Access to Recovery (ATR) Approaches to Recovery-Oriented Systems of Care: Three Case Studies

August 2009

Strength-based

Person-Centered

Peer

Individuals

Community

Culturally Responsive

Family

Access to Recovery (ATR) Approaches to Recovery-Oriented Systems of Care: Three Case Studies

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Background

The concept of recovery lies at the core of the Substance Abuse and Mental Health Services Administration's (SAMHSA) mission, and fostering the development of recovery-oriented systems of care is a Center for Substance Abuse Treatment (CSAT) priority. In support of that commitment, in 2005 SAMHSA/CSAT convened a National Summit on Recovery. Participants at the Summit represented a broad group of stakeholders, policymakers, advocates, recovering individuals, representatives of mutual aid groups, clinicians, and administrators from diverse ethnic and professional backgrounds. Although the substance use disorder treatment and recovery field has discussed and lived recovery for decades, the Summit represented the first broad-based national effort to reach a common understanding of the guiding principles of recovery, elements of recovery-oriented systems of care, and a definition of recovery.

Through a multistage process, key stakeholders formulated guiding principles of recovery and key elements of recovery-oriented systems of care. Summit participants then further refined the guiding principles and key elements in response to two questions: 1) What principles of recovery should guide the field in the future? and 2) What ideas could help make the field more recovery oriented?

A working definition of recovery, 12 guiding principles of recovery, and 17 elements of recovery-oriented systems of care emerged from the Summit process. These principles and elements can now provide a philosophical and conceptual framework to guide SAMHSA/CSAT and stakeholder groups, and offer a shared language for dialog.

Summit participants agreed on the following working definition of 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.*

The guiding principles that emerged from the Summit are broad and overarching. They are intended to give general direction to SAMHSA/CSAT and stakeholder groups as the treatment and recovery field moves toward operationalizing recovery-oriented systems of care and developing core measures, promising approaches, and evidence-based practices. The principles also helped Summit participants define the elements of recovery-oriented systems of care and served as a foundation for the recommendations to the field contained in part III of the *National Summit on Recovery: Conference Report* (CSAT, 2007).

Following are the 12 guiding principles identified by participants (for a complete definition of each of the guiding principles, see the *National Summit on Recovery: Conference Report* [CSAT, 2007]):

- 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 involves a process of healing and self-redefinition;

- Recovery involves addressing discrimination and transcending shame and stigma;

- Recovery is supported by peers and allies;

- Recovery involves (re)joining and (re)building a life in the community; and

- Recovery is a reality.

Participants at the Summit agreed that recovery-oriented systems of care are as complex and dynamic as the process of recovery itself. Recovery-oriented systems of care are designed to support individuals seeking to overcome substance use disorders across their lifespan. Participants at the Summit declared, "There will be no wrong door to recovery," and recognized that recovery-oriented systems of care need to provide "genuine, free, and independent choice" (SAMHSA, 2004) among an array of treatment and recovery support options. Services should optimally be provided in flexible, unbundled packages that evolve over time to meet the changing needs of recovering

persons. Individuals should also be able to access a comprehensive array of services that are fully coordinated to support them throughout their unique journeys to sustained recovery.

Participants identified the following 17 elements of recovery-oriented systems of care (for a complete definition of each of the elements, see the *National Summit on Recovery: Conference Report* [CSAT, 2007]):

- 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;

- Responsiveness to personal belief systems;

- Commitment to peer recovery support services;

- Inclusion of the voices and experiences of recovering individuals and their families;

- Integrated services;

- System-wide education and training;

- Ongoing monitoring and outreach;

- Outcomes driven;

- Research-based; and

- Adequately and flexibly financed.

Purpose Statement

This white paper has been prepared as a resource for States, communities, and organizations planning for, embarking on, or well into systems-change efforts intended to develop, sustain, or enhance components of recovery-oriented systems of care. While States, communities, and organizations each face unique challenges and opportunities, the lessons learned by those that have already begun this process can serve as an invaluable resource to other States and communities, offering not a template for action but a menu of options and strategies for readers' consideration. This paper is intended to offer snapshots of promising approaches and is designed to serve as a starting point for discussion.

Using the principles and elements as a point of reference, this document will provide a brief overview of CSAT's Access to Recovery (ATR) program and will describe the activities and operations of three States that have taken steps toward the development of recovery-oriented systems of care through ATR grants: Connecticut, Washington, and Wisconsin.

Despite their varying historical, political, and service system contexts, the projects highlighted in this paper provide useful examples of strategies that might be applicable to other States and communities. Each reflects an ongoing systems improvement philosophy that is an essential component of the endeavor to create recovery-oriented systems of care. None provides a complete template or roadmap, since each State and community is unique, and since in the development of

recovery-oriented systems of care one seeks not a static end point, but rather a process of continuous systems and services improvement.

These brief case studies are intended to highlight the unique features of each of the three ATR projects, identifying innovative strategies, approaches, and practices that might be helpful to other States and communities as they plan for or implement recovery-oriented approaches.

Overview of Access to Recovery

nitially proposed in President George W. Bush's 2003 State of the Union Address, the Access to Recovery (ATR) initiative seeks to expand the range of addictions treatment and recovery support services available to individuals with substance use disorders through competitive grants to States. In 2004, 14 States and one tribal organization were awarded 3-year grants of up to $7.6 million per year: California, California Rural Indian Health Board, Connecticut, Florida, Idaho, Illinois, Louisiana, Missouri, New Jersey, New Mexico, Tennessee, Texas, Washington, Wisconsin, and Wyoming (SAMHSA, 2004).

In September 2007, CSAT awarded $96 million in new ATR grants to 18 States, five tribal organizations, and the District of Columbia. Awards averaged $4 million annually. Eleven of the 2004 grantees, including the three States discussed in this paper, also received funding in the 2007 round. The thirteen first-time ATR grantees were Alaska Southcentral Foundation; Arizona; Colorado; the District of Columbia; Hawaii; Indiana; Inter-Tribal Organization of Michigan; Iowa; Montana-Wyoming Tribal Leaders Council; Ohio; Oklahoma; the Oklahoma Cherokee Nation; and Rhode Island (SAMHSA, 2007).

As of June 30, 2007, a total of 190,144 individuals had been served under ATR. CSAT has reported the following inception-to-date aggregate discharge data:

- 73.1 percent of individuals reporting substance use at intake reported no use at discharge;

- 23.4 percent of those who reported not having stable housing at intake reported being stably housed at discharge;

- 30.8 percent of individuals who were unemployed at intake reported being employed at discharge;

- 62.4 of those determined not to be socially connected at intake were designated as socially connected at discharge (attended self-help groups or had someone to whom to turn in times of trouble); and

- 85.9 percent of individuals involved with the criminal justice system at intake reported no involvement at discharge.

CSAT has also reported that 48 percent of ATR voucher funding nationally was used to purchase recovery support services. Additionally, 31 percent of treatment providers and 23 percent of recovery support providers for which at least one voucher was redeemed were identified as faith-based organizations (Kopstein, personal communication, October 17, 2007).

Goals, Requirements, and Features of ATR

ATR has three primary goals: 1) expanding consumer choice, 2) tracking and improving

outcomes, and 3) increasing capacity. A major focus of ATR is individual choice. The grant requires that individuals are provided "genuine, free, and independent choice among eligible clinical treatment and recovery support providers, among them at least one provider to which the client has no religious objection." They must also adopt vouchers as a payment mechanism under ATR. Vouchers are intended to support client choice by making available a broad array of services. The voucher systems that grantees are required to establish under ATR serve as an indirect funding mechanism, permitting individuals to select from an array of treatment and recovery support services. Direct funding of services by contracts or grant awards between the State and providers is not permitted under the program.

Tracking and improving outcomes and ensuring accountability are also central themes in ATR. CSAT states that "success will be measured by outcomes, principally abstinence from drugs and alcohol, and includes attainment of employment or enrollment in school, no involvement with the criminal justice system, stable housing, social support, access to care, and retention in services." In support of this goal, CSAT requires grantees to "maintain accountability by creating an incentive system for positive outcomes and taking active steps to prevent waste, fraud and abuse."

ATR is also intended to increase capacity not only by increasing the number of individuals that can be served, but by expanding the array of services available.

Finally, ATR emphasizes the use of faith- and community-based providers, requiring grantees to establish "a process to enable providers

previously unable to compete effectively for Federal funds to participate in the Access to Recovery program (including some faith-based and community providers)" (SAMHSA, 2004).

The ATR RFP explains the distinction between direct and indirect funding. "Indirect funding means that individual, private choice, rather than the Government, determines which substance abuse service provider eventually receives the funds. With indirect funding, the individual in need of the service is given a voucher, coupon, certificate, or other means of free agency, such that he or she has the power to select for himself or herself from among eligible substance abuse service providers, whereupon the voucher (or other method of payment) may be 'redeemed' for the service rendered. Under 'direct' funding, the Government or an intermediate organization with the same duties as a governmental entity purchases the needed services directly from the substance abuse service provider" (SAMHSA, 2004).

The use of vouchers to purchase unbundled services that can be combined into packages tailored to the needs of individuals offers a mechanism for the development of recovery-oriented systems of care. Vouchers, as they are employed under ATR, represent an approach to flexible funding. In addition, to the extent that they are used to develop customized service packages and to increase choice, they are mechanisms to support person-centered approaches.

Recovery support services are a critical component of ATR. These are nonclinical services that assist in removing barriers and providing resources to those contemplating,

initiating, and maintaining recovery from substance use problems. Recovery support services may be specialized and require licensure or certification (e.g., childcare or legal services) or may be in a domain for which there are no licensure or certification requirements (e.g., peer mentoring or spiritual support). Broadly speaking, they can be divided into two categories, those that are provided by peers and those that are not. A peer is an individual who is acting openly as a person in recovery, is explicitly sharing his or her experience as a person in recovery with the individual he or she is serving, and establishes a relationship with the individual served that is based to a significant degree on the peer's experience in recovery.

Under ATR, recovery support services generally, and peer-based services especially, gain a greater centrality than is typically the case in addictions treatment systems. They are not necessarily ancillary since they can serve as the primary component of an intervention that may or may not include treatment. ATR recovery support services include a broad array of services, such as:

- Housing;
- Transportation;
- Food/clothing/basic needs;
- Parenting training;
- Childcare;
- Life skills training;
- Employment coaching;
- Legal services;
- Recreation;
- Service brokerage;
- Recovery coaching;

- Peer mentoring;
- Recovery checkups;
- Outreach; and
- Spiritual support.

Among key challenges ATR grantees face are determining what types of recovery support services to fund; establishing a service typology; selecting and enrolling providers; and developing and implementing performance measures and incentives, reporting requirements, and monitoring protocols. Moreover, the State or tribal authority may need to do extensive training of recovery support providers since many are small community- or faith-based organizations that have little or no experience working with public funders.

Another challenge ATR presents to grantees is the development of voucher systems that operate in tandem with existing funding mechanisms, such as the Substance Abuse Prevention and Treatment Block Grant, State and local funds, Medicaid, public managed care programs, and other sources. Vouchers offer the grantees much flexibility, but they also present challenges related to ensuring integrity and accountability across payment systems and managing administrative costs while setting up secondary payment and service tracking systems.

Information systems are an essential component of the ATR initiative. They provide the infrastructure that supports the many functions required to administer voucher programs. Under ATR, these functions can include providing automated platforms for assessing individuals; tracking slot/service capacity, admissions, and discharges; issuing and tracking vouchers, collecting service and

Government Performance and Results Act (GPRA) data; auditing against other funding systems to avoid double payment for services that would otherwise be reimbursable through standard mechanisms; and tracking treatment and recovery support provider performance.

ATR grants provide an interesting case study in the development of recovery-oriented systems of care since they represent systems-change pilots. Moreover, they reflect many of the key guiding principles and systems of care elements identified through the National Summit on Recovery. Among the guiding principles they exemplify are:

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery is holistic.
- Recovery is supported by peers and allies.
- Recovery is (re)joining and (re)building a life in the community.

ATR reflects a number of the elements of recovery-oriented systems of care identified through the Summit. Below are examples of how the program reflects some key elements:

- **Person-centered**: Emphasizing choice and making it possible to create a menu of unbundled services including spiritual supports.
- **Individualized and comprehensive services across the lifespan**: Making available an array of services that can be flexibly deployed to meet the evolving needs of individuals in recovery.

- **Systems anchored in the community**: Relying on and fostering the development of a broad network of community and faith-based providers and emphasizing peer services.
- **Continuity of care**: Creating funding and care management/recovery support mechanisms to ensure continuity across provider organizations and service systems.
- **Responsiveness to personal belief systems:** Ensuring the availability of a variety of faith-based and secular services.
- **Commitment to peer recovery support services:** Relying on peers as an integral part of the ATR service continuum.
- **Integrated services:** Coordinating and/or integrating efforts across service systems.

Each grantee has developed a unique approach to ATR that is specially suited to the populations it elected to target and the service system from which its ATR project emerged. The remainder of this paper describes the genesis and unique features of the ATR projects implemented by the States of Connecticut, Washington, and Wisconsin. In the discussion of these projects, we provide a project-level overview and identify unique and innovative features that may be of interest to States, local governments, provider associations, recovery organizations, and other treatment and recovery stakeholders who wish to adopt them as part of a strategy to develop recovery-oriented systems of care.

Connecticut ATR

Background

The State of Connecticut was well positioned to implement an ATR program. Beginning in 1999, the State Department of Mental Health and Addiction Services (DMHAS), in partnership with the Connecticut Community for Addiction Recovery (CCAR) and Advocacy Unlimited, Inc., a statewide advocacy organization serving persons with or in recovery from psychiatric disabilities and their families, developed "recovery core values" to guide restructuring of the State's mental health and addiction treatment service systems.   In developing the recovery core values, DMHAS also hosted statewide Recovery Conferences, established a Recovery Institute and Centers of Excellence, and conducted a series of consensus-building retreats for executive directors, medical and clinical leadership, consumers/individuals in recovery, and several other stakeholder groups within the mental health and addiction service communities. The goal of these sessions was to learn about the views of these key stakeholders regarding the concept of recovery and the steps that would need to be taken for recovery to become the overarching principle that guides mental health and addictions treatment in the State (Tondora & Davidson, 2006).

In addition, in 2000, the Connecticut Governor created a Mental Health Policy Council in response to recommendations issued by a Blue Ribbon Mental Health Commission that the Governor had established. The council, co-chaired by the commissioners of DMHAS and the Department of Children and Families (DCF)

and involving 14 other commissioners and key officials, worked collaboratively with the Connecticut Alcohol and Drug Policy Council to drive systems transformation across the State's mental health and addictions treatment systems.

In September 2002, DMHAS issued a policy statement entitled *Commissioner's Policy Statement No. 83: Promoting a Recovery-Oriented Service System* (Kirk, 2002)*.* This document "designated the concept of recovery as the overarching goal, guiding principle, and operational framework for the system of care supported by DMHAS" and committed the State to systems transformation. It defined recovery as follows:

> *Recovery is a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite, or within the limitations imposed by that condition.*

The statement described a recovery-oriented system of care as follows:

> *A recovery-oriented system of care identifies and builds upon each person's assets, strengths, and areas of health and competence to support the person in achieving a sense of mastery over mental illness and/or addiction while regaining his or her life and a meaningful, constructive sense of membership in the broader community.*

This policy statement emphasized that the service system needed to "address the needs of people over time and across different levels of disability."

Connecticut also developed Practice Guidelines for Recovery-Oriented Behavioral Health Care (Tondora & Davidson, 2006). They emphasize the following principles:

- Participation;
- Promoting access and engagement;
- Continuity of care;
- Strengths-based assessment;
- Individualized recovery planning;
- Functioning as a recovery guide;
- Community mapping, development, and inclusion; and
- Identifying and addressing barriers to recovery.

In a separate policy statement on cultural competence, the DMHAS commissioner directed that the DMHAS system "function with cultural competency that responds effectively to the needs and differences of all individuals, based on their race, gender, age, physical or mental status, sexual orientation, and ethnic or cultural heritage" (Kirk, 2003). The parallels with the principles and systems of care elements established through the National Summit on Recovery are numerous and clear.

Approach

The Connecticut ATR program was conceptualized and implemented within the context of these ongoing efforts toward the development of recovery-oriented behavioral health systems. To develop and implement the ATR program, DMHAS partnered with the State's DCF, Department of Correction (DOC), and Department of Social Services (DSS), as well as the Court Support Services Division (CSSD) of the judicial branch. The State also involved faith- and peer-based organizations, advocacy groups, and State universities in the development of its ATR proposal and in the statewide implementation of its program.

Connecticut ATR prioritizes the following populations:

- Adult women served through the State's DCF/DMHAS Project Substance Abuse Family Evaluation (SAFE) or through the DSS Temporary Assistance for Needy Families (TANF) Program;
- Adults with substance use disorders who are under the jurisdiction of Department of Corrections, on parole, or on DOC reentry status;
- Young adults and adults with nondependent substance use problems who might benefit from brief treatment; and
- Adults with substance use disorders identified through the DMHAS Urban Initiatives in Bridgeport and New Haven (Connecticut DMHAS, 2004).

Initially, the Connecticut ATR program was intended only to serve individuals referred by DCF, CSSD, DOC, or DSS. However, in August 2005, eligibility was expanded to include all Connecticut adults with substance use disorders. Over the life of the Connecticut

ATR program, CSSD- and DOC-involved individuals have accounted for 48 percent of individuals served.

Under the Connecticut ATR program, vouchers were deemed the payment source of last resort. ATR funding was only used for individuals who did not have access to entitlements, private insurance, or other resources that could cover the cost of needed services.

Connecticut ATR was implemented and managed through a contract with an administrative services organization (ASO), Advanced Behavioral Health (ABH). ABH's major areas of responsibility include:

- Coordinating authorization for ATR services;

- Facilitating provider voucher reimbursement;

- Managing linkages and coordination of services for recipients while promoting positive treatment outcomes; and

- Collecting and uploading GPRA data in accordance with CSAT deadlines.

ABH also serves as the ASO for Connecticut's State-Administered General Assistance (SAGA) Program, which funds services for individuals who are eligible for publicly funded behavioral health treatment services. The ABH database of services was expanded under ATR to include a full array of recovery support services, including peer- and faith-based services. Use of the ABH database permits services and reimbursements to be tracked across payment sources and thereby increases accountability for services paid through ATR.

ATR provided a vehicle for the State of Connecticut to pilot the establishment of service networks coinciding with its five DMHAS regions. The networks included addictions treatment and recovery support providers, many of which were faith-based or peer-led, and were important in establishing an infrastructure to effectively provide recovery-oriented services locally.

Connecticut's provider networks were established by issuing a request for qualifications (RFQ) through which providers in each region designated a lead agency. The five networks were "defined as a formal affiliation, via Memorandum of Agreement, among…treatment and recovery support providers, including faith- and peer-based providers." They were intended "to provide integrated, coordinated, and comprehensive recovery-oriented…treatment and recovery support services…with continuous monitoring of quality, accountability, and cost-effectiveness" (Connecticut DMHAS, 2004).

The regional networks meet regularly for purposes of systems and services planning and coordination. These meetings have permitted the development of effective partnerships among treatment and recovery support providers. The networks provide the infrastructure to support recovery-oriented systems of care and services under ATR. They also further Connecticut's overall work toward the development of recovery-oriented systems of care.

Connecticut approached both its larger statewide systems transformation and its ATR program at the system, program, and practitioner levels. At the system level, policy was driven by recovery principles and values. At the program level, recovery practice guidelines were developed. Finally, at the practitioner level, Connecticut emphasized person-centered and culturally competent approaches that conveyed hope and respect and conformed to the State's principles relative to recovery-oriented services. The Practice Guidelines for Recovery-Oriented Behavioral Health Care standardize many of the principles that are applied to both ATR and non-ATR services.

The RFQ issued in 2004 to establish the State's five service networks required applicant networks to explain how proposed network providers would "embrace recovery-oriented practice principles and guidelines." These principles and guidelines are listed in the box to the right.

Recovery Support Services

Approximately 85 percent of Connecticut's ATR funding was directed toward recovery support services, including:

- Short-term housing;
- Transportation;
- Faith-based services;
- Basic needs (food, clothing, etc.);
- Case management;
- Childcare; and
- Vocational and educational services.

Connecticut's Recovery-Oriented Practice Principles and Guidelines

- Fostering hope and recovery
- Encouraging active participation of people in recovery at all levels of the system
- Conveying courtesy, dignity, and respect to all persons
- Promoting the rights and responsibilities of each person
- Delivering person-centered, strength-based, and community-focused care
- Providing culturally responsive care
- Offering multiple entry points for easy access
- Providing a menu of effective services and supports
- Optimizing natural supports and community involvement
- Utilizing best and/or evidence-based practices

    (Connecticut DMHAS, 2004)

Recovery specialists (or recovery managers) play a key role in Connecticut ATR. They are often the initial point of contact for individuals seeking services and can provide services prior to, during, and after treatment. Recovery specialists partner with the individual to inventory strengths, identify needs, and determine service needs. They remain engaged with the individual over time, serving as a case manager and working

closely with the ASO and with treatment and recovery support services providers. Faith-based providers make up nearly half (48) of the 107 recovery support services providers in Connecticut ATR. This substantial participation is in part the product of work that preceded the ATR grant. The State supported the Saint Francis Academy for Clinical Pastoral Training, which trained hundreds of faith leaders from different faith traditions, denominations, and sects from across the State. The academy is staffed by consultants in medicine, behavioral health, and ministry who provide a spiritual dimension to healing (Saint Francis Care, n.d.). Pastoral counseling services were made available across all five networks under ATR. Among the 38 ATR providers that had no previous history with DMHAS, 32 were faith-based organizations.

Peer services are also a central component of Connecticut ATR. The Connecticut Community for Addiction Recovery (CCAR) has established four Recovery Community Centers (RCCs) statewide and is in the process of opening four more. These centers offer a wide range of peer services (CCAR, n.d.), including:

- Telephone recovery support;
- Family/community education;
- Family support groups;
- All-recovery groups;
- Volunteer training;
- Recovery training;
- Peer-operated transportation company;

- Recovery coaching (CCAR believes recovery coaching is best delivered by a volunteer, usually another person in recovery);
- Referral to recovery housing;
- Employment support; and
- Social activities supported by peer volunteers.

CCAR developed sober housing certification standards and created a Web-based "product that displays recovery housing listings." This enables users to search for recovery housing by characteristics (e.g., 12-Step, Christian), location, ATR eligibility, gender, and so forth.

An RCC offers regularly scheduled "recovery-related workshops, trainings, meetings, services and social events." An innovative service offered by CCAR is the telephonic recovery support program, through which volunteers/persons in recovery from addictions make weekly telephone follow-up contacts with individuals discharged from treatment programs to offer support and to encourage sustained abstinence and recovery. This program has reduced the need for readmission to treatment and has resulted in a more timely return to treatment for those who relapse and require readmission.

In aggregate, housing support accounts for 45 percent of ATR-funded services in Connecticut. Other leading services purchased include clinical (14 percent) and faith-based (11 percent) services and case management (10 percent). The table on the following page shows the percentage of ATR service funding allocated to various service categories.

Connecticut ATR Voucher Utilization	
Service Description	Percent
Housing	45
Clinical	14
Faith-Based Services	11
Case Management	10
Basic Needs	7
Vocational Services	6
Transportation	4
Other	3
(Trocchi, personal communications, December 7, 2007)	

While 12 percent of Connecticut ATR services were classified as faith-based (e.g., spiritual support), fully 43 percent of Connecticut ATR funding went to faith-based organizations offering a wide range of services, many of which were not faith-based. These services included housing, case management, pastoral counseling and spiritual support. Nationally, 31 percent of national ATR service funding went to faith-based providers.

Despite extensive peer involvement in Connecticut ATR, peer-based services represent a very modest portion of services purchased. This is because the majority are reported under aftercare recovery support services (RSS) and other categories. Additionally, volunteers provide some peer-based services, including the peer telephonic support program.

In addition to supporting a range of recovery support activities, Connecticut is also adopting evidence-based practices. As part of an initiative of the Office of the Medical Director at DMHAS,

the system has made strides in implementing evidence-based practices. These practices include illness management, RRS for people with psychosis, motivational interviewing, opioid agonist therapy, and supported employment. Additionally, DMHAS is implementing Screening and Brief Intervention and Referral to Treatment (SBIRT) in a hospital emergency department and in a Federally qualified health center in New Haven, Connecticut, and the Matrix Model for methamphetamine- and cocaine-dependent individuals.

DMHAS has also been involved with the ongoing development of provider performance measures. Program and performance measures have been developed in four domains: data quality, utilization, access, and outcomes. Web-based reports are accessible at any time to providers who wish to review their data, as well as information on performance measures across all funded agencies. Training for all providers and system managers on how to use the reports and improve data quality has been provided.

Overall, ATR implementation in Connecticut reflects the three-phase systems-change approach adopted statewide for the transformation of behavioral health care (DiLeo, 2006). It is summarized below.

Connecticut Change Management Process

Phase 1: Determine Direction

A. **Develop Concepts and Design Model:** Perform research and propose concepts and models reflecting principles and core values.

B. **Develop Consensus:** Review concepts and models with key stakeholders, including persons in recovery and agency and association directors. Discuss implications of models for systems and services, resource allocation, and agency functioning.

C. **Dissemination:** Disseminate the consensus concepts and models.

Phase 2: Initiate Change

A. **Focus on Quality:** Institute a provider self-assessment process and require funded agencies to develop agency-wide recovery plans for review and approval. Develop performance standards and measures and monitor.

B. **Workforce Development:** Implement intensive, skill-based training across both treatment and recovery support organizations. Practice improvement initiatives play a key role in technology transfer. Recovery organizations assist in training.

C. **Funding:** Introduce new funding and services and realign existing resources.

Phase 3: Increase Depth of Understanding

A. Describe and communicate the beneficial impacts of the changes on other systems (e.g., criminal justice, corrections, and child welfare).

B. Provide advanced training.

C. Continue developing and improving recovery-oriented performance measures (these measures are currently being finalized).

D. Realign fiscal resources through contract language, competitive bidding, and other mechanisms.

Connecticut and the Principles and Elements of Recovery-Oriented Systems of Care

As noted earlier in this paper, ATR projects generally reflect many of the elements of recovery-oriented systems of care developed through the National Summit on Recovery. However, there are areas where the convergence between systems and services developed under Connecticut ATR and the elements that emerged from the Summit is particularly marked. As our review of the project shows, the following elements are notably reflected in Connecticut ATR:

- **Strength-based:** Using strength-based assessments and recovery plans.

- **Culturally responsive:** Requiring the behavioral health system to respond "effectively to the needs and differences of all individuals, based on their race, gender, age, physical or mental status, sexual orientation, and ethnic or cultural heritage" (Kirk, 2003) as delineated in Policy Statement No. 76 and the State's Practice Guidelines for Recovery-Oriented Behavioral Health Care.

- **Responsiveness to personal belief systems:** Making available an extensive pastoral counseling services network in combination with the variety of secular services.

- **Commitment to peer recovery support services:** Reflecting an exceptionally high level of involvement of peers in the provision of recovery support services.

- **Inclusion of the voices and experiences of recovering individuals, and their families:** Involving CCAR and Advocacy Unlimited, Inc., in the planning of recovery-oriented systems of care and services.

- **System-wide education and training:** Providing extensive education and training to implement Connecticut's Practice Guidelines for Recovery-Oriented Behavioral Health Care.

- **Outcomes driven:** Developing performance measures in four domains (data quality, utilization, access, and outcomes) and training and making a reporting function available to providers and systems managers.

- **Research-based:** Adopting evidence-based practices in ATR, including SBIRT, the Matrix Model opioid agonist therapy, and supported employment.

Washington ATR

Background

The State of Washington directly funded six counties (Clark, King, Pierce, Snohomish, Spokane, and Yakima) to implement ATR. Each county administered its voucher program with relative autonomy. King County, which includes Seattle, subcontracted with an ASO to implement its program. The other five participating counties worked directly with community-based and faith-based organizations to design and implement voucher programs, to define the array of ATR-eligible services that would be made available in each county, and to determine how best to coordinate and track services. The county-level voucher systems and other components of ATR were built and served as extensions of the State's existing Web-based reporting system.

Washington State dedicated approximately 90 percent of voucher funding to recovery support services. This was possible, in part, because the Washington Legislature increased addictions treatment funding by more than $20 million, significantly expanding access to treatment. ATR provided a mechanism for helping to ensure that this additional investment in addictions treatment provided a return for the citizens of Washington in terms of improved outcomes and subsequent reduced utilization of publicly funded services. To be eligible for a voucher under Washington ATR, an individual needed to:

- Be in treatment or have recently completed treatment;

- Be diagnosed with a substance use disorder;

- Be motivated to actively engage in recovery;

- Earn 80 percent or less of the median income for Washington State; and

- Sign a Release of Information for ATR providers (Collins, personal communication, December 26, 2006).

Under Washington ATR, recovery support services are linked to treatment using a wrap-around services approach. While a wide variety of services were available under the State's ATR program, from acupuncture, detoxification, and childcare to transportation, peer mentoring, and opiate substitution, the State reported that approximately 37 percent of ATR funding provided housing support and transitional drug-free housing, and 27 percent went to case management-related services, primarily delivered by recovery support specialists (RSSs). This allocation of resources was not planned; however, it reflects the needs of eligible individuals seeking ATR services and the relative costs of the needed services.

Housing support, which Washington defined as transitional rental assistance, utilized 30 percent of ATR voucher funding under the State's initial ATR grant. "Transitional drug-free housing," which the State defined as supportive drug-free living environments that provide support

Washington ATR Voucher Utilization

Service Description	Percent
Housing Support	30
Information and Referral	16
Other Recovery Services	13
Recovery Support Specialist	11
Transportation	7
Transitional Drug-Free Housing	7
Medical Care (Primary)	3
Other	3
Other Medical Services	3
Childcare	2
Pre-Employment Services	2
Initial GPRA Interview	1
Individual Mental Health Services	1
Other Education Services	1

(Collins, personal communication, December 7, 2007)

services, utilized an additional 7 percent of voucher funding during that period.

Washington State reports that the primary care and other medical services to which ATR afforded access had a noticeable beneficial impact. Consequently, a number of participating counties are exploring mechanisms to continue to make these services available after ATR funding is discontinued. Through the vouchers, uninsured and underinsured individuals gained access to primary care and other needed health care services, including dentistry and various kinds of laboratory work which otherwise would have been unavailable to them. The table below documents service expenditures through the end of the initial Washington State ATR grant.

Approach

Washington State adopted a multistage process for eligibility determination, assessment, and service planning. The process typically begins with a client advocate who performs an initial screening to determine whether or not there may be a substance use disorder and shares with likely clients an informational brochure on Washington ATR. A client advocate can be any clinical or recovery support system representative who responds to an initial request for services or engages an individual who may be in need of services. Individuals who are eligible for ATR services and elect to access them are offered a choice of agencies where they can engage with an RSS. The RSS verifies ATR eligibility, and in partnership with the individual seeking services, develops a recovery plan. Once the RSS and individual seeking services have finalized the initial recovery plan, the RSS issues vouchers to procure the desired recovery support services from the ATR-enrolled providers and refers the individual to a treatment provider for an assessment. Vouchers will also cover treatment services when access to appropriate services would not otherwise be available.

Assessments are completed by a certified treatment provider using a computerized Addiction Severity Index (ASI) and other tools that are accessed through the Washington State data system. The certified provider determines a recommended level of care using the American Society of Addiction Medicine Patient Placement Criteria, 2nd Edition, Revised (ASAM PPC 2R; American Society of Addiction Medicine, 2001).

Washington ATR uses motivation or readiness as an eligibility criterion. During the initial interview, the RSS asks the individual if he or she is committed to recovery. If the individual answers in the affirmative, a partnership is established under the RSS to assist the individual in reaching his or her recovery goals. The partnership between the RSS and individual seeking services is intended to last throughout the period that the individual receives services under ATR. One way in which this partnership manifests is through an open discussion of the best way to utilize an initial authorization, typically in the amount of $2,000 or $2,500, to support the individual's recovery goals. Authorizations are valid for 60 days. Additional funding or additional time in services beyond the 60-day initial authorization requires an additional authorization. The 60-day window was established, in part, to accommodate GPRA data collection.

Statewide, there are about 30 RSSs at any given time, each of whom can have a caseload of 100 or more individuals. While there is some variability across counties, the responsibilities of the RSS are to monitor progress, provide advice or counseling, coordinate care, and intervene at times of crisis. In addition, the RSS tracks voucher expenditures and expiration dates and distributes customer satisfaction surveys. The credentials for an RSS vary somewhat across the six counties implementing ATR in Washington State. In some cases, they are credentialed clinicians and in others they are entry-level workers who have not yet achieved certification. Occasionally the RSSs have been employed by agencies that provide treatment services under ATR. When this was the case, referral rates have been monitored closely to ensure that a disproportionate percentage of referrals did not appear to be going to the organization that employs the RSS.

Washington ATR has not purchased peer services extensively. However, it has relied heavily on a network of over 400 Oxford Houses in the State. A substantial portion of vouchers for housing support has gone to cover portions of stays in Oxford Houses.

Project Successes

Washington State reports that ATR has had a number of beneficial effects. It has led to a more person-centered approach to services in which individual choice and preference have heightened importance, there is greater emphasis on culturally specific services, and there is openness to and acceptance of spiritual support and other services that have not historically been funded. In addition, ATR has played a role in moving the State toward a service paradigm designed to support recovery.

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As Washington ATR moves toward project completion, the State and participating counties are planning for the continuation of services. Some of the participating counties are exploring a 0.1 percent increase in the local sales tax to cover the cost of partially sustaining the continuum of services established under ATR.

Washington and the Principles and Elements of Recovery-Oriented Systems of Care

The Washington ATR project generally reflects several of the elements of recovery-oriented systems of care developed through the National Summit on Recovery. However, there are areas where the convergence between Washington ATR and the elements that emerged from the National Summit is particularly marked. They include:

- **Person-centered:** Strongly emphasizing choice and active participation in planning, including allocating the amount of the initial authorization in support of a recovery plan.

- **Individualized and comprehensive services across the lifespan:** Providing an exceptional platform for the collaborative development of individualized and comprehensive service plans.

- **Systems anchored in the community:** Providing access to an extensive network of Oxford Houses and other community-based housing and recovery services firmly anchored in the community.

- **Continuity of care:** Providing extensive care coordination and case management services, especially through the ongoing partnership between the individual served and the RSS.

Wisconsin ATR

Background

The State of Wisconsin benefited from substantial planning and systems-change efforts that preceded its ATR grant. The State chose to implement its ATR program in Milwaukee County through a contract with the Behavioral Health Division (BHD) of the Milwaukee County Department of Health and Human Services. Named Milwaukee WIser Choice (Wisconsin Supports Everyone's Recovery Choice), the Wisconsin ATR program reflects a vision, core values, and a systems improvement strategy that had been in place a number of years before the initial ATR concept was first announced in the 2003 State of the Union Address.

The vision and core values reflected in Milwaukee WIser Choice emerged from the Milwaukee Family Services Coordination Initiative (MFSCI) from 1999 to 2000. MFSCI involved the Wisconsin Department of Health and Family Services, the Wisconsin Department of Workforce Development, and the BHD in a year-long collaborative planning and systems transformation initiative intended to reduce barriers for families involved in multiple service systems. MFSCI fostered cross-system coordination, adoption of a wraparound services approach, development of networks of formal and informal supports, and use of family-centered, strength-based, gender-specific, and culturally responsive approaches (Milwaukee County Department of Health and Human Services, BHD, SAIL Unit, 2007c).

Vision and Core Values

Vision

MFSCI developed a vision and core values through a series of focus groups that included individuals in recovery, service systems representatives, State and local government officials, and other stakeholders. The vision and values were intended to serve as guidelines for systems and services planning and the provision of care. The vision and an abbreviated version of the core values follow.

> **Vision:** To implement a practice change and system transformation in Wisconsin by having a strength-based coordinated system of care, driven by a shared set of core values, that is reflected and measured in the way we interact with and deliver supports and services for families who require substance abuse, mental health, and child welfare services.

Core Values

Family-Centered Approaches: ATR engages a family defined by the individual seeking services. Family-centered teams and systems focus on the well-being of the family as a whole. (Milwaukee County Department of Health and Human Services, n.d.).

Fostering Consumer Involvement: Families are viewed as full and meaningful partners in all aspects of the decision-making process, including the development of service plans.

Building on Natural and Community Supports: Community resources, both formal and informal, are used creatively and flexibly.

Adopting Strength-Based Approaches: ATR builds on the family's unique qualities and strengths and the resources within its environment.

Offering Unconditional Care: The service team adapts to the needs of the family rather than requiring it to adapt to program models.

Collaborating Across Systems: The addictions treatment, mental health, child welfare, and other systems collaborate with individuals and families to create a single system of care.

Utilizing a Team Approach Across Agencies: All family, formal, and informal team members share responsibility, accountability, and authority, and understand and respect each other's strengths, roles, and limitations.

Ensuring Safety: When child protective services are involved, the team maintains a focus on child safety.

Responding to Gender/Age/Culture: Services are responsive to the issues of gender, age, disability, race, ethnicity, and sexual orientation and reflect support, acceptance, and understanding of cultural and lifestyle diversity.

Fostering Self-Sufficiency: Families are supported in achieving self-sufficiency.

Emphasizing Education and Work: ATR is dedicated to education, employment, and related activities supporting resiliency, self-sufficiency, and improved quality of life.

Believing in Growth, Learning, and Recovery: Team members operate from a belief that every family desires change and can take steps toward attaining a productive and self-sufficient life.

Implementing Outcome-Oriented Approaches: Levels of personal responsibility and accountability for all team members, both formal and informal, are discussed, agreed-upon, and maintained. Identified outcomes are understood and shared by all team members. Selected outcomes are standardized and monitored

Through MFSCI, the BHD identified "the empowerment and recovery of all with mental health and substance abuse treatment needs in our community" as its mission. This vision, mission, and goals, and the core values derived from them, led to a multidisciplinary team approach to services that involved family and other allies in the development of service/recovery plans and in the recovery process. The core values provide an overarching philosophy and common language to bridge formal and informal systems. They also establish expectations that support accountability (De Sousa, 2005). The following key elements identified in the BHD vision statement (Milwaukee County Department of Health and Human Services, 2007) are consistent with the principles of recovery and elements of recovery-

oriented systems of care developed through the National Summit on Recovery:

- A behavioral health system that recognizes the partnership with clients, providers, and the community and the accountability to its stakeholders for the effective development and efficient use of resources;

- A recovery-oriented behavioral health system that focuses on the rebuilding of full, productive lives for children, adults, and their families, and supports a full spectrum of services, including primary prevention and early intervention;

- A behavioral health system that attracts, retains, and supports employees and other service providers who are competent and provide excellent quality, as well as culturally and linguistically relevant behavioral health treatment and support services;

- A system in which clients and families are equal stakeholders in service system governance, planning, and delivery;

- A system in which every client has access to strengths-based, individualized, and integrated services that promote health and recovery;

- A behavioral health system where cultural, ethnic, and socioeconomic diversity is valued by providers and clients;

- A vision of behavioral health services and supports that are community based and not institution based; and

- A vision of a behavioral health system that measures its success by establishing and producing clear, quantifiable outcomes.

Approach

Milwaukee WIser Choice serves general population adults ages 18–59 who reside in Milwaukee County, incarcerated individuals who are reentering Milwaukee County from prison, and individuals who are "on probation or parole supervision who are facing revocation proceedings and imprisonment, and who can be safely supervised in the community while benefiting from addictions treatment and recovery support services as an alternative to revocation" (Milwaukee County Department of Health and Human Services, n.d.). To receive services, individuals must meet income eligibility criteria, have a substance abuse or dependence diagnosis, and be referred to treatment. Among the target populations, pregnant women and families with children receive priority (Milwaukee County Department of Health and Human Services, n.d.). The State of Wisconsin requires that at least 50 percent of those served under WIser Choice be from the criminal justice system.

The BHD has operated a voucher program for treatment services since 1994. This program did not cover nonclinical services and was targeted primarily to individuals served under the TANF program. However, because of it, the county already had in place the majority of the infrastructure necessary to support the implementation of the ATR voucher program.

ATR did require the county to implement some changes. For example, faith-based organizations had by and large not served as funded providers for the county. As a result, the county had to establish service categories and enrollment standards for such organizations and then had to recruit them. The BHD also had to create service descriptions and set rates for recovery support services that it had not previously funded.

In Milwaukee County, access to publicly funded treatment and recovery support services is controlled by three freestanding central intake units (CIUs). Two are for the general public and one is dedicated to the criminal justice population. Historically, the function of the CIUs was to ensure that individuals needing treatment were referred to the appropriate type of treatment and that treatment referrals were equitably distributed across agencies. The CIUs served as a triage point, utilizing a brief 30-minute screening process designed to provide sufficient information to make an appropriate addictions treatment referral. Under Milwaukee WIser Choice, the CIUs expanded this process to include assessment with the ASI and placement using ASAM PPC-2R (American Society of Addiction Medicine, 2001). This process takes 60 to 90 minutes. The use of the ASI and ASAM PPC-2R enhanced the CIU screening process, moving it from a substance use screen followed by referral to a treatment agency without appointment to a multidimensional screening process designed to identify the needs of the whole person. In addition, this screening process culminated with an intake appointment at the treatment provider chosen by the individual and with linkage to a recovery support coordinator

(RSC), who works with the individual and other stakeholders to build a recovery plan.

While this expanded screening and assessment process was driven by ATR, it was not funded with ATR resources. Milwaukee County adopted the enhanced screening and linkage process for all BHD-funded addictions treatment services and utilized county resources to expand staffing to accommodate the extended process. This permitted the enhanced screening process to be adopted without reducing the rate at which individuals were screened, assessed, and linked with services through the CIUs.

Once the assessment is completed, a level of care recommendation is made utilizing ASAM PPC-2R. Individuals are than given directories of provider agencies to review. Often, the clinician who performed the assessment will assist the individual in clarifying the factors he or she deems most important in selecting a provider (e.g., distance from residence, hours, approach, or faith orientation). Not only do individuals choose a treatment provider, they also choose the agency that will provide recovery support coordination services.

An RSC is assigned to every individual served under Milwaukee WIser Choice. The county has five RSC field teams. In all, approximately 70 RSCs provide services under Milwaukee WIser Choice. RSCs are not required to be credentialed addictions professionals. However, they do need to have a master's or bachelor's degree and are sometimes certified addictions counselors. The average length of engagement with WIser Choice is 4 months, although longer engagements based on clinical need are not uncommon.

Within 24 hours of assessment and linkage with treatment, an RSC begins working with the individual to develop a preliminary Single Coordinated Care Plan (SCCP) based on immediate needs. This begins a strengths discovery process in which the individual's future vision is identified. During this time, the RSC also works with the individual in treatment to develop a Recovery Support Team. This team includes family or friends (natural resources), service system and provider representatives (formal resources), and sponsors or spiritual leaders (informal resources) (De Sousa, 2005). Within 30 days of admission, the RSC assembles and convenes a team consisting of representatives of relevant service systems, family members, and representatives of community, social, faith, or other organizations. The composition of the team is determined in large part by the individual receiving services under WIser Choice. It is this team, in partnership with the individual served, that develops the SCCP. In the SCCP, the client identifies needs and sets goals he or she wants to achieve in the next 6–12 months. As part of the strength-based service plan, individuals in the team meeting may offer to support the client in achieving those goals.

The plan is updated as goals change or needs are met. It provides a recovery-oriented, cross-systems service plan jointly developed by a multidisciplinary team in partnership with the individual embarking on or renewing a recovery process (Milwaukee County Department of Health and Human Services, n.d.).

Through the end of the initial Wisconsin ATR grant, 51 percent of Milwaukee WIser Choice voucher expenditures were for recovery support services and 49 percent were for treatment. Forty-two percent of recovery support service expenditures were for recovery

support coordination. Utilization by service category is summarized below.

Wisconsin ATR Voucher Funding	
Treatment Services	49%
Recovery Support Services	51%
Ancillary Services	9%
(Sigurdson, personal communication, December 21, 2007)	

When recovery support coordination services are excluded, housing services (e.g., room and board, transitional housing, and short-term or emergency housing) was the recovery support service category that utilized the most voucher funding. Community employment services also accounted for a significant percentage of Wiser Choice recovery support funding. The table below summarizes utilization of recovery support services other than recovery support coordination.

Allocation of Ancillary Services Funding	
Housing & Related Supports	79%
Work-Related Services	14%
Life Skills Development	4%
Domestic Violence Services	1%
Other	2%
(Sigurdson, personal communications, December 21, 2007)	

Project Successes

In January 2007, Milwaukee County reported the following preliminary data on the impacts of Milwaukee WIser Choice (Sigurdson, personal communication, December 21, 2007):

- The total number of recovery support service and clinical treatment providers in the Milwaukee substance abuse network increased from 22 to 170.

- The number of faith-based organizations within the provider network increased from 7 to 40.

- The total number of intakes increased by 61 percent, from 4,318 to 6,945.

- The total number of individuals receiving clinical services increased by 177 percent, from 1,759 to 4,875.

- The percentage of treatment episodes designated as successfully completed increased from 21.3 to 50.7.

- The number of individuals successfully completing treatment increased from an average of 23.6 per month to an average of 145.0 per month.

- The percentage of all clients referred for treatment who presented for their first appointment and received clinical services increased from 40 to 82.

- Sixty-eight percent of all clients who presented for the first treatment appointment continued in treatment for at least 30 days.

Milwaukee County also reported improved outcomes in employment, homelessness, family connectedness, and criminal justice system involvement (Fleege, personal communication, March 28, 2007).

Wisconsin and the Principles and Elements of Recovery-Oriented Systems of Care

The Wisconsin ATR project generally reflects many of the elements of recovery-oriented systems of care developed through the National Summit on Recovery. However, there are areas where the convergence between Wisconsin ATR and the elements that emerged from the National Summit is particularly marked. They include:

- **Family and other ally involvement:** Engaging family and other allies in the recovery planning and management processes. (Milwaukee County Department of Health and Human Services, n.d.).

- **Systems anchored in the community:** Relying on natural and informal resources firmly anchored in the community.

- **Partnership-consultant relationship:** Building services on a collaborative process through which family and other allies, clinicians, and other health and human services professionals work with the individual to develop and support a recovery plan.

- **Strength-based:** Using a strength-based service plan and building concurrently on the recovering individual's strengths and those of the team.

- **Culturally responsive:** Assuring that services "are responsive to the issues of gender, age, disability, race, ethnicity, and sexual orientation and reflect support, acceptance, and understanding of cultural and lifestyle diversity".

- **Integrated services:** Relying on multidisciplinary teams and integration or coordination across multiple service systems.

Conclusion

Access to Recovery and each of the ATR projects discussed in this paper embody a significant number of the principles of recovery and elements of recovery-oriented systems of care that emerged from the National Summit on Recovery. As noted earlier in this document, ATR emphasizes individual choice and the use of faith-based and other community-based resources. It also recognizes the important role peers can play in recovery, and focuses on outcomes and accountability. In addition, the voucher program that is required under ATR provides a mechanism for flexibly financing services. Thus, ATR as a whole reflects a variety of recovery-oriented principles and elements, including using person-centered approaches, anchoring systems in the community, responding to personal belief systems, and flexible financing.

Each ATR project reviewed in this white paper reflected the unique characteristics of the service systems from which it emerged. Connecticut and Wisconsin built on prior systems-change efforts, enhancing and consolidating gains made prior to ATR. Washington ATR furthered capacity-expansion efforts already undertaken, enhancing and consolidating treatment capacity gains by complementing them with an array of needed recovery support services. Connecticut adopted a statewide model and used ATR funding to move toward the establishment of formal networks that correspond to each of its five service regions. Washington and Wisconsin, both of which have county-based addictions treatment systems, focused on implementation through counties. Washington implemented ATR across six counties; Wisconsin chose a single county to implement ATR. Connecticut expanded an existing contract with an administrative services organization to implement ATR, whereas Washington allowed each of the counties implementing ATR to decide how best to implement services under the grant. Milwaukee County in Wisconsin elected to contract directly with providers.

States and counties are each unique in their regulations, funding mechanisms, and funding mixes and in the relationships between addictions treatment and other key service systems, such as the mental health, child welfare, and criminal justice systems. This gives rise to unique challenges and opportunities. Across States and communities, different strategies are likely to be optimal for developing services and systems that reflect the principles and systems of care elements. The variety of contexts reflected across the three States studied in this document will provide examples of strategies that may be useful to systems and services planners working in a variety of regulatory and funding contexts.

One theme that emerged across all three ATR case studies included in this paper is the critical nature of the relationship between the vision, priorities, and approaches reflected in the ATR project and two other factors: 1) the organizational, regulatory, and funding context in which the project was implemented; and 2) the planning, policy, and systems development activities that the State or local government had already initiated. Each of the projects reviewed in this document reflected the guiding vision or

priorities of the State or county in which it was implemented. Each of these ATR projects built upon, complemented, or enhanced existing infrastructure and initiatives. This may have been important to their success.

By starting with the guiding vision or priorities of the States or communities in which they were implemented, and by involving a variety of stakeholders, including recovering individuals and organizations that represent them, faith-based organizations, and all levels of service systems from clinicians and provider organizations to system regulators and funders, these projects were able to develop the momentum necessary to drive significant systems changes.

Each of these case studies provided evidence that systems change is a process that builds gradually on existing capital, requires support from champions, and is inspired by a vision that is unique to each State or community. It also echoes fundamental principles that are broadly shared across States and communities. They reflect confidence in the ability collectively and individually to improve systems to meet the needs of individuals with substance use disorders.

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Appendix

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A Life in the Community for Everyone

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