


**Recovery Oriented System of Care
Day 1**



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**Illinois Regional ROSC
Key Stakeholders Symposium**
March 21, 2011




Training Overview

- Why consider Recovery Oriented Systems of Care from a service recipient (also referred to as client or consumer) perspective
- Review ROSC framework beginning with definitions, principles and operational values within the ATTC Technology Transfer model
- Consider implications of recovery language, role delineation, and healthcare reform with a ROSC
- Engage participants in activities that will help them translate, disseminate, and adopt ROSC locally, with consideration of the ways in which systems that support recovery will change

Treatment is Effective





Achievements of Modern Behavioral Health Systems Include

- The quality and effectiveness of treatment (behavioral healthcare) has increased tremendously over the last 30 years
- Increased accessibility: from less than 50 to greater than 13k specialty addiction treatment programs
- Professionalization of addiction medicine & addiction counseling
- Systems of early intervention, EAP, SBIRT
- Increased awareness of the need for Evidenced Based Practices and co-occurring treatment interventions
- Screening/assessment/diagnostic tools




And Yet.....



NYC Outpatient treatment outcome

Completion rate on par w/ national average of 36% for outpatient modalities

Laudet, Stanick, & Sands, JSAT 2009




Challenges Facing Addiction Treatment Systems

- **Unmet Need:** > 20 million Americans need treatment, < 10 % seek or access it, and many arrive under coercive influences
- **Low Pre-Treatment Initiation Rates**
- **Low Retention:** > 50 % fail to complete treatment
- **Inadequate Service Dose:** most receive less than NIDA's recommended 90 day minimum dosage
- **Lack of Continuing Care:** only 1 in 5 receive post-discharge recovery plan
- **Recovery Outcomes:** 50% return to using within 1 year with 80% returning within the first 90 days
- **Revolving Door:** > 60% have one or more treatment episodes, 24% 3 or more, 50% readmitted within 1 year



Challenges Facing Mental Health Treatment Systems

- **Unmet Need 2001:** less than one half of adults with SMI receive treatment (SAMHSA)
- **Low Retention:** a quarter of individuals have contact with the public systems for 8 days or less (Bray et al., 2004)
- **Low Dose of Tx:** Insufficient doses of medication and short length of treatment have all been associated with poorer outcomes (DHHS, 1999, Young et al., 2001)
- **High Recidivism:** in higher levels of care, often leading to policies that limit access to care
- **Extremely High Burden of Disability:** When compared with all other diseases (such as cancer and heart disease), mental illness ranks first in terms of causing disability in the United States, Canada, and Western Europe, according to a study by the World Health Organization (WHO, 2001).



Historical Forces Leading to Long Term Recovery Focus

- Explosive growth in advocacy groups and mutual aid societies
 - **Cultural and political awakening of individuals/families in recovery**
 - Diversification of mutual aid
 - New recovery advocacy movement
 - New recovery support institutions
- Increasing frustration on the part of behavioral health providers



Where Are We Now?

Where Are We Now?




Where Are We Now?

Current Focus of Attention/Intervention:

Stages of Recovery


- Pre-Recovery Initiation
- **Recovery Initiation and Stabilization**
- Recovery Maintenance
- Quality of Life Enhancement
- Community Health

William White



There is some movement

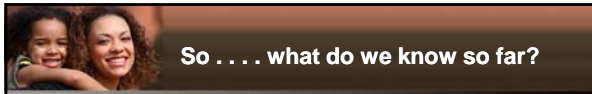
- Discovery that addiction shares many characteristics with other chronic medical disorders (McLellan, et al, 2000)
- Growing interest in addressing the question “how would we treat addiction if we really believed it was a chronic disorder?”
- Adopting models of “disease management” in primary health care to long-term management of addictive disorders



Addiction compared to other Chronic Illnesses: Relapse and Compliance Rates

Addiction/Chronic Illness	Compliance Rate (%)	Relapse Rate (%)
Alcohol	30-50	50
Opiate	30-50	40
Cocaine	30-50	45
Nicotine	30-50	70
Insulin Dependent Diabetes		
Medication	<50	30-50
Diet and Foot Care	<50	30-50
Hypertension		
Medication	<30	50-60
Diet	<30	50-60
Asthma		
Medication	<30	60-80

O'Brien CP, McLellan AT 91996). Myths about the Treatment of Addiction. The Lancet, Volume 347(8996), 237-240

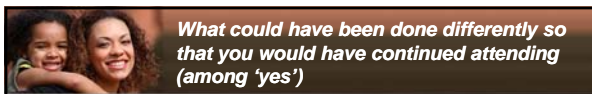


So . . . what do we know so far?

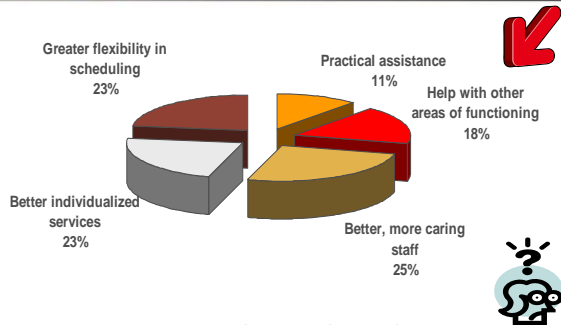
- Current treatment systems are effective
- Challenges are becoming critical
- Many forces are pushing for treatment systems to focus on Recovery as a new paradigm that goes beyond treatment as usual

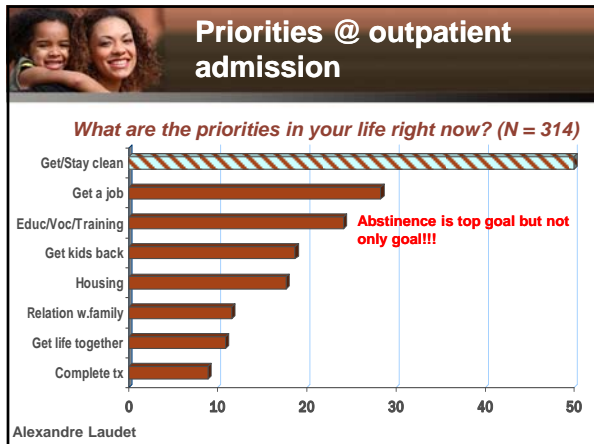


What do service recipients really want from treatment providers?



What could have been done differently so that you would have continued attending (among 'yes')








Why Transformation: A Person's Perspective


I've been struggling with trying to maintain recovery for fifteen years....I've been in other programs, got some good treatment....but for me, for me this was the missing ingredient right here. This is what I needed to not just get clean but stay clean. Because it helped me to identify and realize what I need to do with my life after I'm clean. It's given me a sense of purpose, you know. I spent all those years drinking and drugging and it was like, now that I'm clean what am I going to do with my life?

Barbara, person in recovery, Amistad Village Project



Conceptual & Language Clarity

Recovery management (RM) is a philosophical framework for organizing addiction treatment and recovery support services across the stages of pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality of life enhancement for individuals and families affected by severe substance use disorders.




Recovery Management Application and Stages of Recovery

Focus of attention/intervention:

Stages of Recovery

- Pre-Recovery Initiation
- Recovery Initiation and Stabilization
- Recovery Maintenance
- Quality of Life Enhancement
- Community Health

William White



1. Attraction, Access & Early Engagement

AC

- 10% access data; late stage and under coercion; waiting list drop-out data; attrition data (more than 50% will not complete)

RM

- Assertive community education & outreach
- Assertive waiting list management
- Lowered threshold of engagement; rethinking motivation; institutional outreach
- Changes in administrative discharge policies




2. Screening, Assessment & Placement

AC

- assessment is categorical, pathology-focused, professionally-driven, an intake function & focused on individual
- placement based on problem severity.

RM

- assessment is global, strengths-based, client focused (rapid transition to recovery plans), continual and encompasses the individual, family and recovery environment
- recovery capital factored into placement decisions




3. Composition of the Service Team

AC

- model uses disease rhetoric but few medical personnel
- recovery rhetoric but decreasing involvement of recovering people

RM

- expands role of medical (including primary care physicians) and other allied professionals, recovering people (P-BRSS) and culturally indigenous healers
- emphasizes reinvestment in volunteer and alumni programs




4. Service Relationship

AC

- dominator model
- emphasis on professional authority, great power discrepancy, role of client is one of compliance

RM

- sustained recovery partnership (long-term consultation) model
- emphasis on prolonged continuity of contact, client as co-leader, philosophy of choice, greater use of personal/professional self, contrasting ethical guidelines



5. Service Dose, Scope & Quality

AC

- model has become ever briefer, narrower via reimbursable services & continues to incorporate methods lacking scientific support

RM

- model emphasis on importance of dose (NIDA principles—90 days), role of ancillary services and weeding out practices that are not linked to recovery outcomes or that may produce inadvertent injury



6. Locus of Service Delivery

AC

- model locus is the institution: How do we get the individual into treatment, get them from their world to our world?
- problem of transfer of learning

RM

- model emphasizes the ecology of long-term recovery: How do we nest recovery in the natural environment of this individual or create an alternative recovery-conducive environment?



7. Assertive Linkage to Communities of Recovery

AC

- passive linkage, low affiliation and high early attrition, single pathway model of recovery

RM

- assertive linkage, multiple pathway model of recovery, linkage beyond recovery mutual aid groups
- active relationship with local service committees, involved in recovery community resource development



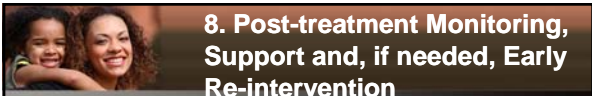
8. Post-treatment Monitoring, Support and, if needed, Early Re-intervention

AC

- “Aftercare” as an Afterthought
- only 1 in 5 (McKay, 2001) to 1 in 10 (OAS, SAMHSA, 2005) adult clients receive such care (McKay, 2001) and only 36% of adolescents receive any continuing care (Godley, et al, 2001)

Even though

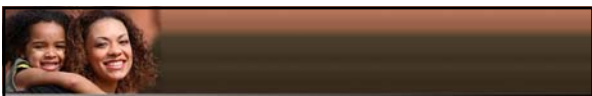
- Post-discharge continuing care can enhance recovery outcomes (Johnson & Herringer, 1993; Godley, et al, 2001; Dennis, et al, 2003)



8. Post-treatment Monitoring, Support and, if needed, Early Re-intervention

RM

- Post-treatment monitoring & support (recovery checkups)
- Stage-appropriate recovery education & coaching
- Assertive/continued linkage to recovery resources
- Early re-intervention & re-linkage to Tx and recovery support resources
- Recovery community building

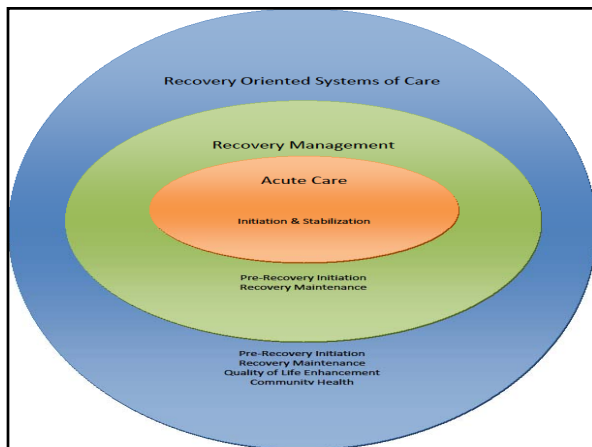


RM does not eliminate the AC model



Conceptual & Language Clarity

Recovery-oriented systems of care (ROSC) are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by co-occurring disorders. **The *system* in ROSC is not a treatment agency but a macro level organization of a community, a state or a nation.**





Conceptual & Language Clarity

Recovery-oriented systems of care (ROSC) are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by co-occurring disorders. **The *system* in ROSC is not a treatment agency but a macro level organization of a community, a state or a nation.**

What Helps?

Sources of support in long-term recovery

Pathways pilot (N = 52 CCAR members, median abstinence duration 12 yrs)

Source of Support	Percentage
Spirituality/faith	53%
Family	53
Recovering peers	43
Spouse	18
Self/inner strength	17
Friends	11
Clinicians	7

Laudet, Savage & Mahmood, J. Psychoactive Drugs, 2002

RECOVERY

Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life.



RECOVERY-ORIENTED SYSTEMS OF CARE (ROSC)

A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.






Values Underlying a ROSC

Operational Elements of a ROSC

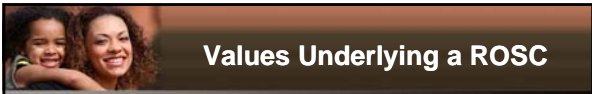




Values Underlying a ROSC

- **Person-centered**
ROSC places the individual at the center of the services and supports offered. ROSC recognizes that there are **many pathways** to recovery, including treatment, peer-to-peer recovery support, faith-based recovery support, medication-assisted recovery, and others.

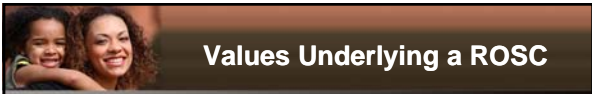
ROSC offers choice among a **flexible menu of services and supports** designed to meet each **individual's specific needs**.



Values Underlying a ROSC

- **ROSC is self-directed**

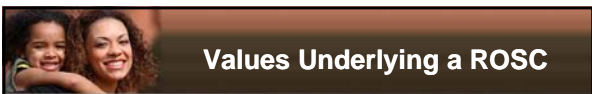
In a ROSC, the service recipient is **encouraged and assisted** in exercising the greatest level of **choice** and **responsibility** of which he or she is capable.



Values Underlying a ROSC

- **Strength-based**

ROSC identifies and builds on the assets, strengths, resources, and resiliencies of the **individual, family, and community**, rather than emphasizing needs, deficits, and pathologies.



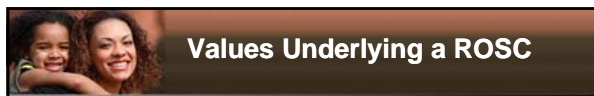
Values Underlying a ROSC

- **Participation of family members, caregivers, significant others, friends, community**

ROSC acknowledges the **role** family members, caregivers, significant others, friends, and the community can play in the **recovery process**.

Family members, caregivers, significant others, friends, and other allies are incorporated, whenever appropriate, in recovery planning and recovery support.

Additionally, a ROSC recognizes that family members, caregivers, significant others, friends, and other allies may have their own needs for supports or services.

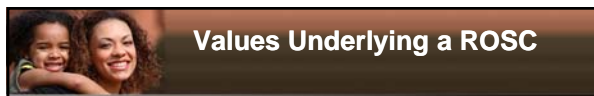


Values Underlying a ROSC

• **Individualized, comprehensive services and supports**

ROSC recognizes that there are many pathways to recovery and promotes a **philosophy of individual choice**.

ROSC offers a broad array of supports to meet the holistic needs of the individual. Services are designed to **support recovery** across the **lifespan**, with the understanding that needs and resources shift and change with age and life-stage, as well as **over the course of recovery**.



Values Underlying a ROSC

• **Community-based services and supports**

ROSC is situated within and draws on the **strengths, resilience, and resources of the community**, including professional and **non-professional** organizations and groups such as:


- Community-based organizations
- Recovery Community Organizations (RCOs)
- Faith-based Organizations
- Civic Organizations
- Schools, etc.




Operational Elements of a ROSC


• **Collaborative decision-making**

Service recipients are **empowered and supported to collaborate** with professionals, peers, and other formal and informal service providers to **direct their own recovery** to the greatest extent possible.

 **Operational Elements of a ROSC**

- **Continuity of services & supports**
Coordination ensures **ongoing** and **seamless connections** with services and supports for **as long as** the service recipient needs them.

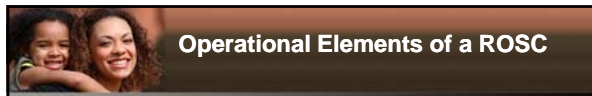


 **Operational Elements of a ROSC**

- **Service quality & responsiveness**
Services and supports are evidence-based, developmentally appropriate, gender-specific, culturally relevant, trauma-informed, family-focused, and **appropriate** to the person's **stage of life and stage of recovery**.

 **Operational Elements of a ROSC continued**

- **Multiple stakeholder involvement**
Involving **all segments of the community** including treatment and recovery professionals, policy-makers, administrators, people in recovery, family members, representatives from allied health and social service agencies, community leaders, and others with concern for substance use disorder recovery **promotes trust and transparency** in the design and delivery of services and supports.

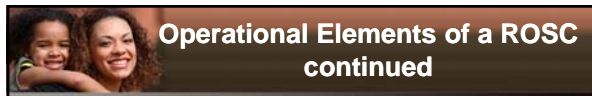


Operational Elements of a ROSC

▪ **Recovery community/peer involvement**

People in recovery and their family members, caregivers, significant others, friends, and other allies are included among **decision-makers** and have a meaningful role in service design, provision, and quality improvement. **They** are **involved** in the design of all systems, services, and supports.

Peer-to-peer recovery support services are included in the array of services offered and provided



Operational Elements of a ROSC continued

▪ **Outcomes-driven**

▪ **for the individual**

▪ **for the system**

Systems and service design and quality are **driven by performance data** that at a minimum achieve identified outcomes **for the individual as well as for the system.**



Operational Elements of a ROSC continued

▪ **Adequately and flexibly funded**

Federal, state, county, and municipal resources are coordinated to generate increased resources and strategically allocate resources. **Funding for a flexible menu of services is provided.**






Elements of a ROSC



Continuity of Services: Assertive Outreach, Engagement, and Early Intervention



Strategies to Promote Assertive Outreach and Engagement

- Engage potential service recipients through street and/or phone outreach when possible, helping to reduce anxiety and establishing rapport
- Peers as mentors during initial contact (welcome centers) utilizing charismatic and engaging peers in reception area
- Build strong linkages between levels of care through peer-based recovery support services (P-BRSS)
- Instill hope and increase expectations of positive treatment outcomes (e.g. invite people to storytelling sessions)
- Establish relationships with natural supports to promote early identification
- Implement assertive, warm handoffs



Strategies to Promote Engagement (cont'd) and Retention

- Use telephone based P-BRSS or tele-counseling or tele-video counseling to reach those in rural areas (Baca et al., 2007)
- Utilize telephone calls, reminder notes, emails etc. to strengthen engagement following missed appointments (peers)
- Change policies related to administrative discharge
- Work with criminal justice partners to develop graduated sanctions for relapse and/or low participation
- Offer flexible service hours
- Provide case management services to address obstacles and focus on life...

**Individualized Comprehensive Services and Supports:
Beyond Symptom Reduction**





Self Direction

Strategies

- Professionals support people in making their own choices
- Risk taking is supported even when failure is an option
- Goals and strategies are determined in partnership and are directed by the person in recovery
- Services are person centered and adapted to fit the needs and preferences of individuals. Menus of services and supports exist.



Strategies to Promote Individualized Comprehensive Services

- Co-occurring services
- Global, ongoing assessments
- Recovery plans
- Develop a flexible menu of services and a philosophy of choice
 - Life skills groups/opportunities (finances, physical health, parenting, stress management, spirituality, entrepreneurial skills, etc...)
 - Recreational and social opportunities
 - Trauma informed care
 - Supported employment opportunities
- Services in non-stigmatized settings
- Services integrated with physical health
- Mutually beneficial collaborations

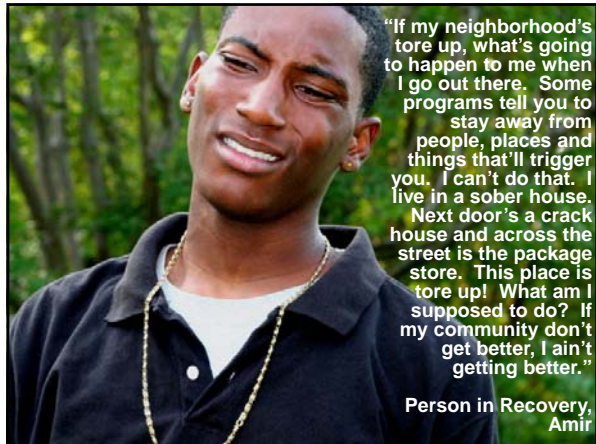


Continuity of Services and Supports: Supporting the Continuum of Wellness



Strategies to Promote Continuity of Services and Supports

- Identify and engage the allies who will be a part of the person's ongoing recovery plan EARLY in the treatment process
- Develop a continuing care plan that is directed by the person and which addresses all life domains and utilizes all of the natural/community supports strengthened during treatment
- Coach family members, friends and allies on supporting recovery
- Develop a menu of options for individuals to receive ongoing support and early re-intervention
- Utilize recovery coaches and peer support to help people develop or connect to a culture of recovery in their community
- Increasingly shift source of support from professionals to natural supports
- In areas that have few recovery resources, support the development of peer-led support groups



“If my neighborhood’s tore up, what’s going to happen to me when I go out there. Some programs tell you to stay away from people, places and things that’ll trigger you. I can’t do that. I live in a sober house. Next door’s a crack house and across the street is the package store. This place is tore up! What am I supposed to do? If my community don’t get better, I ain’t getting better.”

Person in Recovery,
Amir



Community Based Services and Supports:

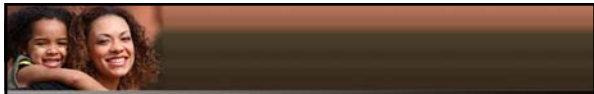
Community Health and Wellness



Strategies to Promote Community Integration and Community Health

- Services or supports that exist in the community are not re-created in treatment
- Services oriented around helping people to re-establish a life in the community
 - e.g. **Supported Employment**
- Address housing, transportation, and provide services that assist people in building skills
- Identify resources in the community and form strategic partnerships





So what model is out there to speed up technology transfer/systems change?






WOW!!!!

WHAT EXCITES YOU?

WHOA!!!!

WHAT EXCITES YOU?


WHAT CHALLENGES YOU?



**Let's See What You
And Your Region Are
Up To.**

**Promoting Cross System
Collaborations Within ROSC**





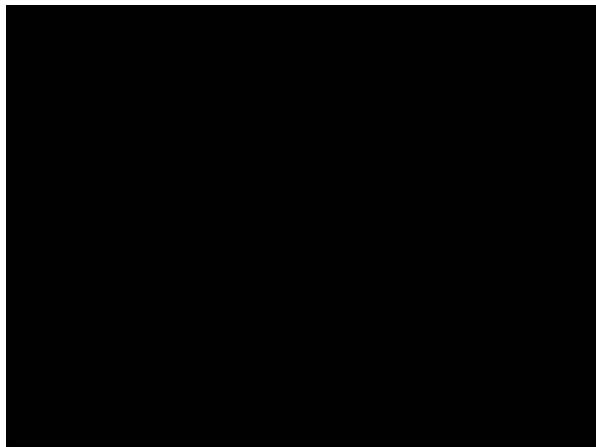
**Differences between MH
and Addiction Recovery**

- The challenge of language: "Chronic Illness"
- Differences in the type, frequency and duration of ongoing support?
- Substances are powerfully reinforcing
- Peers historically had a role in addiction recovery, leads to the need for role clarification between a recovery coach, counselor and a sponsor
- In SMI recovery may involve ongoing management of symptoms
- Different Concepts of Recovery?



Similarities between MH and Addiction Recovery

- The ultimate goal of recovery transformation is the same: a meaningful, fulfilled life in the community
- Both entail moving beyond a focus on symptom reduction and redefining oneself
- Family and community contexts can provide environments to promote wellness
- Both involve overcoming stigma
- Underlying principles are the same
- The process of systems transformation is the **SAME PROCESS...**
- The same types of services, supports and opportunities promote wellness in everyone





Benefits for Criminal Justice Systems and Populations

- Increased Attraction: People typically referred after very long addiction careers. ROSC provides increased opportunities for early intervention.
 - **First offenders programs**
 - **Early diversion programs**
- Increased Access: finite capacity of the treatment system leads to long waiting lists. CJ has an opportunity to expand the use of and develop recovery natural supports. Opportunities for partnership with both prevention, treatment, and grass roots community.
- Increased Engagement and Treatment Outcomes




Implications for Criminal Justice Systems and Populations

- Recovery Capital Assessments
- Implications of Chronic Care Approach: Importance of Graduated Sanctions
- Effectiveness of peer-support to assist with transitioning between cultures
 - **Illinois Inner Circle and Winner Circle**
- Appropriate dose, duration and intensity of treatment
- Continued monitoring AND support that integrates natural community based supports
- Holistic Sentencing Recommendations: Rebuilding lives within the context of communities
- Others??



Implications for Child Welfare

- Assertive Linkages
- Assessment of Recovery Capital
- Mobilization of Natural Supports
- Relevance of Recovery Planning
- Graduated Sanctions
- The Power of Peer Support
- Others?



Implications for Prevention Services

The Federal Perspective: "Prevention Prepared Communities"

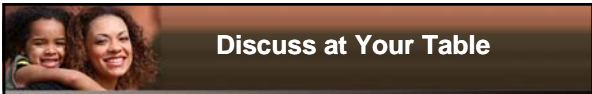
Community Systems Perspective

- Rather than addressing a single problem prevention efforts simultaneously consider a wide ranging set of problems
- Rather than focusing on individuals at risk, studies the entire community
- Employs interventions that alter the social, cultural, economic and physical environment rather than only individual behavior
 - Example: SPFSIG



Conceptual Integration of Prevention in a ROSC

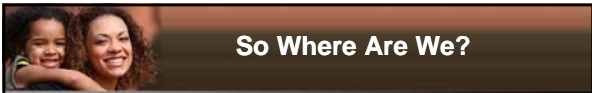
- People and their families exist on a continuum of health and wellness
- More holistic recovery planning will reveal opportunities for increased prevention services within a ROSC
- A ROSC expands the focus beyond individual health to **community health**, this entails promoting wellness for all
- Rather than diminishing the role of prevention services, developing a ROSC moves prevention into the mainstream



Discuss at Your Table


What are the implications for your particular field or the work that you do?

What activities come to mind that foster cross system collaboration within a ROSC?



So Where Are We?

- Take a minute to reflect on what we have discussed today
- We learned about Recovery, Recovery Management, and Recovery Oriented Systems of Care
- We learned that the Technology Transfer Model is indicated to disseminate the ROSC framework out into the field
- We discussed how it made us feel
- We looked at what we are doing at a regional level
- We looked at the implications of ROSC for us all across divisions, fields, etc.



So Were Are We?

WOW!!!

How about a little home work?

**Recovery Oriented System of Care
Day 2**



Rafael Rivera
Cherie A. Hunter
David Njabulo Whithers

**Illinois Regional ROSC
Key Stakeholders Symposium**
March 22, 2011

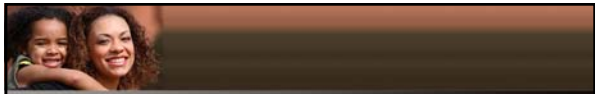


Recap


- We learned about Recovery, Recovery Management, and Recovery Oriented Systems of Care
- We learned that the Technology Transfer Model is indicated to disseminate the ROSC framework out into the field
- We discussed how it made us feel
- We looked at what we are doing at a regional level
- We looked at the implications of ROSC for us all across divisions, fields, etc.



Persons in Recovery (PIR), Peer-based Recovery Support Services (P-BRSS), and the Recovery Community: Integrating these components and forming a ROSC.



What do we know about persons in need of addiction recovery?



Basic Facts

- >20 million Americans are in need of treatment (recovery) and less than 10% (1.8 million) will access it
- Incessant decrease (> 30% over last 25 years alone) in both public and private funded treatment slots
- Women, single parents with young children, ethnic minorities and individuals from low socio-economic status do not access treatment at the same rate as White Americans or the affluent
- Field founded by people in recovery (PIR) but a constant decrease in the role that PIR play in treatment
- Treatment is the dominate method for leading people to recovery (abstinence based recovery, i.e. AA, NA, etc.)
- 50, 80, 90 reality is applicable across both public and private funded treatment programs


Vision Vs. Reality

<p>Vision 1935-1970</p>	<p>Reality 2011</p>
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**In a ROSC, what
do we mean when
we say
“recovery”?**


**T or F
Recovery is . . .**

- Abstinence from AOD
- Abstinence from AOD combined with 12-step support group attendance
- Abstinence from AOD combined with faith-based attendance
- Abstinence from AOD combined with 12-step and faith-based attendance
- Achieved through daily medication assistance – methadone, Vivitrol, Buprenorphine
- Best defined by the person pursuing it




PIR, aka Peers, Recovery Coaches, Peer-specialists, etc.

- Individuals who self-identify as persons in addictive and/or mental disorder recovery (some long-term others not-so-long) who utilize their lived experiences as a primary and in some cases sole credential for assisting others in overcoming their mental and or addictive disorder
- Their roles are quite different from
 - Sponsors
 - Clinicians
 - Two hatters (PIR who work in treatment)
- There is no hierarchy in a ROSC; the role of peers is equivalent to all other staff



Roles of Persons in Recovery

- *Assertive outreach workers:*
 - Responsible for engaging active substance users and individuals impacted by mental disorders and linking them with appropriate care (long-term recovery)
- *Peers:*
 - *Greeters* in treatment environments and faith institutions and are often times the first to encounter clients presenting for care (short-term recovery)
- *Recovery Coaches:*
 - Providers of peer-based recovery support services (P-BRSS) within treatment programs, faith-based programs, and Recovery Community Organizations (RCOs) , (before, during and post discharge)



Roles of PIR cont'd

- *Executive Directors* of both faith and secular treatment programs
- *Directors* of Recovery Community Organizations (RCO)
- *Evaluators* of treatment and recovery programs
- *Researchers* focusing on effectiveness of peer-based recovery support services



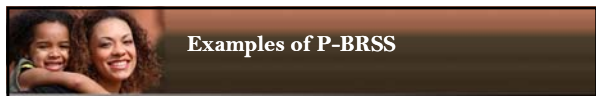
Robert Martin Peer Specialist

In the beginning it was very degrading at times, it was very intense between peer support staff and traditional staff. Their attitude in the beginning was “these people have these 2 weeks CPS training and who do they think they are to tell us how to do our jobs.” It was split right down the middle. It was us vs. them for a minute. Now the respect is on both sides. We compliment each other. The therapists learned that the stuff they write on the paper about what the person needs, we can actually go out in the community and get those things started.... They don't have to just be words on a paper anymore...



What are Peer-based Addiction Recovery Support Services (P-BRSS)

- Essentially they include “non-clinical” services provided by “members of 12-step, faith-based, medication assisted and mental health recovery communities” for “people in or seeking recovery” (For Us and By Us - FUBU) – Bill White refers to them as individuals who are “experientially credentialed”
- They are not intended to supplant addictive or mental disorder treatment programs, but instead are designed to augment and support these services



Examples of P-BRSS

- Assertive/street outreach programs
- Social detox programs
- Pre-recovery treatment programs
- Peer-led addiction treatment programs
- Peer-led transitional housing
- Recovery Centers
- Faith-based recovery support groups (Celebrate Recovery, Victorious Lady Seminar)
- Gender-specific support groups
- Health specific support groups (HIV, HCV, etc.)

Examples of P-BRSS cont'd

- LGBTQ specific support groups
- Social Entrepreneurial Programs - Recovery at Work (RAW)
- CAC training for people in recovery
- Multi-campus Recovery College (MCRC)
- SAVED SISTA Project (homeless communities and homeless shelters, medical and social detox programs, FQHC, 12-step, faith-based, and gender-specific recovery communities, apt complexes, outpatient and residential treatment facilities (addictive and mental disorder programs), LGBT community, and faith-communities)

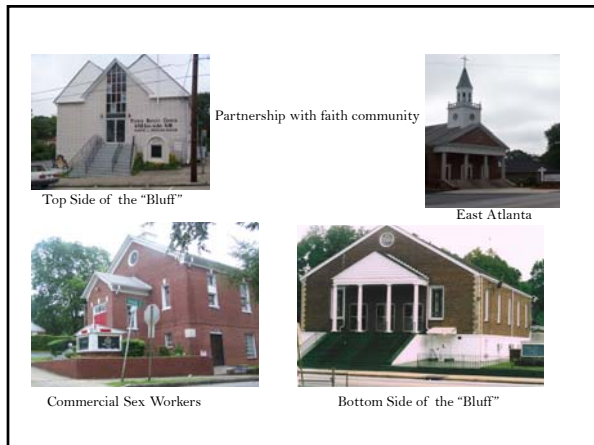






Recovery and Faith Communities: Integral Components of a ROSC

- *Mobilizing the 12-step recovery community*
 - *Service work extends beyond their 12-step community*
 - *Ongoing ethics training*
 - *Education on many pathways to recovery*
 - *Education on the value of combining formal learning with lived experiences*
- *Mobilizing the faith-community (recovering and non-recovering)*
 - *Encourage open-mindedness*
 - *Respect their recovery approach*
 - *Acknowledge their historical contributions*
 - *Look to them for leadership*







Outreach/Rapid Testing Team

- Volunteer staff (38) all members of Atlanta's 12-step and faith-based addiction recovery community



True or False

ROSC includes a major role for persons in recovery (PIR)

ROSC promotes a belief that treatment does not work

ROSC utilizes an acute care approach to treatment/recovery

ROSC will result in several addiction counselors being displaced

ROSC is based on a micro system philosophy

ROSC is expensive to implement

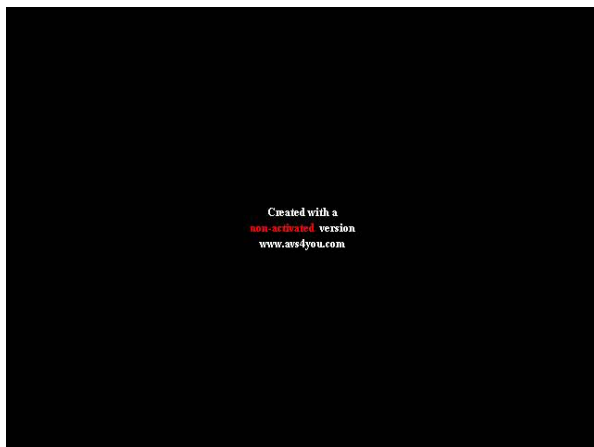
ROSC advocates a client-centered approach to recovery



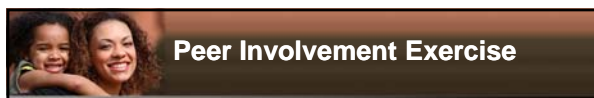
Strategies to Promote Peer Involvement

Gloria

After participating in all of the trainings I began to find power in sharing my story with others at the Consortium where I was going to get help for my mental illness issues. Now I am a presenter for Taking Recovery to the Streets, a two-day WRAP facilitator, member of Enon Tabernacle Baptist Church, have a new home, new car. I am employed as a file clerk, and I am a full-time student at the University of Phoenix online with a GPA of 4.0 in pursuit of my Associates Degree in Psychology. I am thankful to God and the Recovery Foundations (Training). I am "living Life to the Fullest!"

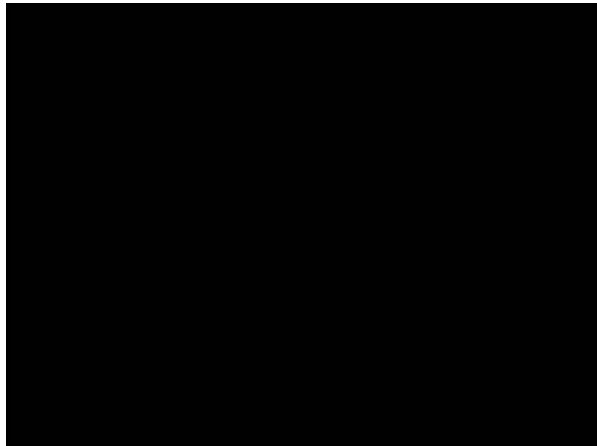


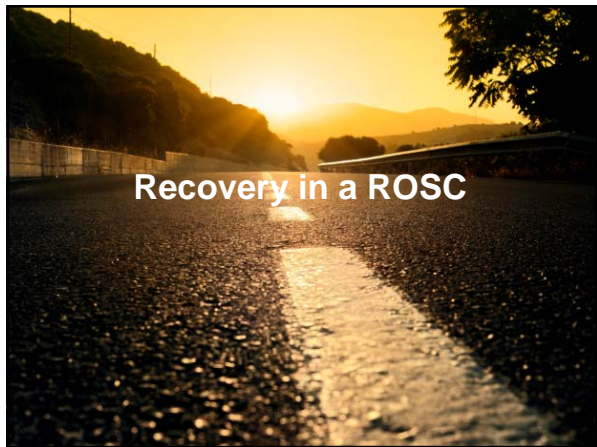
Created with a
non-advised version
www.ars4you.com




Peer Involvement Exercise


- Create an agency:
- What might a peer at your agency look like
 - Would they be a person in recovery or no or a mixture of persons in recovery and not in recovery
 - What type of services would they provide and in what environment
- Report Out






 ROSC Elements

What Does It Feel
and Look Like?



ROSC Elements

What Does It Feel and Look Like?




Tools: Where are your systems in the change framework?

Pre-Contemplation

- Stakeholders not giving any consideration to aligning services. They tend to defend existing service delivery systems and do not believe that there is a need to modify them.

Contemplation

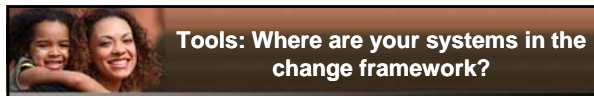
- Stakeholders see some of the challenges associated with the way in which services and systems are currently configured. They may be considering the possibility of aligning services but they are ambivalent and unsure of the long-term benefits.



Tools: Where are your systems in the change framework?

Preparation

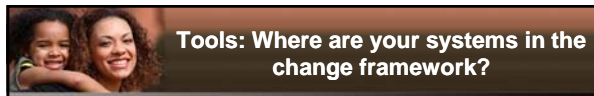
- Stakeholders have made a commitment to transforming their service system and are engaging in the necessary planning. During the Preparation stage, stakeholders focus on the development of a shared vision of a recovery oriented system of care, along with the identification of guiding principles or values that are relevant to their system and community.



Tools: Where are your systems in the change framework?

Action

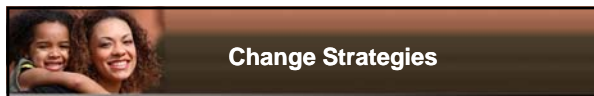
- Stakeholders are actively involved in aligning all levels of the service system with a recovery orientation. They are modifying their behavior and relational dynamics. Additionally, there is a considerable investment of time, energy and resources devoted to operationalizing all of the principles of recovery oriented care.



Tools: Where are your systems in the change framework?

Maintenance

- Stakeholders are engaged in activities to ensure that the practice changes in the system are sustainable. They ensure that recovery oriented care is supported by regulatory and fiscal alignment and that lessons learned are fed back into the system. The focus during this stage is on consolidating and reinforcing the gains made during "Action."




Change Strategies


Stages of Change	Major Focus of Alignment	Technology Transfer Phase
Pre-Contemplation	Conceptual	Awareness Raising
Contemplation	Conceptual	Knowledge Dissemination
Preparation	Conceptual and Practice	Adoption
Action	Practice and Contextual	Implementation
Maintenance	Practice and Contextual	Evaluation



Stage	Attitude Towards System Transformation	Area of Alignment	Core Strategies
Pre-contemplation	Treatment works sufficiently. We are just under-resourced. We need more money to provide an expanded service array but we don't see the need for a philosophical shift of any kind. We already provide recovery oriented care. There's no real urgency around increasing the coordination and integration of prevention and treatment services.	Conceptual	<p>Implement awareness raising activities to establish the need for change.</p> <p>Utilize national data to underscore national challenges and reduce defensiveness about the need for change locally.</p>




Stage	Attitude Towards System Transformation	Area of Alignment	Core Strategies
Contemplation	There are significant problems with the current design of the system but the obstacles to addressing them seem insurmountable. Alternatively stakeholders see the need for change but are not sure what to change and how to go about it. Recovery related practice changes are considered but the commitment to move in this direction may be diminished amidst concerns about low funding, system crises, and lack of clarity about how to proceed. There may be an awareness of the need to further coordinate prevention and treatment services in order to meet common goals, but minimal efforts have occurred to date.	Conceptual	In addition to the previous, implement strategies to increase the sense of urgency.




Stage	Attitude Towards System Transformation	Area of Alignment	Core Strategies
Preparation	We have decided and are going to make major changes in service philosophy and practices. Diverse stakeholder groups are being engaged in planning efforts. Concrete goals are being set to begin the process within the coming year. The role of both prevention and treatment within a ROSC are being explored. We are seeking support to help guide and sustain the process.	Conceptual Practice	In addition to the previous, increase understanding of how a ROSC is different from traditional systems and develop implementation plan.



Stage	Attitude Towards System Transformation	Area of Alignment	Core Strategies
Action	We are actively making changes in practices, philosophy and policies at all levels of the system. Stakeholders may perceive the process as energizing, chaotic and challenging. Prevention and treatment efforts are collaboratively working toward shared goals. Prevention efforts are leveraged to promote community wellness and increase general community and recovery supports. Lessons learned in different parts of the system are being disseminated to increase momentum	Practice Contextual	In addition to the previous, examine the implications that new practices have for all levels and aspects of the system.



Stage	Attitude Towards System Transformation	Area of Alignment	Core Strategies
Maintenance	We have come a long way. We are implementing recovery-oriented care throughout the system and the administrative structure has shifted to support this, but we recognize the need for continued improvement.	Practice Contextual	



Assessment Tools

- Several self-assessment tools in your packets geared to
 - Provider
 - Administrators/Managers
 - Family member/Significant other
 - Person in recovery



Transformation During an Economic Downturn?




Cost Neutral Strategies

- Mobilizing the community of people in recovery
- Holistic assessments
- Recovery planning
- Partnerships with natural supports
- Consultation approach
- Recovery check-ups
- Family Inclusion
- Menu of supports and services




Batten Down the Hatches?




DMHAS, CT

- Maximize existing service capacity
- Achieve savings by interrupting cycle of repeated crises and acute care admissions
- Reinvest savings into recovery supports and clinical services



Examples from CT (DMHAS)


1. Focus on community life and natural supports - development of supportive housing units for 550 individuals. Over 60% now working or in training and inpatient costs decreased by 70%.
2. Urban Initiative (Housing) 600% decrease in ER visits, 375% decrease in detox days
3. Recovery House – 69% connect to care versus 39% without recovery house stay



Examples from Connecticut

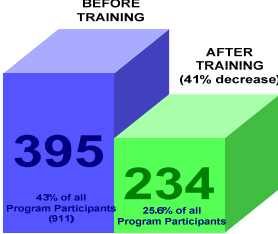
- 24% decrease in expenses
- 46% increase in number of people served statewide
- 62% decrease of acute care
- 40% increase in outpatient care
- 25% decrease in annual cost per client
- 14% lower cost with recovery support

From Kirk, in Kelly & White in press



Increase in Community Participation: Transportation

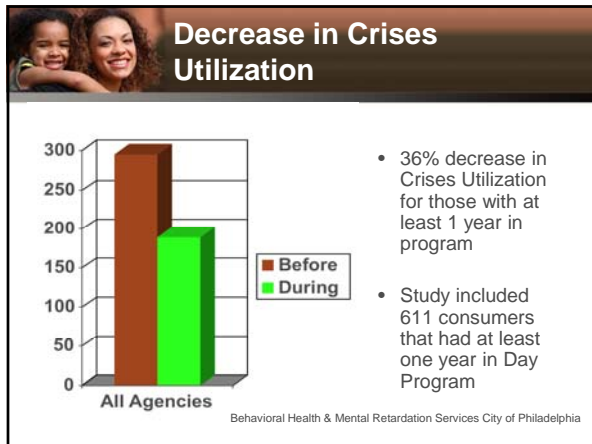
PERSONS USING MEDICAID FUNDED VAN TRANSPORTATION BEFORE & AFTER PUBLIC TRANSIT TRAINING

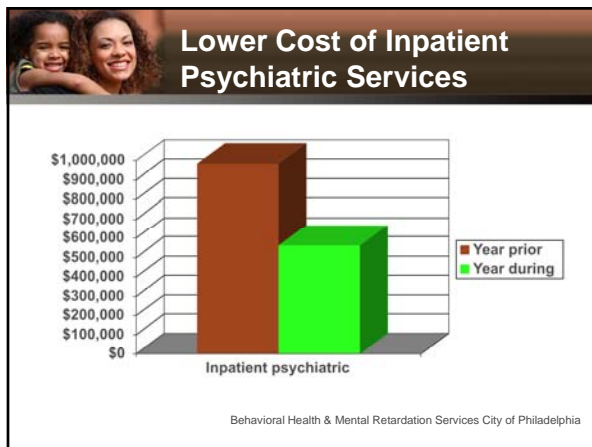


Category	Count	Percentage of all Program Participants
BEFORE TRAINING	395	43% of all Program Participants (913)
AFTER TRAINING (41% decrease)	234	25.6% of all Program Participants

Behavioral Health & Mental Retardation Services City of Philadelphia

\$951,300 ANNUALIZED MEDICAID SAVINGS





Provider Perspective

Joe Schultz, NET, Philadelphia

There's been a huge turnaround in outcomes. Consumers do better.....We have more people completing treatment than we've ever had!Even when they leave early the peer specialists are able to reengage a lot of them. That didn't happen before. The attendance rate has gone from 50% to over 75%...now counselors feel they are actually helping people. They can actually see the results of all the work they do...

What Can You Do?


We Are Not Done Yet!

What are three things that you can do within the next 3 weeks?

Implications For States & Providers

- **Need For Infrastructure To Work With Insurance**
- Grant Funds Re-conceptualized To Not Duplicate Insured Benefits
- Medicaid Changes and State Insurance Mandates
- **Integration of MH/SU with Primary Care**
- Health Homes and Accountable Care Organizations
- **Electronic Health Records**
- Payment Reform Pilot Programs
- **Evidence Based Practices**
- Licensure and Credentialing Standards





Please fill out the
evaluations that are in
your packet.

Thank You



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