections

George S. Braucht, LPC; Brauchtworks Consulting
Website: www.brauchtworks.com; Email: george@brauchtworks.com
Retired, Georgia Department of Community Services/State Board of Pardons and Paroles

1. Assess actuarial risk/needs,
2. Enhance intrinsic motivation (Responsivity),
3. Target Interventions based on principles or risk, need and responsivity using appropriate dosage and treatment,
   A. Risk Principle: Prioritize supervision and treatment resources for higher risk offenders;
   B. Need Principle: Target interventions to criminogenic needs;
   C. Responsivity Principle: Be responsive to temperament, learning style (sic), motivation, culture; and gender when assigning offenders to programs;
   D. Dosage: Structure 40-70% of high-risk offenders' time for 3-9 months; Treatment: Integrate treatment into sentence/sanction requirements).
4. Skill train with directed practice using cognitive behavioral treatment methods (Responsivity),
5. Increase reinforcement: four reinforcements to every punishment (Responsivity),
6. Engage ongoing support in natural communities (Responsivity),
7. Measure relevant processes/practices (Responsivity),
8. Provide measurement feedback (Responsivity).

Risk Principle	=	**Who** to target and **How much**
Need Principle	=	**What** to focus on
Responsivity Principle	=	**How** to help
Collaboration Principle	=	**With whom**
Front-End Loading Principle	=	**When**

Four dynamic risk-need factors

References

1. Andrews, D. A. & Bonta, J. (2010, 5th ed.). The psychology of criminal conduct. New Providence, NJ: Mathew Bender & Company.

2. Crime and Justice Institute at Community Resources for Justice (2009, 2nd ed.). Implementing evidence-based policy and practice in community corrections. Washington, DC: National Institute of Corrections. https://s3.amazonaws.com/static.nicic.gov/Library/024107.pdf

3. National Institute of Corrections. (2004). Implementing evidence-based practices in community corrections: The principles of effective intervention. Washington, DC: Author. https://s3.amazonaws.com/static.nicic.gov/Library/019342.pdf

GEORGIA FORENSIC PEER MENTORING

Referral Form 190523

Confidentiality Notice: Mentors do not have the right to disclose any of this confidential information to anyone outside of her or his agency except as allowed by law.

Name: Canu Elpme	Today's Date: 6/28/19
EF # 1234567	Prison or Jail Release Date: 6/10/18
Date of Birth: 09/02/87	Parole/Sentence Discharge Date: 12/2035

Contact your Supervision Officer before the scheduled appointment if you cannot attend.

FPM Appointment Date: 7/4/19	Week Day: Thursday	Start Time: 9:00am

Counselor: Greta Listner	Phone: (123) 456-7890	Email: listner@curzemal.org	Location: Warner Robins
Officer: Fare N. Firm	Phone: (098) 765-4321	Email: firm@dcs.ga.gov	Location: Warner Robins
FPM: Ben There	Phone: (876) 543-2109	Email: there@gmhcn.org	Location: Warner Robins

Pre-Referral Information: Please do not leave any line blank.

FPM Referral Initiated by ..... Self ☐ Officer ☑ Counselor ☐ or Other: _____

Recent Prison Release from: check all that apply ..... RSAT: ☐; MH Level 2+: ☑

Aftercare Program Other Than FPM is ..... Required ☐ Unavailable ☑ Unnecessary ☐

Recent AOD Use or Recurring MH Challenge Indicated by Family/Employer/Other ..... Yes ☐ No ☑

Recent Re-arrest Risk Score Increase ..... Yes ☑ No ☐

Other Comments: None

Research indicates that the below factors distinguish between people who successfully completed supervision from those who were re-arrested. Please do not leave any line blank - enter NA if Not Applicable.

1) Current: A) Re-arrest Risk Score (0-10): 8 B) Supervision Level: High

2) Special Conditions of Release or Sentence: ..... Substance Abuse Assessment ☐ Mental Health ☐

Other: None

3) Last Conviction ..... Property Crime: Yes ☑ No ☐; Drug Sale: Yes ☐ No ☑

4) Previous Probation or Parole Revocation ..... Yes ☑ No ☐

★5) Days Employed Since Prison/Jail Release 68

★6) Number of Residences Since Release from Prison/Jail 4

★7) Total Drug Tests Taken Since Prison/Jail Release ..... 2 # Positive: 1

8) Last Drug Test Date: 6/24/19 Result: Negative ☐ or Positive for: THC

★9) Currently in Other Programs (List): WRDRC

Recovery Capital Tools

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Recovery Capital Assessment Plan and Scale (ReCAPS) 160717

Robert Granfield and William Cloud introduced "recovery capital" and defined it as the volume of internal and external assets that can be brought to bear to initiate and sustain recovery from alcohol and other drug problems. Recovery capital, or recovery capacity, differs from individual to individual and within the same individual at multiple points in time consisting four components.

Social capital is the sum of resources that each person has as a result of relationships, and includes both support from and obligations to groups to which they belong; thus, family membership provides supports but also entail commitments and obligations to the other family members. **Physical capital** is the tangible assets such as property and money that may increase recovery options (e.g., being able to move away from existing friends/networks or to afford an expensive detox service). **Human capital** includes skills, positive health, aspirations and hopes, and personal resources that enable the individual to prosper. Traditionally, high educational attainment and high intelligence have been regarded as key aspects of human capital that may help with some of the problem solving that is required on a recovery journey. **Cultural capital** includes the values, beliefs and attitudes and rituals that link prosocial identity to social conformity and the ability to accommodate dominant social behaviors

White and Cloud (2008) proposed that recovery capital interacts with problem severity to shape the intensity and duration of supports needed to achieve and sustain recovery. This interaction informs the intensity or level of care one needs in terms of professional treatment and the intensity and duration of post-treatment recovery support. The figure below suggests how combinations of problem severity and recovery capital could differ.

High Recovery Capital	High Problem Severity /Complexity
Low Problem Severity /Complexity	Low Recovery Capital

People with high problem severity but very high recovery capital may require fewer resources to initiate and sustain recovery than an individual with moderate problem severity but very low recovery capital. Where the former may respond very well to outpatient counseling, linkage to recovery mutual support groups and a moderate level of ongoing supervision, the latter may require a higher intensity of treatment, greater enmeshment in one or more recovery cultures (e.g., placement in a recovery home, greater intensity of mutual support involvement, involvement in recovery-based social activities), and a more rigorous level of ongoing monitoring and supervision.

Clinical addiction assessment instruments do a reasonably good job of evaluating problem severity and complexity (e.g., co-occurring medical/psychiatric problems) while few instruments measure recovery capital. The scale on the following pages is intended as a self-assessment instrument to help an individual measure her or his recovery capital. The scale can be completed and discussed in an interaction and/or it can be completed by the individual and then discussed with a professional or peer helper. Subsequent reviews and modifications of the assessment and plan can be used to track progress.

Modified and distributed with the permission of William L. White to George S. Braucht, LPC & CPCS: brauchtworks.com/toolkit

Assessment of Recovery Capital (Groshkova, Best & White; 2012)

Please ✓ if you agree with any of the following statements

1.	Having a sense of purpose in life is important to my recovery journey	☐
2.	I am able to concentrate when I need to	☐
3.	I am actively involved in leisure and sport activities	☐
4.	I am coping with the stresses in my life	☐
5.	I am currently completely sober	☐
6.	I am free from worries about money	☐
7.	I am actively engaged in efforts to improve myself (training, education and/or self-awareness)	☐
8.	I am happy dealing with a range of professional people	☐
9.	I am happy with my personal life	☐
10.	I am making good progress on my recovery journey	☐
11.	I am proud of my home	☐
12.	I am proud of the community I live in and feel a part of it	☐
13.	I am satisfied with my involvement with my family	☐
14.	I cope well with everyday tasks	☐
15.	I do not let other people down	☐
16.	I am free of threat or harm when I am at home	☐
17.	I am happy with my appearance	☐
18.	I engage in activities and events that support my recovery	☐
19.	I eat regularly and have a balanced diet	☐
20.	I engage in activities that I find enjoyable and fulfilling	☐
21.	I feel physically well enough to work	☐
22.	I feel safe and protected where I live	☐
23.	I feel that I am in control of my substance use	☐
24.	I feel that I am free to shape my own destiny	☐
25.	I get lots of support from friends	☐
26.	I get the emotional help and support I need from my family	☐
27.	I have a special person that I can share my joys and sorrows with	☐
28.	I have access to opportunities for career development (job opportunities, volunteering or apprenticeships)	☐

Advanced Recovery Management

Not secure | recoveryoutcomes.com/rec-cap/

Provider Login | Client Login | Support

ARMS RECOVERY MANAGEMENT

recoveryoutcomes.com

Home | REC-CAP | Upcoming Events | Schedule a Demo!

REC-CAP ASSESSMENT & RECOVERY PLANNING TOOL

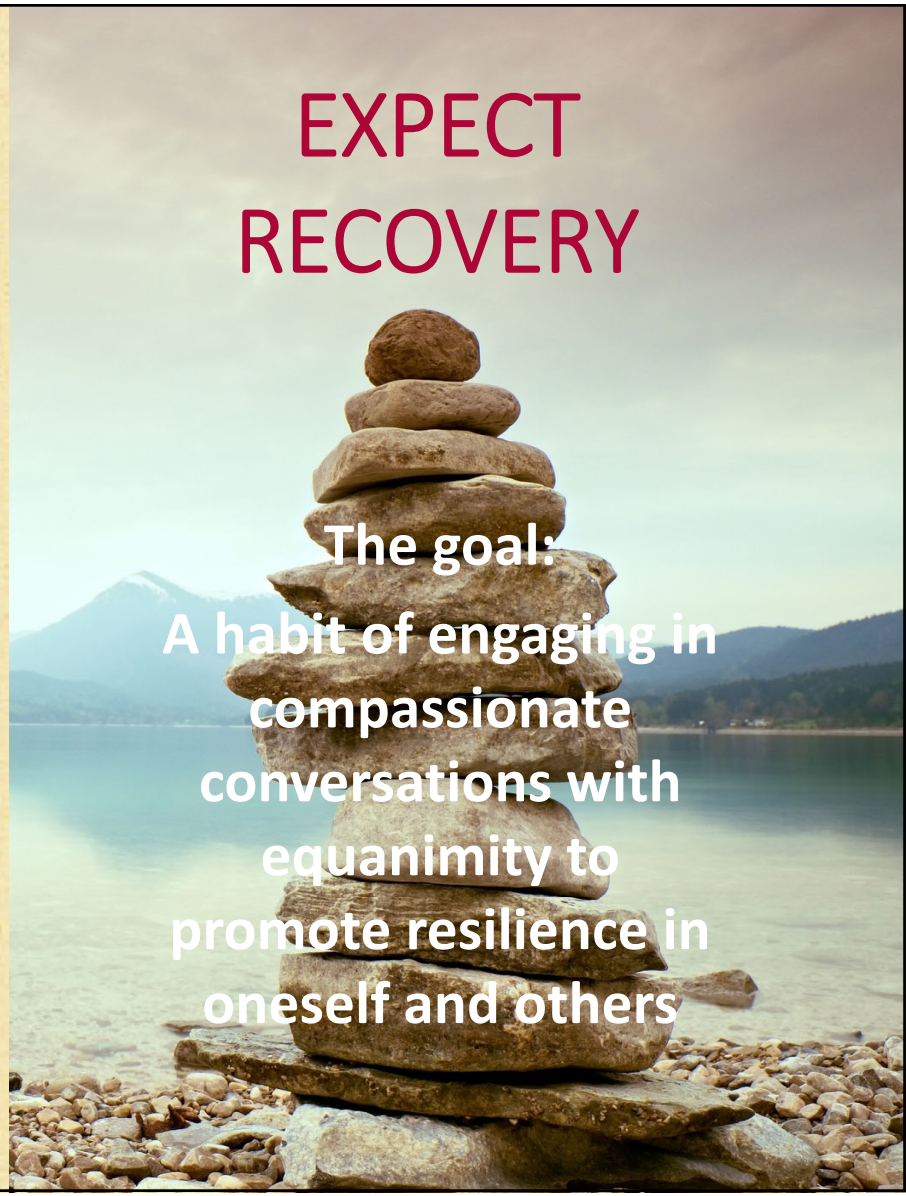
"Longitudinal studies have repeatedly demonstrated that addictions treatment (particularly for 90 or more days) is associated with major reductions in substance use, problems and costs to society ... However, post-discharge relapse and eventual re-admission are also the norm ...The risk of relapse does not appear to abate until 4 to 5 years of abstinence ... Retrospective and prospective treatment studies report that most clients undergo 3 to 4 episodes of care before reaching a stable state of abstinence ... In spite of this evidence of chronicity and multiple episodes of care, most ... treatment continues to be characterized as relatively self-encapsulated, serial episodes of acute treatment with post discharge aftercare typically limited to passive referrals to self-help groups."

U.S. Department of Health and Human Services – Substance Abuse and Mental Health Services Administration Report to Congress

REC-CAP: THE BRIDGE FROM TREATMENT TO SELF-DIRECTED RECOVERY

Leave a message

EXPECT RECOVERY



The goal:

A habit of engaging in compassionate conversations with equanimity to promote resilience in oneself and others

Measuring and Building Recovery Capital Through Peer Coaching

David Whitesock, J.D.
Chief Innovation Officer, Face It TOGETHER

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Delivery of effective, science-based peer coaching for **people living with addiction**, including **loved ones**

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Personalized Support

Effective, tailored coaching to help those affected get well

Connect to Care

Help in understanding treatment options, insurance, and links to resources

Flexible and Convenient

Get coaching from any location, with less disruption to your work and life

Lasting Results

Track and measure progress with comprehensive data and outcomes

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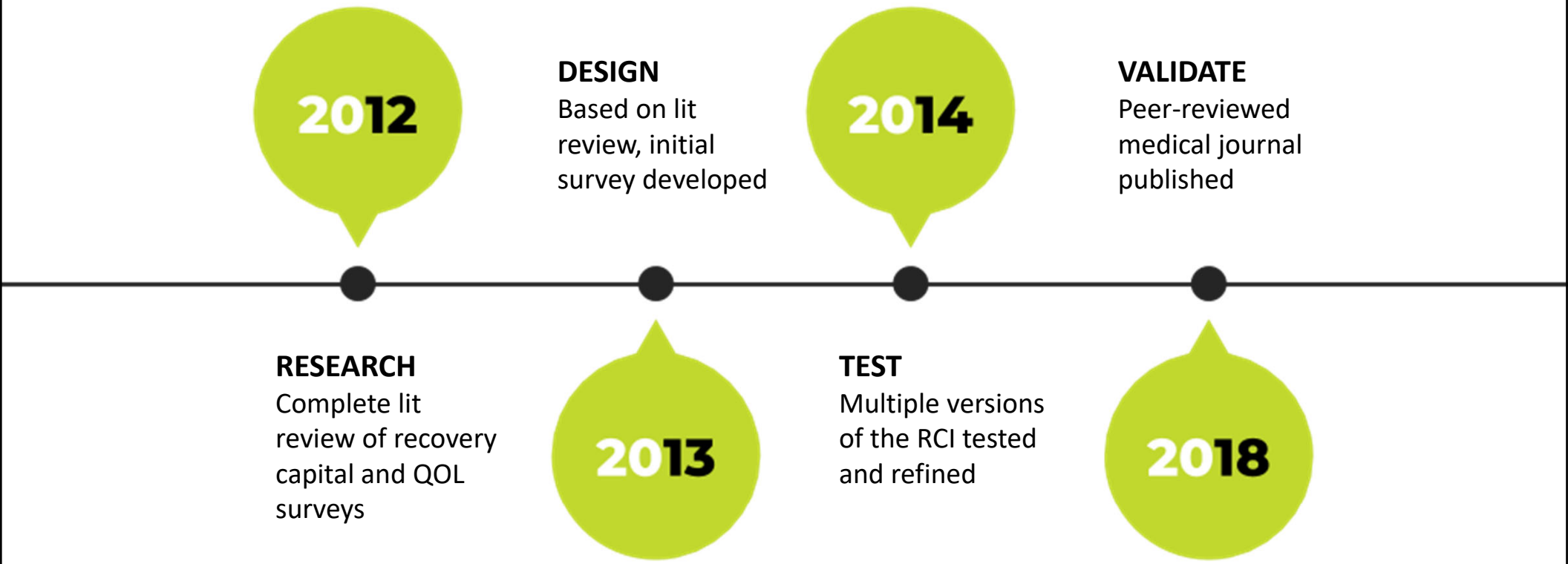
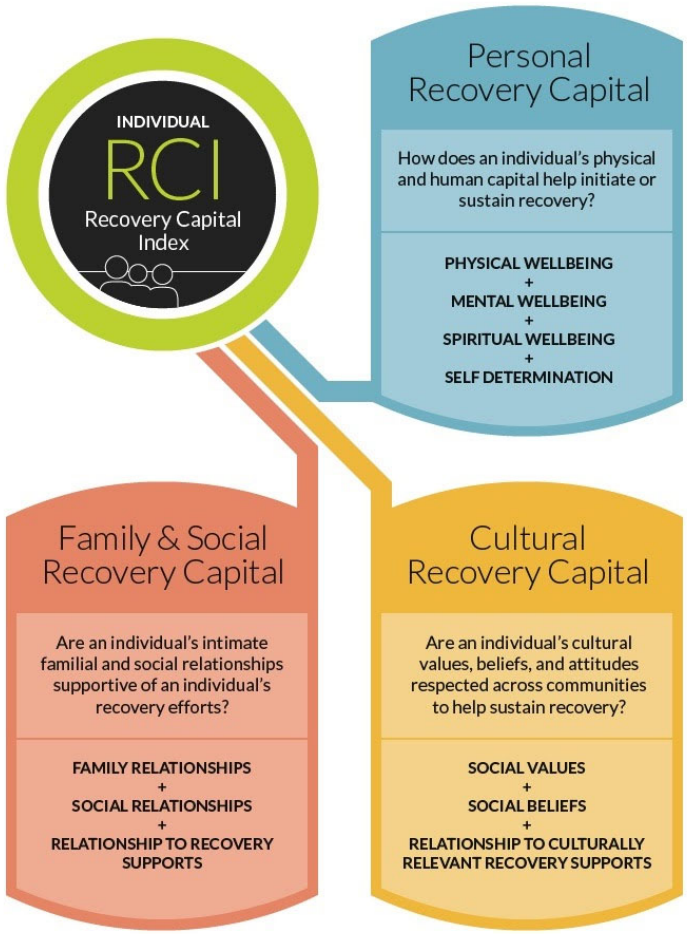
Sobriety alone does not tell us much about a person's whole well-being


2012
DESIGN
Based on lit review, initial survey developed
2014
VALIDATE
Peer-reviewed medical journal published
RESEARCH
Complete lit review of recovery capital and QOL surveys
2013
TEST
Multiple versions of the RCI tested and refined
2018



Personal Capital	Social Capital	Cultural Capital
General Health	Family Support	Beliefs
Mental Well-Being	Significant Other	Spirituality
Nutrition	Social Support	Cultural Relevance
Employment	Social Mobility	Sense of Community
Education	Healthy Lifestyle	Values
Housing Situation	Access to Health Care	
Transportation	Safety	
Clothing		

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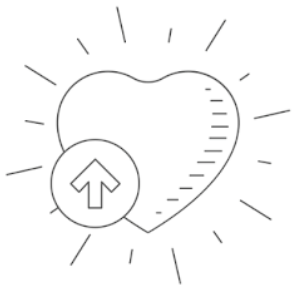
Track progress

Measure changes in personal, social and cultural recovery capital over time.

Inform care

Gain insight from the multidimensional assessment and tailor care to the individual.



Prove outcomes

Assess intervention effectiveness and demonstrate results with meaningful data.

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Validating a Survey for Addiction Wellness: The Recovery Capital Index

By David Whitesock, JD/MA; Jing Zhao, PhD; Kristen Goettsch, MA; and Jessica Hanson, PhD

Abstract

Background: Evaluating addiction wellness encompasses more than sobriety. The Recovery Capital Index (RCI), developed by Face It TOGETHER (FIT), measures addiction wellness using three domains and 22 components providing a comprehensive baseline and assessment of intervention effectiveness to allow for the tracking of client progress and to tailor support. The RCI is a holistic, person-centered metric irrespective of a person's treatment modality, recovery, or wellness pathway.

Methods: FIT and Sanford Research set a goal to validate the RCI's effectiveness to measure the factors associated with addiction wellness through a retrospective cohort study of FIT clients with the disease of addiction to alcohol and/or other drugs. Study cohort included 154 client intake records with corresponding RCI scores. The RCI was subjected to descriptive analyses using stacked barplots and side-by-side boxplots. The Cronbach and correlation coefficients were used to check the reliability and validity of the components within each domain. Differences of RCI against clients' characteristics were examined using Tukey's test of multiple comparisons of means.

Results: The validation process verified the design of the RCI domains – personal, social, and cultural capital. Variables significantly related to addiction wellness, based on the RCI, are: primary addiction, addiction identification, employment, and income. The RCI accurately described the individual's current state of recovery.

Conclusions: This project validated the RCI as a tool to measure addiction wellness. The RCI measures what it is intended to measure. The results allow FIT and Sanford Research to next validate the RCI instrument's predictive nature for measuring behavior change.

Background

For as long as individuals have been surviving alcohol and other drug addiction (also understood as substance use disorder) – entering and maintaining "recovery" – there has lacked a method or instrument for measuring the broad and ambiguous concept of recovery. Generally, the use or non-use of a substance has been a leading or primary indicator of treatment and/or recovery success. With other indicators, such as employment, housing, and criminal justice involvement, the scope of measurement has been limited to a specific demographic – an underserved and less economically positioned population. Despite treatment providers, criminal justice, and other agencies' continued reliance on abstinence as a measure of success (e.g., program completion, recovery, etc.), a mainstream acceptance of a more holistic measurement is prevailing, albeit, against competing definitions of recovery.

Two of the most respected organizations in the addiction field – Substance Abuse and Mental Health Services Administration (SAMHSA) and Betty Ford Institute (now Hazelden Betty Ford Foundation) – have illustrated the lack of consensus around the notion of recovery. SAMHSA defines recovery as a "process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[5] The Betty Ford Institute Consensus Panel

gure 2. Components of the RCI

wellness.

outcomes
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nts within

Secondly, the Cronbach was used to check the reliability of the subscales within each capital. Spearman correlation matrix of the subscales within each capital was performed to examine the content validity. Furthermore, inter-capital correlations were conducted to test the construct validity whether a unique index could be representative of multiple domains.

Finally, differences of RCI against various client characteristics were examined using Tukey's test of multiple comparisons of means. This analysis was used to understand the sensitivity of the RCI on key risk and demographic factors. A p value of less than 0.05 was considered significant in the aforementioned tests.

Protections. This instrument validation study was reviewed by the Sanford Health Institutional Review Board on Oct. 4, 2017, identified as not human research, and exempt from a full review. Assessments used in this retrospective review were non-identifiable and collected through FIT clients as part of the coaching program that they consented to participation in. The FIT informed consent is for participation in services and ongoing assessment and to inform and identify processes for data collection, secure storage, and release of information

gure 3. Stacked barplots of three capitals

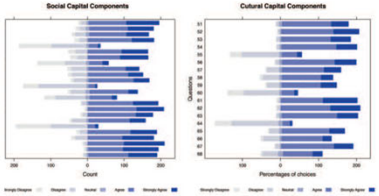
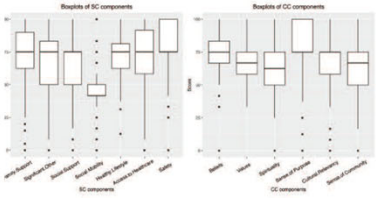


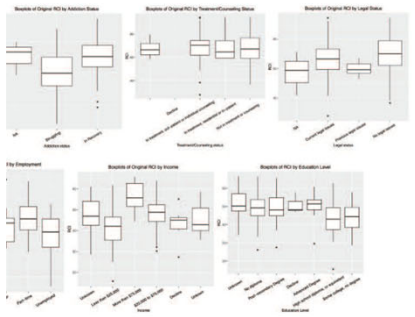
Figure 4. Boxplots of RCI components



2. Spearman correlation matrix of 9 subscales

Basic Human Needs	Family and Home	Social Network	Health Activities and Environment	Social Values	Spirituality and Purpose	Community Connectedness
0.47	0.29	0.31	0.44	0.30	0.50	0.42
0.55	0.28	0.16	0.47	0.18	0.30	0.37
1.00	0.42	0.22	0.59	0.25	0.34	0.41
0.42	1.00	0.37	0.47	0.20	0.25	0.36
0.22	0.37	1.00	0.32	0.32	0.34	0.49
0.59	0.47	0.32	1.00	0.51	0.46	0.57
0.25	0.20	0.32	0.51	1.00	0.58	0.54
0.34	0.25	0.34	0.46	0.58	1.00	0.52
0.41	0.36	0.49	0.57	0.54	0.52	1.00

Boxplots of RCI by categories of different clients' characteristics



ile others were overshad-
disagree" answers, like
as consistent with survey
as written with "strongly
. The distributions of 22
l domains, as introduced
e visualized in Figure 4.
nal capital had overall
the other two capitals,
varied thoughts over per-
Employment", "Financial
Living Situation" being
nents. "Social mobility"
e components, reflecting
d similar social mobility

e Cronbach's of the 9
hat these subscales had
sistency. In addition,
ubscales was presented in
than 0.05. While these
tions could measure one
called a "factor," these

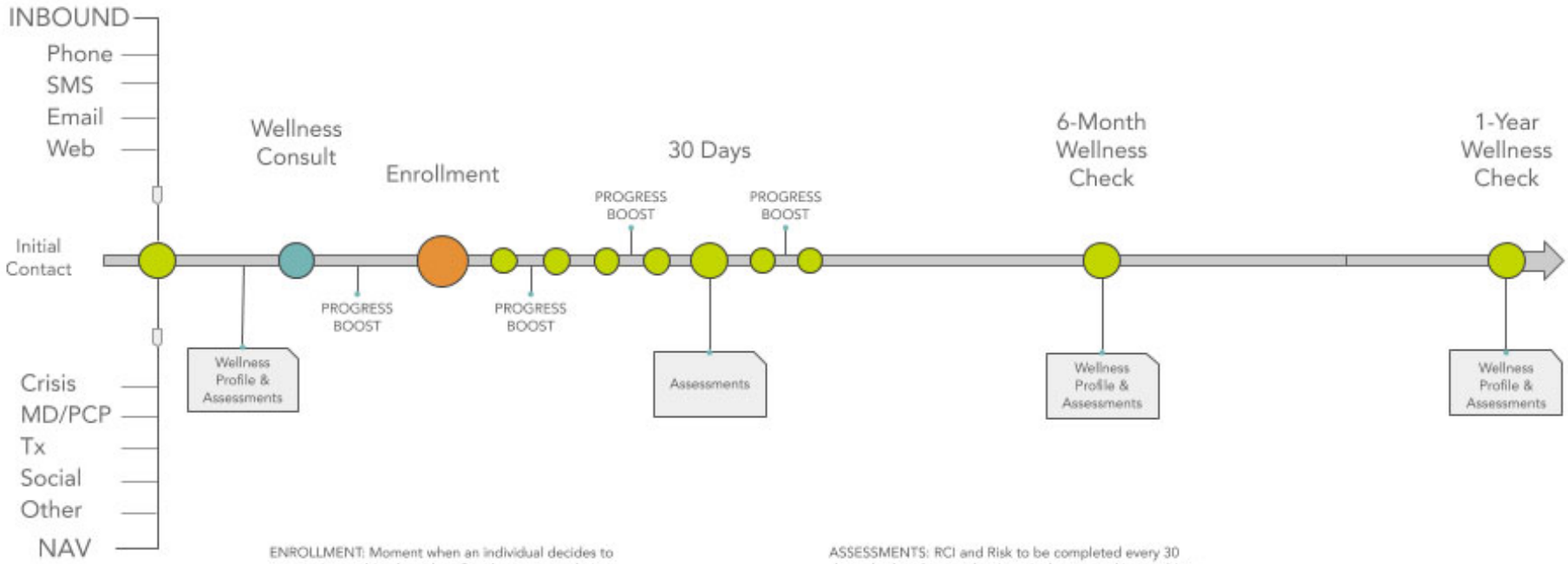
Table 3. Spearman correlation matrix of the three capitals

	Personal Capital	Social Capital	Cultural Capital
Personal Capital	1.00	0.54	0.47
Social Capital	0.54	1.00	0.56
Cultural Capital	0.47	0.56	1.00

correlation coefficients were not extremely high which indicates that any two of the variables were measuring slightly different aspects of the "factor." In addition, inter-factor correlations of the three capitals were conducted and shown in Table 3. These moderate positive relationships with correlation coefficient around 0.5 verified the design of three capitals measuring different aspects of RCI.

Comparison of RCI Responses Based on Demographics. The distributions of RCI against each of the demographic variables were first visualized by the side-by-side boxplots (Figure 5), which illustrated the capability of RCI to capture both similarities and differences among categories of individual variable. For example, RCIs of clients addicted to prescription were overall higher than those of whom addicted to marijuana, while similar to the those in alcohol addiction group. To further examine and quantify the

** Peer-reviewed study verified the recovery capital framework, Physical Capital, Social Capital, and Cultural Capital, and validated the Recovery Capital Index as a tool to measure addiction wellness. May 2018, South Dakota Medicine.*



ENROLLMENT: Moment when an individual decides to engage in coaching based on Coach recommendations, whether paying or covered by a grant.

ASSESSMENTS: RCI and Risk to be completed every 30 days whether the member is actively engaged in coaching or not.

Wellness Plan
Better Addiction Care

Face It TOGETHER®

Recovery Capital Index Scorecard ☐ /100

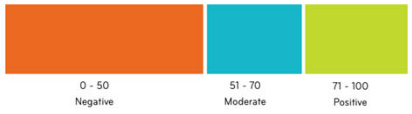
Recovery Capital are all the things inside you and around you that affect your addiction wellness. The Recovery Capital Index (RCI) a 360-degree measurement that you and your coach can use to track your progress and personalize your coaching and Wellness Plan. The RCI is most helpful when competed every 30 days.

Please note: *The Recovery Capital Index is not a diagnostic or clinical measure.*

Personal Capital ☐ /100	Social Capital ☐ /100	Cultural Capital ☐ /100
General Health ☐	Family Support ☐	Beliefs ☐
Mental/Emotional Wellbeing ☐	Significant Other ☐	Values ☐
Nutrition ☐	Social Support ☐	Spirituality ☐
Employment ☐	Social Mobility ☐	Sense of Purpose ☐
Education ☐	Healthy Lifestyle ☐	Cultural Relevance ☐
Financial Wellbeing ☐	Access to Healthcare ☐	Sense of Community ☐
Housing/Living Situation ☐	Safety ☐	
Transportation ☐		
Clothing ☐		

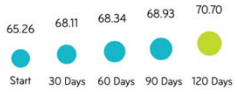
What Your Score Means

Based on scores from hundreds of members.



Average Member RCI Score

When actively involved in coaching.



Wellness Plan
Better Addiction Care

Face It TOGETHER®

Progress Areas

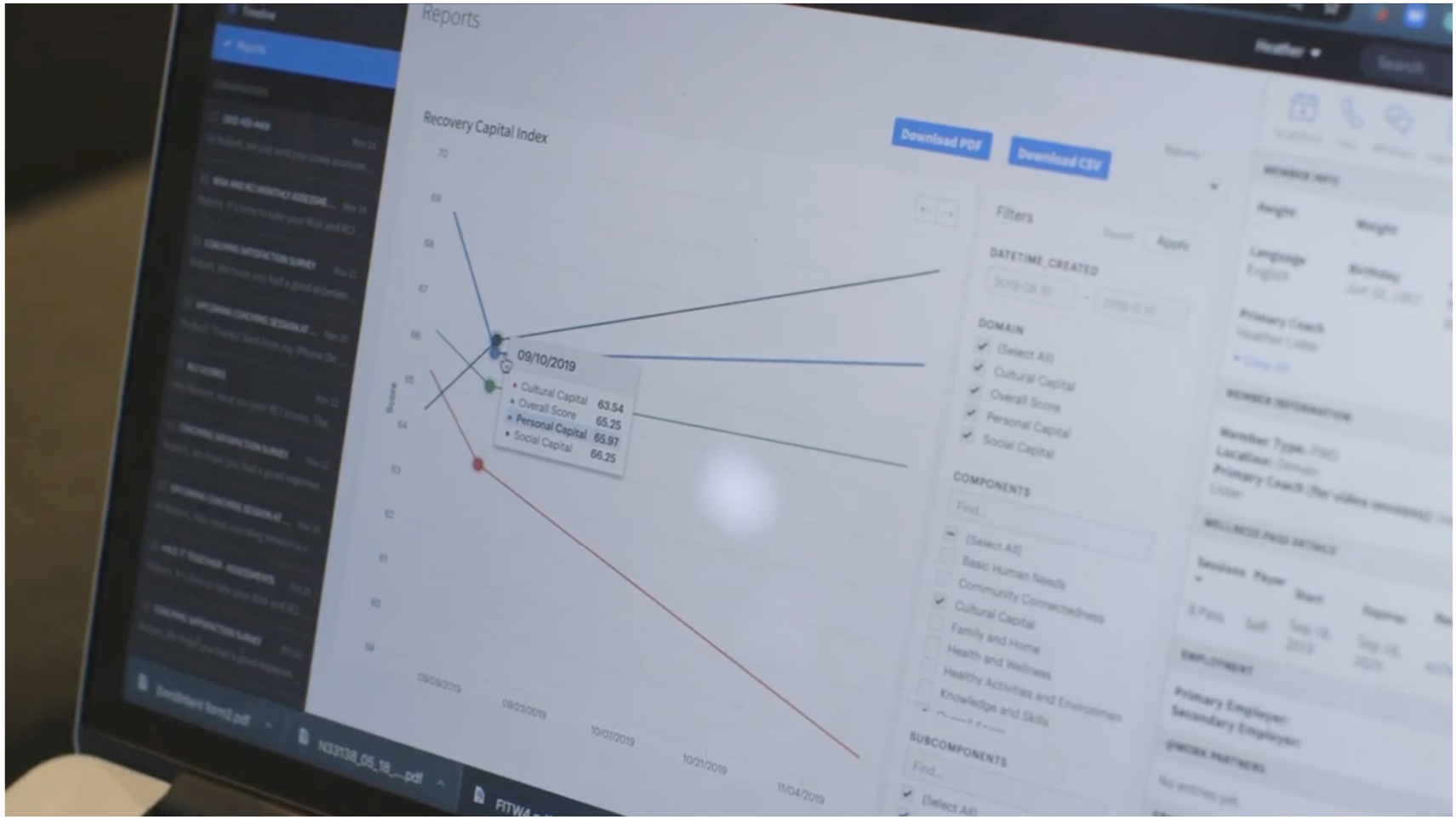
A few areas the coach has identified based on what you've told us so far.

Goals & Actions

These are goals and actions based on input from the first Wellness Consult session. You are free to modify. Your coach will work with you over time to develop action strategies and adjust over time.

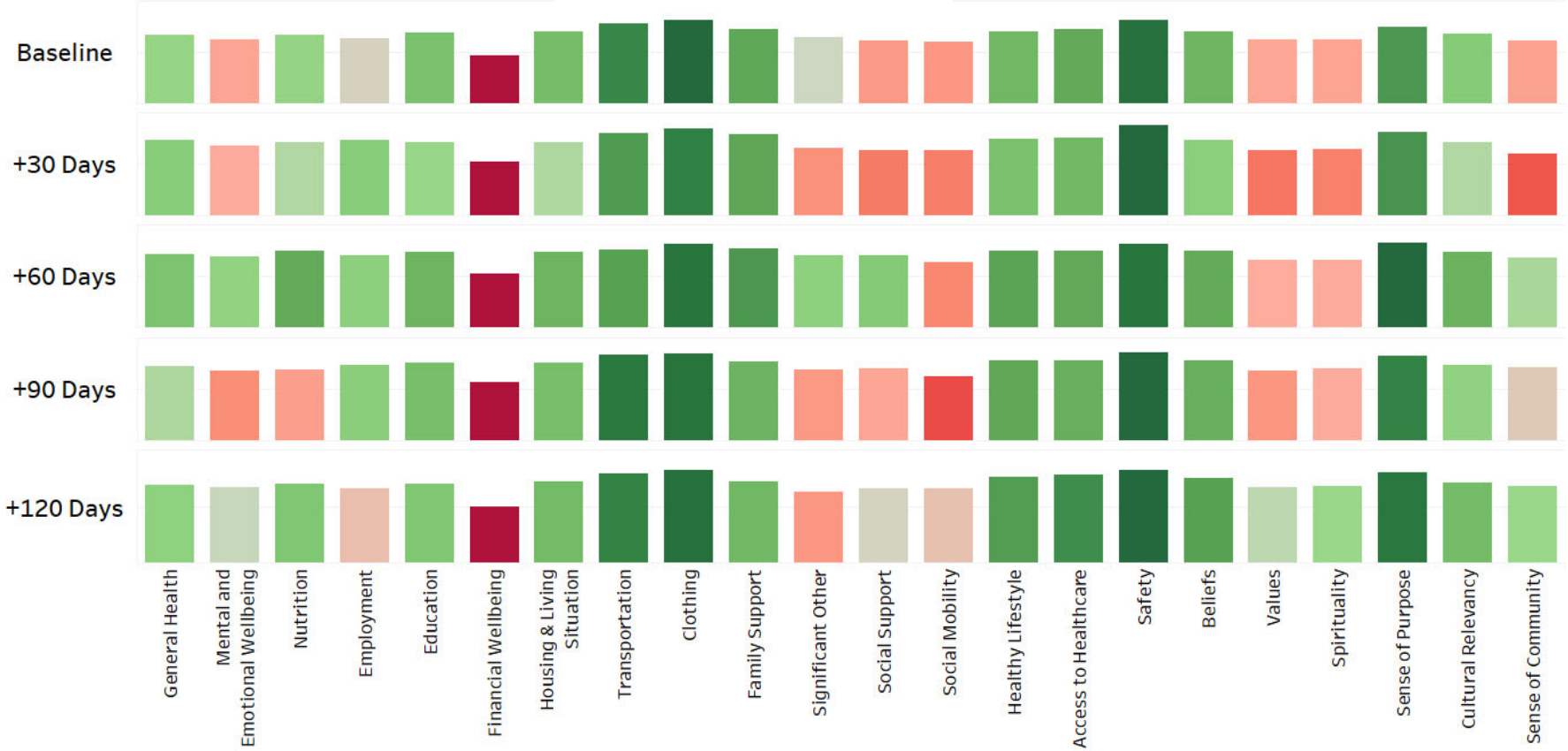
Goals	Actions	Due Date

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program



BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Subcomponents



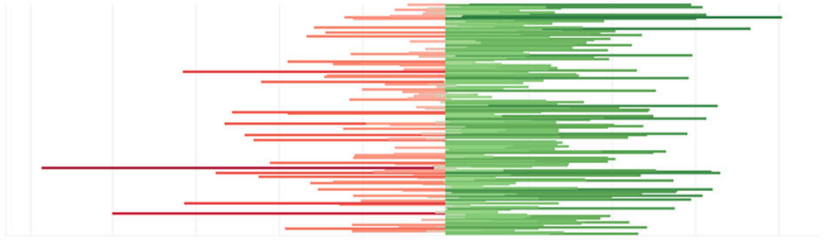
BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Change in RCI Total Score: Baseline to Final RCI (Regardless of when taken)

Members Coached by Denver & South Dakota

PWD Members

% Change by Member
Red = Negative Change
Green = Positive Change



Average % Change from baseline RCI to final RCI

6.04%

Members with a positive change from baseline RCI to their final RCI

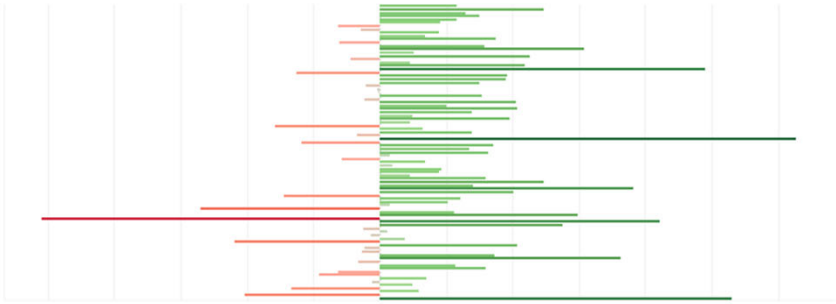
259

Members with a negative change from baseline RCI to their final RCI

100

LO Members

% Change by Member
Red = Negative Change
Green = Positive Change



Average % Change from baseline RCI to final RCI

4.33%

Members with a positive change from baseline RCI to their final RCI

62

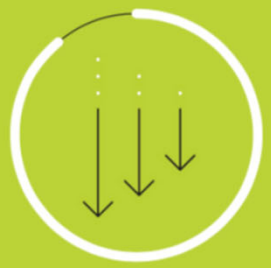
Members with a negative change from baseline RCI to their final RCI

27

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

People with Addiction

AT 60 DAYS OF COACHING:



89%
reduce the negative impact on their employment

79%
reduce involvement with criminal justice system because of addiction-related issues

AT 90 DAYS OF COACHING:

75%
reduce their healthcare usage because of addiction-related issues

75%
are now seeing a primary care physician

AT 120 DAYS OF COACHING:

83%
have more meaningful participation in their community

Loved Ones

AT 30 DAYS OF COACHING:

33% have more meaningful participation in their community

AT 60 DAYS OF COACHING:

38% now have people in their community that look to them for support

AT 90 DAYS OF COACHING:

69% are less likely to have addiction negatively impacting their employment

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** Note: SROI analysis conducted by Ecotone Analytics GBR.*

“Recovery capital constitutes the potential antidote for the problems that have plagued recovery efforts”

William White | recovery researcher and author

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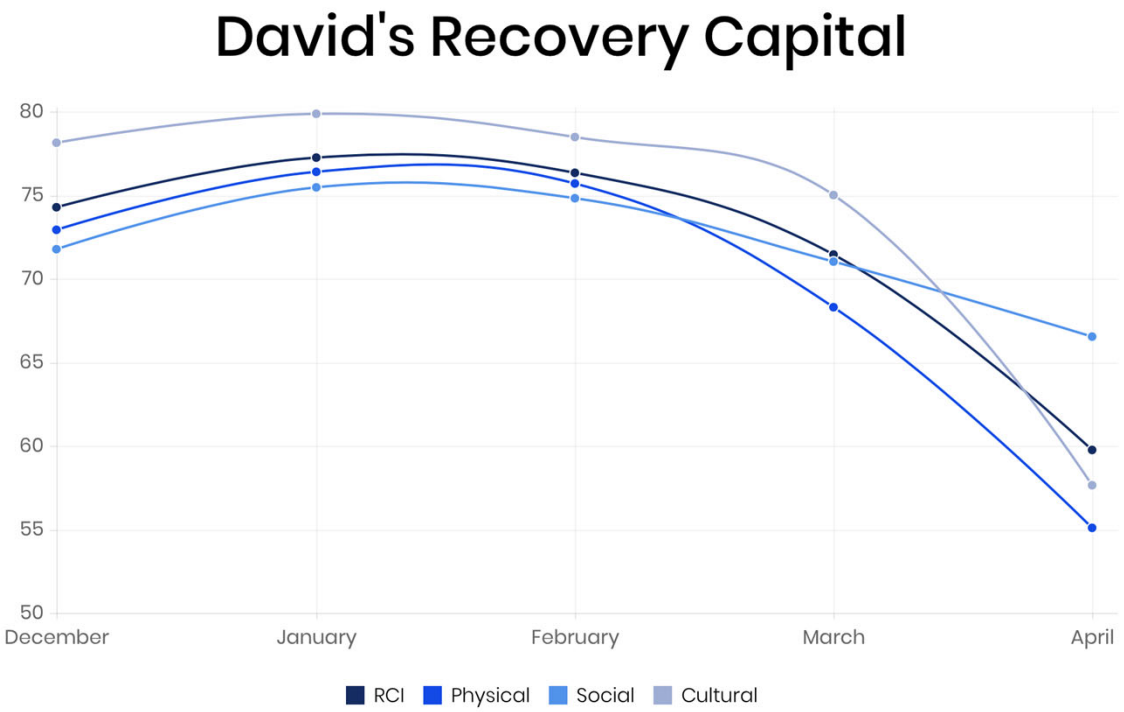

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Questions

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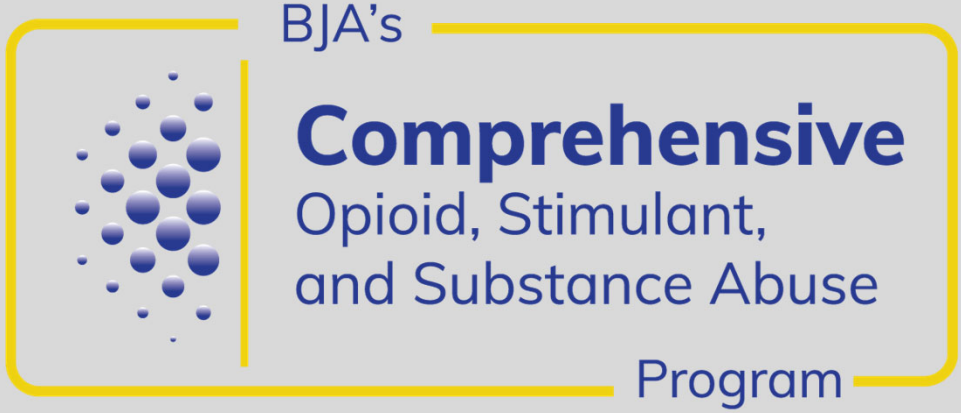
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