

Summary of the Center for Substance Abuse Treatment's (CSAT's) Regional Recovery Meetings

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**Substance Abuse and Mental Health Services Administration (SAMHSA)
Center of Substance Abuse Treatment (CSAT)**

**Summary of the Center for Substance Abuse Treatment's (CSAT's)
Regional Recovery Meetings**

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Executive Summary

The Center for Substance Abuse Treatment's (CSAT's) Partners for Recovery Initiative (PFR) conducted five regional recovery meetings between April 2007 and January 2008, to build on the work on recovery-oriented systems of care (ROSCs) initiated at CSAT's National Summit on Recovery. The meetings were designed to achieve several goals including: informing individuals about the National Summit on Recovery; providing resources related to the operationalization of ROSCs; allowing States and organizations to share lessons learned; and providing a venue for individual State team planning. Further, the meetings expanded and continued a dialogue across the country about recovery-oriented system change.

All 50 States, the District of Columbia and Puerto Rico were invited to send teams to attend the meetings. The regional recovery meetings included teams from all, but one State. The meetings were held in the: Western Region, Portland, Oregon; Southwest Region, Dallas, Texas; Central Region, Chicago, Illinois; Northeast Region, Newport, Rhode Island; and Southeast Region, Charleston, South Carolina. Participants included a diverse group of 210 individuals that serve as change agents in their respective States. They included: 17 Single State Authorities (SSA) and 34 SSA designees; 50 treatment providers or treatment provider association representatives; 48 representatives of recovery organization or of the recovering community; eight faith-based providers; two recovery/faith-based providers; one treatment/faith-based provider; 20 research representatives; and 30 other types of stakeholders.

The guiding principles and system of care elements developed at the National Summit served as a foundation for the meetings' discussions and for a proposed recovery-oriented systems improvement framework. The framework, which applies a comprehensive public health approach to implement the systems elements, is a tool to support policy development and planning to address substance use problems and related health conditions. Fundamental to the framework is the vision that systems and services should be responsive to the needs and desires of individuals, families, and communities and support health, wellness, and recovery.

Lessons Learned

An outcome of the meetings was the lessons shared by individuals implementing systems change efforts within States, cities, organizations, and communities. The lessons demonstrated that:

- Systems change requires conceptual clarity, overcoming resistance, organizational commitment, and strong leadership.
- An infrastructure is needed to support the process, including staff planning, management resources, education and training.
- Definition of roles and responsibilities are important to prevent confusion.
- A perfect plan is not necessary to begin the change process.
- Change agents in one's State can greatly assist in the implementation process.
- A process which involves transparency among the partners creates greater trust.
- Constant communication is essential to secure a commitment from others and to keep the process moving in a positive direction.

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General Impression across the United States: Where are States in their Development and Implementation of Recovery-oriented Systems Change?

A general picture of where States are in planning and implementing ROSCs was formed through the regional meeting process. Some States have begun planning and implementing ROSCs; others are starting to plan ROSCs; and others have not yet begun to plan this systems change effort. The assessment of States' implementation is as follows:

- Five States (10 percent of the States participating in the regional meetings) have begun planning and actively implementing ROSCs.
- Eighteen States (35 percent) are implementing systems elements and are beginning to plan implementation of ROSCs.
- Twenty-two States (43 percent) are implementing individual or several systems elements.
- Six States (12 percent) are considering implementation of ROSCs.

Findings from Regional Planning Sessions

When asked about their definition of ROSCs, the majority of States in all regions emphasized the importance of a full continuum of care, which utilizes multiple systems and integrated systems of care. Most States identified the importance of educating and promoting the concept of recovery and the value of ROSCs to States, communities, and providers and collaborating across systems of care as necessary steps to implementing ROSCs. When asked about implementation activities that States had already taken, States across all regions reported that they had conducted systems-building efforts (e.g., planning and developing partnerships) to engage multiple stakeholders in the designing and implementation.

States reported great similarity in the challenges to implement ROSCs. Across all regions, the primary challenge identified was inequitable, inadequate, and inflexible funding streams for treatment and recovery support services. Additional challenges included: resistance to change from multiple sources, including resistance from treatment and recovery support providers; lack of knowledge on ROSCs; and stigma and discrimination related to addictions. Finally, States provided concrete activities they were prepared to take over the next 12 months. However, due to States being at different stages in implementing ROSCs, a range of activities were planned.

Outcomes and Next Steps

The meetings provided a forum for States to develop a brief action plan to implement recovery-oriented systems change over the next 12-months. They are a tool that teams can use to broaden the dialogue and continue the planning process in their States.

CSAT will continue to support recovery-oriented systems improvement efforts. The agency is engaged in a variety of activities and is developing resources to support States and communities in implementing ROSCs.

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I. Regional Recovery Meetings: An Overview

The Center for Substance Abuse Treatment's (CSAT's) regional recovery meetings were designed to build on the work initiated at CSAT's National Summit on Recovery. The goals of the meetings included: informing individuals about the National Summit on Recovery; providing resources related to the operationalization of ROSCs; allowing States and organizations to share lessons learned; and providing a venue for individual State team planning.

In September 2005, the Center for Substance Abuse Treatment (CSAT) convened the National Summit on Recovery. Through that process, a broad-based consensus on the guiding principles of recovery and elements of recovery-oriented systems was reached at a national level. This effort provided a general framework to begin a larger conversation across the nation about recovery-oriented systems of care (ROSCs). The Summit participants recommended that one of the next steps in developing ROSCs include a series of regional meetings to continue the dialogue and encourage State development. Beginning in April 2007 and ending in January 2008, CSAT's Partners for Recovery Initiative (PFR) sponsored five regional meetings across the country to assist States and communities in this process.

The guiding principles and system elements, which were developed at the National Summit and laid for the foundation for the proposed recovery-oriented framework, are presented below:

Guiding Principles of Recovery

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery involves a personal recognition of the need for change and transformation.
- Recovery is holistic.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.
- Recovery emerges from hope and gratitude.
- Recovery is a process of healing and self-redefinition.
- Recovery involves addressing discrimination and transcending shame and stigma.
- Recovery is supported by peers and allies.
- Recovery is (re)joining and (re)building a life in the community.
- Recovery is a reality.

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Recovery-oriented Systems of Care Elements

- Person-centered
- Family and other ally involvement
- Individualized and comprehensive services across the lifespan
- Systems anchored in the community
- Continuity of care
- Partnership-consultant relationships
- Strength-based
- Culturally responsive
- Responsive to personal belief systems
- Commitment to peer recovery support services
- Inclusion of voices and experiences of recovering individuals and their families
- Integrated services
- System-wide education and training
- Ongoing monitoring and outreach
- Outcomes driven
- Research based
- Adequately and flexibly financed

Following the National Summit, CSAT collaborated with its partners to further synthesize the elements of ROSCs and then developed a draft definition and description. This information, along with the findings from the Summit and feedback from the field began to inform the development of a framework to support policy development and planning to address substance use problems and related health conditions. The framework identifies and defines specific guiding principles of recovery and recovery-oriented system of care elements and applies a public health approach to implement the elements. Fundamental to these principles and elements are that the systems and the services, as well as additional supports, should be responsive to the needs and desires of individuals, families, and communities.

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Preliminary ROSCs Definition

ROSCs can be defined as person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness, and recovery from alcohol and drug problems

ROSCs:

- Offer a comprehensive menu of services and supports that can be combined and readily adjusted to meet individuals' needs and chosen pathways to recovery;
- Encompass and coordinate multiple systems providing responsive and outcomes-driven approaches to care; and
- Require an ongoing process of systems improvement that incorporates the experiences of those in recovery and their family members.

The application of a public health approach emphasizes disease prevention and health promotion and represents a shift from the systems' current response to substance use problems. Like many other health conditions, substance use disorders can be managed, but not cured. Therefore, to disrupt the cycle of addictions, a public health approach that concentrates not only on the needs of those with chronic conditions, but on the needs of the general population is the preferred strategy. In the current addictions system, the focus and resources are primarily dedicated to responding and/or treating individuals with complex and chronic conditions. A public health approach responds to substance use problems in a comprehensive manner by addressing the needs of the entire population and by supporting prevention, early intervention, and health promotion. By combining a public health approach with the principles of recovery and system of care elements, ROSCs establish four broad goals to improve systems to support individuals, families and communities:

1. Support preventive strategies related to substance use problems and disorders;
2. Intervene early with individuals with substance use problems;
3. Improve outcomes; and
4. Support sustained recovery for those with substance use disorders.

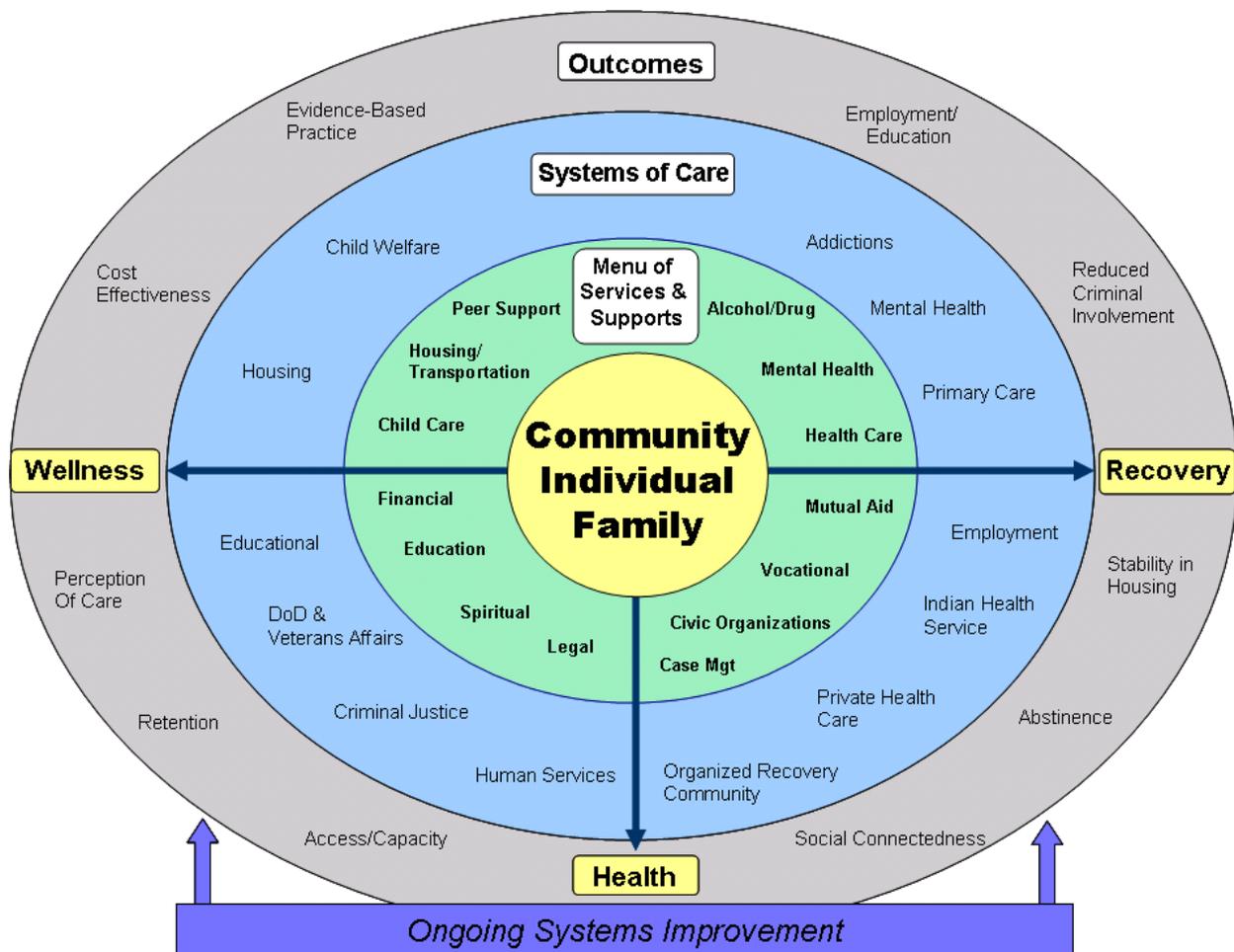
The ROSCs framework is a tool that States and communities can use to enhance and modify their structures based on their strengths and needs. The implementation of ROSCs is a dynamic process, which incorporates the input of individuals, families, and communities; establishes goals and priorities based on those factors; and institutes a continual process of reevaluation and systems improvement. The framework provides a structure for the addictions system to execute leadership in broadening the continuum of care to more effectively serve individuals, families, and communities and also provides a tool to work with a variety of formal and informal systems.

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Implementing ROSCs involves shared responsibility and partnerships. Although the addictions system is primary responsible for coordinating ROSCs activities, the ultimate outcomes of health, wellness, and recovery for individuals, families and communities must be a shared commitment. Individuals and family members are active contributors to the process; service providers, policymakers, systems professionals, and the community all have a role in supporting ROSCs. Within ROSCs, the role of the addictions system is to directly provide a comprehensive range of services for those at-risk of substance-use problems and those diagnosed with substance use disorders; to collaborate with other systems to access supports for clients within the addictions system; and to collaborate to improve the provision of substance use services within other systems.

This proposed concept of the framework is illustrated in the diagram below:

Proposed Recovery-Oriented Systems of Care Framework



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Implementing Recovery-Oriented Systems Change

There are many factors that have contributed to the need and desire for ROSCs, including the growth and diversification of recovery communities; the emergence of a new recovery advocacy movement; advances in science and technology; the release of influential reports (e.g., Institute of Medicine Quality Chasm Series); an increasing focus on collaboration and accountability; and the implementation of Federal and State initiatives. In response to these factors, stakeholders at the State and national levels began discussing the need for recovery-oriented systems change, and States and communities have initiated recovery-oriented efforts and have become learning laboratories for larger systems change efforts.

Many States, localities, and providers have been implementing elements of ROSCs for some time. However, several systems barriers have constrained systematic implementation. Traditional systems resistance to change, complicated legislative and regulatory issues, and insufficient resources have created impediments to implementing systems enhancements. Additionally, a policy and planning framework has not existed to support State and community change efforts. Although the development of the ROSCs framework is in the early stages of development, it provides a resource to structure local efforts. Using the basic framework, States and communities can initiate their own planning processes to enhance local systems. Basic planning steps include:

- Developing a conceptual framework;
- Performing assessments;
- Building capacity;
- Developing and implementing a plan;
- Performing evaluation; and
- Incorporating findings.

State and local plans must be specific to a planning area (e.g., State, city, county) based on the data collected, stakeholder input, and the goals and priorities for the area. The regional recovery meetings provided a venue to initiate or enhance State planning efforts.

PFR developed and disseminated several resources to the regional meeting participants to advance recovery-oriented approaches and provide information on ROSCs:

- *National Summit on Recovery Conference Report*
- *Approaches to Recovery-Oriented Systems of Care at the State and Local Level: Three Case Studies*
- *Provider Approaches to Recovery-Oriented Systems of Care: Four Case Studies*
- *Access to Recovery (ATR) Approaches to Recovery-Oriented Systems of Care: Three Case Studies*
- *Guiding Principles and Elements of Recovery-Oriented Systems of Care: What do we know from the research?*

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II. Attendees Background, Locations, and Dates of CSAT's Regional Recovery Meetings

Five regional meetings were conducted between April 2007 and January 2008:

- Western Region, Portland, Oregon, April 2007: 10 States
- Southwest Region, Dallas, Texas, July 2007: 9 States
- Central Region, Chicago, Illinois, September 2007: 8 States
- Northeast Region, Newport, Rhode Island, October 2007: 11 States
- Southeast Region, Charleston, South Carolina, January 2008: 12 States/D.C./territory

All 50 States, the District of Columbia, and Puerto Rico were invited to attend the meetings. All invitees were able to attend with the exception of one State.

Through the Single State Authority (SSA) for substance abuse services, each State was invited to send a four-member team to the regional meeting. SSAs were asked to send individuals with the authority to affect change within their State. State teams consisted of the SSA or designee; treatment provider association representative or a treatment provider; representative of a recovery organization or of the recovering community or faith-based provider; and a researcher, which could be substituted. States could elect to pay for a fifth participant to attend the meeting; nine States brought a fifth person. A total of 210 participants attended the regional meetings.

Participants included:

- 17 SSAs and 34 SSA designees (only one State did not send a SSA/SSA designee)
- 50 treatment providers or treatment provider association representatives
- 48 representatives of recovery organizations or of the recovering community
- Eight faith-based providers
- Two recovery/faith-based providers
- One treatment/faith-based provider
- 20 research representatives
- 30 other types of stakeholders

The participants can be further identified by the following information:

- Allied State/county level agencies (27 participants from a range of agencies including mental health and mental retardation, health and welfare, consumer affairs, public health, and purchasing)
- University professors (4 participants)
- CSAT grant programs (3 participants: 1 each from ATR, COSIG, SPF SIG)
- Specialty treatment providers (9 participants from organizations serving adolescents, dual disorders, adult/methadone treatment, child and families, women, etc.)
- Prevention providers (2 participants)
- Criminal justice/corrections (2 participants)
- Physicians (2 participants)

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- Charities (2 participants)

Other individuals who attended the meetings included:

- 14 representatives from ATTCs
- Nine speakers
- Three Federal government employees
- Three national organizations staff (LAC, FAVOR, and SAAS)
- Four consultants on the PFR Team

III. Outline of the Meetings

Although adjustments based on the evaluations were made to the five regional meetings, all of the agendas followed a similar schedule and included the same components. Ms. Shannon Taitt, CSAT's PFR Coordinator, opened each of the meetings with the following purposes:

1. To support planning and implementation of ROSCs at the State and community levels;
2. To allow time for States to plan future activities;
3. To provide resources to States; and
4. To learn what is occurring across the region regarding the development of recovery approaches and ROSCs.

Ms. Melanie Whitter of Abt Associates then provided a framework for the meeting's discussions by presenting on the National Summit on Recovery, the definition of recovery, the guiding principles of recovery, and the ROSCs elements. After Ms. Whitter laid the foundation for the meeting, the participants split into two breakout groups. These groups discussed the systems elements and provided feedback regarding their States' strengths and challenges in applying the elements.

Following the breakout groups, two presentations were given at each meeting. The presentations outlined strategies in implementing recovery-oriented systems change from perspectives of State representatives, local government officials, and treatment providers. During the remainder of the meeting, individual State planning teams met and States reported their brief action plans to the larger group. The individual State planning sessions were structured to support States in planning recovery-oriented systems change. States were then invited to present components of their State plans, including the steps necessary, steps already taken, and the steps they are prepared to take over the next 12 months to implement their change plans. After each regional meeting, PFR provided participants a summary of the meeting.

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IV. Overview of Panel Presentations and Lessons Learned

Individuals leading systems change efforts were invited to present information on their approach to implementing ROSCs. Speakers provided information on the ways in which their States, cities, organizations, and communities operationalized ROSCs. An overview of each speaker's presentation is shown below. The speakers also provided lessons learned and recommendations that are described at the end of this section.

April 2007 – Northwest Region: Portland, Oregon

- Christina Dye, Bureau Chief of Arizona's Bureau of Substance Abuse Treatment and Prevention,
- Karen Wheeler, MA, Manager in the Addictions and Mental Health Division at Oregon's Department of Human Services

July 2007 – Southwest Region: Dallas, Texas

- Don Coyhis, founder of The Wellbriety Movement and White Bison
- Jennifer Horvath, Project Manager of Health Care Systems at Connecticut's Department of Mental Health and Addiction Services

September 2007 – Central Region: Chicago, Illinois

- Michael Boyle, MA, President and CEO of Fayette Companies
- Deborah Hollis, MPA, from Michigan's Division of Substance Abuse and Gambling Services

October 2007 – Northeast Region: Newport, Rhode Island

- Paul Radomski, Administrator of Adult Community Mental Health and Alcohol and Other Drug Abuse Services at the Milwaukee County Department of Health and Human Services
- Jennifer Horvath, Project Manager of Health Care Systems at the Connecticut's Department of Mental Health and Addiction Services

January 2008 – Southeast Region: Charleston, South Carolina

- Arthur Evans, PhD, Director of the Philadelphia Department of Behavioral Health and Mental Retardation Services
- Candace Hodgkins, PhD, LMHC, Senior Vice President of Clinical Services Administration for Gateway Community Services (GCS)

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Overview of Presentations

Regional Meeting 1: April 2007 – Northwest Region, Portland, Oregon

Christina Dye, Bureau Chief of Arizona's Bureau of Substance Abuse Treatment and Prevention, presented on Arizona's experience in creating their recovery-oriented system. Beginning in 2001, there was a major shift in focus within the Arizona Department of Health Services/Division of Behavioral Health (ADHS/DBHS). The system evolved to include the reliance on licensed provider agencies and the development of non-traditional support providers. One of the goals of this transformation was to diversify and expand the workforce through non-traditional providers, including those with bilingual and bicultural competency. Another goal was to maximize Medicaid reimbursement for a growing entitled population. The Health Care Common Procedure Coding System (HCPCS) H codes for substance abuse, mental health, and behavioral health services were developed and approved for reimbursement by the Centers for Medicare and Medicaid Services (CMS). Additionally, Arizona developed an 80-hour class in skills and competencies of peer support specialists. Enrollees earn college credit through South Mountain Community College, and the University of Arizona offers a similar program through the Recovery Support Specialist Institute.

Karen Wheeler, MA, Manager in the Addictions and Mental Health Division at Oregon's Department of Human Services, discussed Oregon's phased process to implement ROSCs. In 2006, Oregon initiated a recovery-oriented systems change process. The Division crafted the *Resilience and Recovery Policy Statement* as their vision statement for the change effort. To inform the process they have: 1) conducted focus groups to capture the perspective and insight of individuals in recovery; 2) collected data and extensively analyzed their programs, policies, and data; and 3) implemented evidence-based practices and developed Recovery Homes/Oxford Houses. To further implement ROSCs, Oregon is reviewing and analyzing: 1) payment mechanisms; 2) regulatory issues, which include a process of reviewing and revising administrative rules and processes for quality assurance; 3) integration of case management into the Medicaid benefit package; and 4) promotion of peer-delivered services.

Regional Meeting 2: July 2007 – Southwest Region, Dallas, Texas

Don Coyhis, founder of The Wellbriety Movement and White Bison, presented on how Native Americans are intricately involved in the recovery process of their community and members through the Wellbriety Movement. The Wellbriety Movement is based on the Four Laws of Change for Native American community development that provide a culturally-specific view of healing and recovery from the American Indian Medicine Wheel. The Four Laws are: 1) change comes from within; 2) development must be preceded by a vision; 3) a great learning must take place; and 4) you must create a healthy forest and the whole community needs to be part of the healing process. Wellbriety combines the philosophies of Alcoholics Anonymous and 12-step programs with the cultural teachings of the Medicine Wheel. This integration helps to provide a culturally appropriate and spiritually familiar context to the 12-step program.

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Jennifer Horvath, Project Manager of Health Care Systems at Connecticut's Department of Mental Health and Addiction Services (DMHAS), discussed Connecticut's strategy for change and the implementation of ROSCs. The State's strategy integrated a multi-year implementation process, including: consensus building; technology transfers to utilize "best practices"; incorporating existing initiatives; re-orientation of systems to support recovery; and a transition of providers to recovery-oriented performance outcomes. In 2002, DMHAS issued the *Commissioner's Policy Statement No. 83: Promoting a Recovery Oriented Service System* that defined recovery and recovery-oriented systems. Following the policy statement, Connecticut developed Practice Guidelines for Recovery-Oriented Behavioral Health Care that included instructions on participation, promoting access and engagement, continuity of care, identifying barriers, and individualized recovery.

Regional Meeting 3: September 2007 – Central Region: Chicago, Illinois

Michael Boyle, MA, President and CEO of Fayette Companies, discussed Behavioral Health Recovery Management (BHRM) as a component of ROSCs. The mission of BHRM is to apply the principles of disease management to assist in serving individuals with chemical dependency and/or serious mental illness. It is a collaborative model which brings together services, consumers, and traditional and non-traditional service providers. The principles are: 1) recovery focus, instill hope and support people's strengths; 2) individual empowerment; 3) fight stigma; 4) utilize evidence-based practices; 5) match type of treatment to specific individuals; 6) application of technology; 7) service integration; 8) recovery partnership – moving the professional relationship from an expert service provider to a recovery consultant; 9) develop and utilize recovery support in the community; 10) ongoing support and monitoring; and 11) continual evaluation.

Deborah Hollis, MPA, Administrator of Michigan's Division of Substance Abuse and Gambling Services, reported on the changes that are occurring at the State level in Michigan. On July 5, 2006, an Administrative Rule change went into effect to add four new licensing categories including case management, early intervention, integrated treatment, and peer recovery support services. This rule change served as the groundwork for larger system change efforts in the State. Michigan is working to integrate a wide range of systems, including corrections, child welfare, State police, and education into their recovery-oriented activities. The State is also working with the Great Lakes Addiction Technology Transfer Center (ATTC) to provide statewide training. Next steps for Michigan include forming ROSCs workgroups, continuing policy development, enhancing monitoring at various levels, and integrating technical advisory group recommendations.

Regional Meeting 4: October 2007 - Northeast Region, Newport, Rhode Island

Paul Radomski, Administrator of Adult Community Mental Health and Alcohol and Other Drug Abuse Services (AODA) at the Milwaukee County Department of Health and Human Services (DHHS) discussed DHHS's process for redesigning their system. In May 2003, the Milwaukee DHHS determined their system required a redesign and formed the AODA Re-Design Community Coalition (RDCC). The RDCC's function was to examine the system in four areas:

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service system access, service array, evaluation, and information system. The end product was the development of an AODA "Blueprint" with the ultimate goal of re-designing the system. A key component in the system change effort is the provision of comprehensive screening and access to the system through four central intake units. These units provide screening and assessment that identifies the type of AODA treatment and recovery support services appropriate for the individual. There are a wide array of services offered, including medically monitored detoxification, community residential services, outpatient/intensive outpatient, day treatment, co-occurring disorder treatment, narcotic treatment services and an intoxicated driver program. Examples of recovery support services include transitional housing, child care, transportation, employment training and placement, and daily living skills. Additionally, Milwaukee County has funded a Recovery Support Coordinator (RSC) who works with the individual and other stakeholders to build a recovery plan.

Jennifer Horvath, Project Manager of Health Care Systems at the Connecticut's Department of Mental Health and Addiction Services, presented again at the Northeast regional meeting. Please see description above.

Regional Meeting 5: January 2008 – Southeast Region, Charleston, South Carolina

Arthur Evans, PhD, Director of the Philadelphia Department of Behavioral Health and Mental Retardation Services discussed the City of Philadelphia's transformation activities. In 2004, the Philadelphia Department of Behavioral Health and Mental Retardation Services (DBH/MRS) began a process of systems change. The city and partners spent considerable time analyzing their current system and the goals of recovery to inform the process. The Department also outlined 10 changes in service practices, including: 1) engagement and a greater focus on early identification; 2) greater use of assessment instruments; 3) increased service retention; 4) shift toward a philosophy of choice rather than prescription, empowering clients to manage their own recoveries; 5) quality of service relationship; 6) greater accountability for delivery of clinical services; 7) increase in dose and duration of total services and decrease in the number of acute care episodes; 8) emphasis on transfer of learning from institutional to natural environments; 9) post-treatment check-ups and supports; and 10) a welcoming attitude towards re-admitted clients. Philadelphia's transformation has involved cross-system collaboration among the Department of Human Services, Office of Supported Housing, the Court Systems, prisons, schools, and police. To further strengthen their efforts, they formed community coalitions, awarded mini-grants to providers and community-based organizations, supported faith-based initiatives, and created the Philadelphia Compact which is an initiative to improve children's social and mental health.

Candace Hodgkins, PhD, LMHC, Senior Vice President of Clinical Services Administration for Gateway Community Services discussed the importance of providing a wide array of recovery-oriented, person-centered services. When Gateway Community Services (GCS) was originally founded in 1978, the sole purpose was to treat alcoholics through detoxification and Alcoholics Anonymous. Through the years, the organization has evolved to become a comprehensive agency that focuses on holistic rehabilitation for individuals suffering from the mental, physical, and spiritual effects of addiction and related mental health problems. Gateway focuses on addiction as a chronic disorder and is abstinence-based. From 1989 to 2005, GCS purchased

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three properties to house men, women, and children of clients. GCS provides a wide array of recovery-oriented services, including e-therapy, on-site trauma services, legal support, job coaching, child development, transitional and permanent housing, and educational services, which are unbundled services so that individuals can move flexibly through the system based on individual need. GCS works with the clients to provide choices and supports engagement of clients into services at a rate suitable for the individual.

Lessons Learned and Recommendations

Based on the presenters' experience in implementing recovery-oriented systems change, they were asked to provide lessons learned and recommendations to the regional meeting participants. Their insights and recommendations are presented below.

Lessons Learned

Systems change requires conceptual clarity, overcoming resistance, organizational commitment, and strong leadership. An infrastructure is needed to support the process, including staff planning and management resources and education and training. Definition of roles and responsibilities are important to prevent confusion. It is not necessary to have a perfect plan to begin the change process. Change agents in the State can greatly assist in the implementation process. A process that involves transparency among the partners creates greater trust. Continual communication is essential to secure a commitment from others and to keep the process moving in a positive direction.

Recommendations

- Pursue efforts where early successes can be achieved.
- Promote accomplishments to motivate additional change activities.
- Use all tools available to the State, such as peer-to-peer services and case management.
- Conduct process, evaluation, and performance measurement at the beginning of the implementation process, make changes based on these analyses, and enhance monitoring of contracts for increased accountability.
- Involve clients and families at the State, provider, and community levels and use financing and other incentives to leverage systems change.
- Develop job descriptions and standards, enhance recruitment and training efforts, provide competitive pay, and create a code of ethics.
- Invest in a skilled grant writer.
- Conduct ongoing stigma reduction efforts.
- Use managed care technologies to accomplish public sector goals and share the vision of systems change with other States and communities.

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V. General Impression across the United States: Where are States in their Development and Implementation of Recovery-oriented Systems Change?

States are at different stages in conceptualizing and implementing recovery-oriented systems change. Participants expressed that the meetings assisted them in preparing and advancing ROSCs, as they provided an opportunity to share and learn from other State teams and provided time to develop a brief action plan. Through the presentation of the State plans, the meetings provided a general picture of where States are in planning and implementing ROSCs. The assessment of States' implementation is as follows:

- Five States (10 percent of the States participating in the regional meetings) have begun planning and actively implementing ROSCs. These States are actively adapting and are re-engineering their systems of care to become more recovery-oriented.
- Eighteen States (35 percent of the States participating in the regional meetings) are implementing systems elements and are beginning to plan implementation of ROSCs.
- Twenty-two States (43 percent of the States participating in the regional meetings) are implementing one or more systems elements.
- Six States (12 percent of the States participating in the regional meetings) are considering implementation of ROSCs.

VI. Regional and National Themes

Region-specific themes were not identified from the breakout groups and State planning sessions. This may be due to the fact that many States are at the early stages of implementing ROSCs. The meetings primarily served to raise awareness about recovery-oriented systems change and as an opportunity to reflect on accomplishments and to share ideas for future implementation. During the breakout sessions, States discussed the recovery-oriented systems of care elements in relation to their States' environments and their ability to implement ROSCs. Individual States offered many creative techniques and strategies to fund and deliver recovery-oriented services within their existing systems, while also noting specific challenges to implement ROSCs and the individual systems elements. Creative methods included:

- Providing partnership mini-grants and pilot projects for services.
- Funding innovative services through States' managed care mechanisms, including recovery high schools and sober dorms.
- Using contingency management and incentives to increase attendance and engagement of families.
- Supplying pre-treatment services as a response to long waiting lists for treatment services.
- Funding a prevention resource center which provides outreach, screening, and referral services.
- Requiring licensed Level I and II trauma centers to provide screening and brief intervention.

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States also discussed specific challenges that create difficulties in implementing ROSCs. These included:

- Identifying a common philosophy, articulate champions, and fearless leadership by policymakers.
- Having zoning for recovery housing impacted by NIMBY – not in my backyard.
- Assessing registered nurses and case management services for faith-based organizations.
- Gathering input from recovering persons who have not participated in treatment.
- Braiding substance use disorders and mental health disorders funding streams.
- Convincing constituents to invest in human capital and ROSCs.
- Reducing burdensome paperwork requirements to allow time for person-centered care/services.

The breakout sessions were designed to prepare individuals for the State planning sessions that followed and provided an opportunity for States to learn strategies from each other to operationalize ROSCs, while considering their own strengths. An analysis of the themes developed in the breakout sessions and State discussions is presented below.

Breakout Sessions

With the exception of the Northwest meeting, participants began the breakout sessions with a general discussion of the systems elements of ROSCs defined at the 2005 National Summit on Recovery. During the free-flowing discussion facilitated by a member of the PFR team, participants responded to several probes, which included:

- What are the definitions of the elements of ROSCs?
- Are any elements of ROSCs missing?
- Do you agree with the elements?

The discussions mainly centered on the following elements: individualized and comprehensive services across the lifespan; integrated services; system-wide education and training; outcomes driven; research based; and adequately and flexibly financed. Participants across the regions raised several similar themes regarding these systems elements. Themes included the importance of:

- Learning and working with other systems to provide a comprehensive range of individualized services.
- Integrating and collaborating with traditional and non-traditional systems (health care, faith-based organizations, education, and criminal justice) and working across territorial boundaries.
- Training/educating all systems of care on addictions treatment and recovery.
- Piloting the integration of ROSCs and validating that ROSCs are effective.
- Developing flexible funding, policies, rules, and practices.

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Additionally, when participants were probed on missing elements to the draft ROSCs framework, addressing stigma in various systems was specifically mentioned. Participants also thought the framework should be used to support a phased systems change process. In discussing systems change and how to aid the implementation process, participants suggested: 1) examining and internalizing ROSCs as a philosophy, not a 'to-do' list; 2) focusing on key strategic objectives based on priorities in the State; 3) prioritizing and organizing the systems elements to aid implementation; and 4) defining terms and developing a ROSCs glossary.

After the general discussion of the systems elements, the participants engaged in dialogue regarding their respective States' strengths and challenges in implementing the elements and discussed their current recovery-oriented activities, considered areas where additional work was needed, and learned about activities in other States. Participants identified opportunities to maximize partnerships and community resources and supports, creative methods to change attitudes and norms and address institutional and social barriers, approaches to establish their infrastructures to support ROSCs, and techniques to promote innovation and accountability to implement ROSCs. In the discussion of States' strengths in implementing ROSCs or specific elements, participants focused on similar elements. These elements included:

- Individualized and comprehensive services across the lifespan.
- Commitment to peer recovery services.
- Inclusion of the voices and experiences of recovering individuals and their families.
- Integrated services.
- Adequately and flexibly financed.

Strengths most commonly mentioned consisted of:

- Meeting clients/individuals where they are in their recovery process and where they are located (geographically and type of setting).
- Using peers and peer recovery support services to support others, provide services, and drive systems change.
- Including people in recovery and family members on advisory councils, boards, and workgroups.
- Integrating and providing services by collaborating across systems, departments, organizations and fields.
- Funding ROSCs services through existing State and Federal grant programs.

Several States also indicated that due to several successful grant programs (Access to Recovery, Recovery Community Support Services, and Co-Occurring State Infrastructure Grants) and others grants programs, they can apply what they have learned from these efforts to inform future systems change.

Finally, States identified several similar challenges to implementing the systems elements. These challenges were raised across all regions and included:

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- Providing person-centered, comprehensive, and individualized services in an environment of constrained resources, regulatory, contractual, and organizational inflexibility, and changing population demographics.
- Changing perceptions regarding addictions and dealing with resistance to change from the community, health care systems, and other allied systems regarding addictions.
- Providing culturally congruent and age-appropriate services.
- Integrating peers into the treatment environment, while maintaining the integrity of the peer role.
- Clarifying providers' roles and responsibilities on who should treat and serve the addictions consumer.
- Developing and conducting trainings on ROSCs in a variety of settings and for a variety of people/professions.
- Defining, collecting, and analyzing quantifiable outcomes on ROSCs, when existing data systems are not integrated and are not designed for these purposes.
- Implementing ROSCs within the existing fragmented, inflexible, and inadequate funding system.

In addition to the challenges that were directly associated with a systems element, the problems associated with the workforce (inadequate pay and benefits, general retention and recruitment issues) and stigma associated with addiction and substance use disorders were discussed in all the regions.

State Responses to Worksheet Questions

One of the objectives of the regional meetings was for the participants to leave the meeting with a brief action plan for the next 12 months to advance ROSCs in their States. To this aim, the meeting provided States with three hours to contemplate recovery-oriented systems within their States' political, social, and financial environments and develop this action plan. State teams were provided a worksheet to guide the preparation of the plan. The worksheet consisted of the following questions:

1. What should recovery-oriented systems look like?
2. What steps are necessary to move toward ROSCs?
3. What steps have you already taken to implement ROSCs?
4. What challenges do you face in implementing ROSCs?
5. What steps are you prepared to take to support this change effort in the next 12 months?

Findings from ROSCs Planning Questions

Across all regions, States reported similar visions of ROSCs and some States specifically expressed that their States' visions of ROSCs encompassed the National Summit on Recovery's systems elements. In all regions and across the majority of the States, States identified the importance of a full continuum of care, which utilizes multiple systems and integrated systems of care. Additionally, across all regions, States emphasized that ROSCs include the following:

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- Involvement of recovering individuals, families, faith-based organizations, and communities in the design and operation of ROSCs.
- A person-centered and strength-based continuum of care.
- Readily accessible (24 hours a day, 7 days a week, 365 days a year) and individualized services.
- Cross-systems collaboration.

There was less consistency across States in describing necessary steps for implementing ROSCs. However, most States identified the importance of educating and promoting the concept of recovery and the value of ROSCs to States, communities, and providers and collaborating across systems of care. Additional steps identified by the States as necessary to implement ROSCs included the following:

- Supporting a qualified workforce.
- Obtaining stakeholder buy-in across systems.
- Reducing administrative and funding barriers.
- Promoting peer and recovery-support services.

While States are at different stages in planning and implementing ROSCs, the majority of States mentioned similar activities they have conducted to begin to implement the process. Across all regions, States reported that they had conducted systems-building efforts (e.g., planning and developing partnerships) to engage multiple stakeholders in the implementation of the system. Additionally, States have utilized existing Federal, State, and local resources and grants to deliver and support recovery-oriented services and supports.

Across all regions, States reported similar implementation challenges. The primary challenge States identified in implementing ROSCs was inequitable, inadequate, and inflexible funding streams for treatment and recovery support services. Additional challenges included: resistance to change from multiple sources, including resistance from treatment and recovery support providers; lack of knowledge on ROSCs; and stigma and discrimination related to addictions.

Finally, when States identified activities that they are prepared to take over the next 12 months to support this systems improvement effort, it was evident that States are at different stages in implementing ROSCs. Some States are planning and implementing ROSCs; others are starting to plan ROSCs; and others have not yet begun to plan this systems change effort. While States are at different phases, the majority of States across all regions noted the importance of communications and awareness-raising activities to implement ROSCs. Many other activities were identified to advance the process at the State and community levels. Some of the activities follow:

- Educate and stimulate support for ROSCs by conducting State hearings and meetings to promote buy-in; providing education and training activities for providers and stakeholders; and holding ROSCs conferences.
- Fund a limited amount of recovery-oriented activities to initiate systems change;

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- Conduct strategic planning to formalize a State ROSCs plan.
- Review language to ensure it is recovery-oriented.
- Formulate recovery-oriented guidelines and competency-based credentials;
- Offer mini-grants to build recovery-oriented capacity.
- Seek or enhance Medicaid funding for ROSCs.
- Consider technological innovations to support ROSCs initiative.

VII. Outcomes and Next Steps at the State Level

As has been mentioned, States are at different stages in planning and implementing ROSCs and the intent of CSAT's Regional Recovery meetings was to continue a dialogue on ROSCs with the States and to provide resources to enhance their planning efforts in this area. The Federal government, States, and communities are constantly striving to improve systems of care and the work that has been accomplished on the ROSCs framework provides a foundation for the addictions field to build upon. The regional meetings provided States with materials on ROSCs and an opportunity to hear presentations from those implementing ROSCs and to network and collaborate with other States.

The meetings also provided a forum for States to develop a brief action plan to implement recovery-oriented systems change over the next 12 months. Although the time allotted for this task was limited, the intention was for States to begin or to enhance current implementation efforts through a structured process. As was reflected across regions, the development and implementation of ROSCs requires the involvement of numerous systems stakeholders, including individuals in recovery and their family members. The development of the brief action plans provided a discussion piece for teams to take back to their States to broaden the dialogue and planning process. Following the meetings, several participants have contacted PFR and informed staff that they are pursuing additional ROSCs planning activities. Additionally, many States expressed a desire to reconvene 12 months after the meeting to observe the States' progress.

VIII. Next Steps from CSAT

CSAT supports a recovery-oriented systems improvement philosophy and a public health approach for implementing systems change. The agency is currently engaged in a variety of activities and is developing resources to support States and communities in implementing ROSCs. These efforts are visible through PFR, Recovery Community Services Program (RCSP), Recovery Month, and Access to Recovery (ATR), and will likely be more visible throughout the agency in the future. Some of the steps that CSAT is taking to demonstrate its commitment to the process and to provide recovery-oriented resources to support implementation efforts are:

- **CSAT's Cross-Cutting Work Group on Recovery and ROSCs** – CSAT has established a Cross-cutting Work Group on Recovery and ROSCs which includes staff members from all CSAT Divisions and Offices. The purpose of this Work Group is to

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- focus on coordinating recovery-related efforts across CSAT to ensure a unified voice to the field.
- **White Paper: *The Role of Recovery Support Services in Recovery-oriented Systems of Care*** - This SAMHSA paper describes the state of recovery support services and provides a framework for future activities that will support the continued development of these services.
 - **Conference Report: *Emerging Peer Recovery Support Services and Indicators of Quality*** – This conference report discusses emerging indicators of quality for peer recovery support services. The report can be accessed via: <http://rcsp.samhsa.gov/lessons/index.htm>.
 - **Recovery-oriented Tool-kit** – This tool-kit will provide resources for those implementing recovery-oriented systems change, including: policies, administrative rules, strategic plans, practice guidelines, vision statements, workforce competencies, training outlines, surveys, protocols, and a literature review. A special module will be included on integrating recovery support services into ROSCs and will focus on regulatory, financing, and quality assurance.
 - **Literature Review** – This literature review will cite the need for recovery-oriented systems change, conceptual designs, literature related to recovery principles and systems elements, and implementation efforts.
 - **Educating State Legislators on ROSCs** – This project is designed to educate State legislators and legislative staff about ROSCs. It will include web-assisted audio conferences, a Fact Sheet, project website, a presentation at the National Conference of State Legislators (NCSL) Health Chairs Meeting and an Issue Brief.
 - **Awareness Raising Activities** – Presentations by CSAT and grant programs staff will continue to be conducted at State and national events to raise awareness about the importance of ROSCs, e.g., Community Anti-Drug Coalitions of America (CADCA), State Associations of Addiction Services (SAAS), National Association of State Alcohol and Drug Abuse Directors (NASADAD), Association for Addiction Professionals (NAADAC), and the Addiction Technology Transfer Center (ATTC) events.
 - **Resources on the PFR website** – Recovery-oriented resources and resources on the topic of recovery and ROSCs will be posted on the PFR website at www.pfr.samhsa.gov.