Approaches to Recovery-Oriented Systems of Care at the State and Local Levels: Three Case Studies

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Strength-based

Person-Centered

Peer

Individuals

Community

Culturally Responsive

Family

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Three Case Studies

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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 (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 now provide a philosophical and conceptual framework to guide SAMHSA/CSAT and other 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 individuals.

Individuals should also be able to access a comprehensive array of services that are fully coordinated to support individual and unique pathways to 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 developed as a resource for States, organizations, and communities embarking on systems-change efforts to develop recovery-oriented system. Each State, local government, community, and organization encounters a unique set of opportunities and challenges when it commits to developing recovery-oriented systems of care. Nonetheless, there are many broadly applicable lessons that can be drawn from the experiences of other States and communities.

Developing and implementing recovery-oriented systems of care are rewarding, difficult, and complex processes. This process is relatively new to the addictions treatment and recovery field, and minimal information is available to guide States, communities, and organizations wishing to develop recovery-oriented systems of care. The case studies presented in this document provide examples of recovery-oriented approaches at various stages of development. By providing a range of examples, States and communities can explore approaches best suited to their circumstances. None provides a complete template or roadmap, since each State and community is unique, and since the development of recovery-oriented systems of care is a continuous process of systems and services improvement. Ultimately, each State, organization, and community will develop recovery-oriented systems of care based on individual needs and strengths.

Using the principles and elements as the framework, this white paper will highlight the activities and operations of two statewide systems and one city system that have taken steps toward the development of recovery-oriented systems of care. It will present case studies highlighting work under way in Arizona, Michigan, and the City of Philadelphia. The case studies will describe the following:

- Approaches to systems change;

- Systems and program models;

- Funding mechanisms;

- Challenges encountered, including workforce and training needs, regulatory and other systems barriers, and reluctance to change among key stakeholder groups;

- Research used to inform the approach; and

- Motivating factors and other elements critical to the implementation of recovery-oriented systems of care.

The City of Philadelphia: A Model of Systems Transformation

Background

Historically, the City of Philadelphia's substance use disorders and mental health agencies provided traditional, institution-based addictions and mental health treatment that often reflected acute care intervention models. However, within that broader context, a subset of organizations had been piloting and developing recovery-oriented systems of care framework for many years. These organizations recognized that individuals are capable, with some assistance and a network of supports, of managing their lives without alcohol and drugs. They understood that by providing a recovery-oriented systems of care framework individuals would "increase their capacity to participate in valued relationships and roles, and embrace purpose and meaning in their lives" (City of Philadelphia, n.d., p. 2).

Beginning in 2004, the City of Philadelphia embarked on a process to transform the city's behavioral health system to a recovery-oriented model in which coordination of services and continuity of care would be greatly enhanced. The City of Philadelphia stated the values that would drive its development of recovery-oriented mental health and addiction systems in a white paper developed to support the transformation process. Those values are shown in the box below.

Transformation: The Process of Systems Change

Systems transformation within the City of Philadelphia's Department of Behavioral Health and Mental Retardation Services (DBH/MRS) occurred after a change in leadership. The new

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Values of Recovery-Oriented Mental Health and Addictions Systems

The values of recovery-oriented mental health and addiction systems are based on the recognition that each person must either lead or be the central participant in his or her own recovery. All services need to be organized to support the developmental stages of this recovery process. Person-centered services that offer choice, honor each person's potential for growth, focus on a person's strengths, and attend to the overall health and wellness of a person with mental illness and/or addiction play a central role in a recovery-oriented system of care. These values can operate in all services for people in recovery from mental illness and/or addiction, regardless of the service type (i.e., treatment, peer support, family education).

director, Dr. Arthur Evans, had extensive prior experience transforming the State of Connecticut's behavioral health system to one focusing on a recovery-oriented systems of care framework. He led Philadelphia on a similar transformation process beginning in 2004.

DBH/MRS leadership dedicated the first few months of the transformation process to assessing the city's existing behavioral health system, getting to know providers, and identifying the needs of the system. Initial assessments revealed that the city lacked a collective emphasis on support for long-term recovery that included linkages between treatment providers, indigenous and faith-based organizations, and other community resources to ensure continuity of care through community supports and institutions that sustain long-term recovery.

Cognizant of the difficulty involved in initiating a large-scale change process, particularly under the direction of new leadership, Dr. Evans and his team first moved to develop consensus among key stakeholders regarding the need for systems transformation. This process began with the development of a Recovery Advisory Committee composed of 25 individuals,

Recovery Advisory Committee, adopted the following definition of recovery (City of Philadelphia, n.d., p. 23):

> *Recovery is the process of pursuing a fulfilling and contributing life regardless of difficulties one has faced. It involves not only the restoration but also continued enhancement of a positive identity as well as personally meaningful connections and roles in one's community. It is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members*

The Recovery Advisory Committee also serves as a steering committee for several workgroups that have been formed as a part of the transformation process. These workgroups were charged with examining specific topics germane to the development of recovery-oriented systems of care. These topics included trauma-informed services, cultural competence, evidence-based practices, and faith-based services. Under the leadership of

> **Recognizing that the City's system had many strengths and that recovery-oriented systems of care framework existed in some areas, DBH/MRS set out to systematize the transformation to a recovery-oriented system of care through a shared vision and common direction (City of Philadelphia, n.d., pp.4-5).**

including people in recovery and their family members, providers, advocates, and city staff. The first task of the committee was to define recovery for what would be the City of Philadelphia's transformed system. In 2006 DBH/MRS, following the recommendation of the

the Recovery Advisory Committee, the workgroups were charged with ensuring that their work remains connected to the larger system vision and contributes to its realization.

Following development of the definition of recovery, advisory committee members went on to identify recovery values and principles within domains the group felt were important. Concurrently, DBH/MRS conducted a formal system-wide survey designed to identify community strengths and intended to serve as a tool in building consensus and buy-in. The survey asked individuals in recovery, their family members, providers, and recovery advocates to identify recovery strengths within the community. This provided an opportunity for individuals and organizations to highlight their own recovery-oriented activities and afforded the city an opportunity to identify potential models for the rest of the system. More than 3,000 individuals responded to the survey. In addition, stakeholder meetings involving more than 450 individuals from all components of the behavioral health system were convened. The meetings provided city officials with a chance to gather direct feedback about the strengths and the needs of the system and to gather information on views regarding the priorities and staging of the system transformation process. Through this process, the Recovery Advisory Committee constructed a set of priorities for transformation.

The city's behavioral health leaders were committed to the creation of a shared vision and to guaranteeing conceptual clarity. Therefore, the city conducted frequent community forums, conferences, and workshops engaging individuals in recovery and their family members, as well as providers and advocates, in dialog about the vision and the transformation. This principle of a shared vision and conceptual clarity would continue throughout the transformation process. As the process gained momentum, the city invited experts in recovery to present on their work. For example, William White, senior research consultant on the Behavioral Health Recovery Management project, made presentations on the concepts of recovery management and on addiction as a chronic illness to DBH staff, recovering individuals, and providers.[1] He also spoke with members of the broader community, including families and community-based organizations not a part of the DBH/MRS service system.

The Recovery Advisory Committee dedicated approximately nine months to the establishment of recovery values and priorities that flowed from them. Once these were established, efforts were focused on the development of the white paper, as well as a blueprint for change. The white paper, *Innovations in Behavioral Health: An Integrated Model of Recovery-Oriented Behavioral Health Care*, discusses the concepts and history of recovery, general principles of recovery, and the shared need for a transformation to recovery-oriented care for both substance use disorders and mental health. The blueprint, which was under development at the time this case study was written, presents the recovery-oriented vision for the system and describes the process through which the vision, shared goals, and systems priorities were developed. It is intended to encourage DBH/MRS staff, providers, and other key stakeholders to begin thinking about how the priorities and goals of the transformed system will affect their services, organizations, and staff. Each entity involved in transformation will be asked what practice changes will be implemented, as well as what policies and administrative issues will be addressed.

Transformation: What Are the Next Steps?

Moving forward, the City of Philadelphia plans to develop implementation plans that will guide the city and its partners in creating a system that embodies the shared vision and conceptual framework and builds on the resources and models identified through the survey and the many public forums and meetings. System-wide education and training is a top priority in the implementation of the transformed system. The city has developed recovery training to be delivered across the system. This is the first formal training that DBH/MRS staff, individuals in recovery and their families, and providers will participate in together. People in recovery and their families will assist with facilitating the training. The 2-day session will lay the conceptual foundation of recovery and a recovery-oriented system of care upon which transformation efforts will be built. Additionally, an advanced training session is currently under development. The advanced training will help individuals acquire the skills and knowledge necessary to operate within a recovery-oriented system of care. A workgroup is in the process of identifying the skill and knowledge sets critical for individuals providing services within a recovery-oriented system of care.

The city has also released requests for concept papers, asking providers to apply for $10,000 mini-grants to enhance and expand existing services to support recovery-oriented systems of care. The mini-grants will not fund new programs but will instead encourage providers to examine their systems and identify where and how they can infuse recovery-oriented principles and transform policies and practice.

The city is also encouraging community-based organizations other than treatment providers to apply for the mini-grants, recognizing that there are many pathways to recovery and that some individuals are more comfortable seeking assistance from faith-based or peer-based organizations or other natural supports. Each of the mini-grant applicants must have an implementation team that includes recovering people. The hope is that these mini-grants will help to raise awareness, increase recovery capital in communities, and develop innovative approaches to system transformation.

As a follow-up to the mini-grants, the intent is to host a conference in which treatment and other community-based organizations make presentations on innovative systems transformation solutions. During the follow-up conference, the city intends to rely solely on the experience of stakeholders from its system for presentations on innovative systems-change efforts and lessons learned.

The city and stakeholders are discussing several other change efforts, including:

- Funding collaborations between providers and people in recovery to develop consumer-run businesses;

- Increasing the number of support groups (peer-run, consumer-run, self-help) around the city;

- Developing a cadre of peer specialists who can team with treatment providers to provide peer recovery services;

- Establishing employment and internship collaborations in which providers and local businesses provide employment

and career opportunities for individuals completing treatment;

- Initiating collaborative efforts with Philadelphia community colleges to develop a leadership academy for individuals in recovery. Completion of the academy training would qualify recovering individuals to serve as advocates in the DBH/MRS or in a provider organization;

- Co-locating physical and behavioral health services within some of the city-run health clinics, focusing largely on areas with significant ethnic diversity;

- Sponsoring train-the-trainer programs for people in recovery to assist in continued efforts to disseminate the vision of systems transformation in the city;

- Creating family resource and support centers run by families of people in recovery; and

- Building on the strengths of existing programs that have:
  o employed pretreatment support;
  o demonstrated success by enhancing retention and treatment outcomes; or
  o developed strong, long-term recovery maintenance supports.

Many of these ideas are in the early stages of concept development. However, the process through which they are evolving encourages innovative thinking among providers, community-based organizations, and city staff. Through this process, the city is encouraging providers to think creatively in the creation and adoption of model programs to support

recovery-oriented approaches. If an attempted approach is not successful, the providers will not be sanctioned for trying something new. Instead, the city encourages providers to try different approaches based on lessons learned.

> The City is not defining or proscribing program design, giving providers the flexibility to use their internal strengths to create programs and initiatives that will support the vision.

Funding System Transformation

Much of the funding for the current system transformation effort in the City of Philadelphia came from a surplus in Medicaid. DBH/MRS has relied on this surplus to fund many of the innovative programs that have been created. Rather than funding startup or new programs (which can be costly), the city has focused on providing small amounts of money to enhance or shift existing programs to reflect the values and principles of the new system.

Challenges

Agreeing on a common definition of recovery was the first challenge in the transformation process. Because people conceptualize the term "recovery" in many different ways, it was both important and challenging to develop a broadly supported definition. Additionally, consensus needed to be developed and reached on the terms and principles of "recovery management" and "recovery-oriented systems of care."

Providers were initially anxious when the city—their primary funding source— proposed significant systems change and articulated new

directions. Early in the transformation process, this manifested as resistance on the part of many organizations. The anxiety among treatment providers and other organizations heightened when the city discussed an all-inclusive process that would evolve over the long term but provided no clear timeframe. Such an open-ended process left many providers uncertain and nervous about their place in the system. All of these challenges were overcome, however, by open communication, articulation of the shared vision at every opportunity, and ensuring that the planning, decision-making, and implementation processes remained inclusive.

Lessons Learned

The Philadelphia experience confirms that building trust and including all voices throughout the process is critically important to systems-change efforts. The city consistently demonstrated a willingness to listen and not make unilateral changes, aiding in the development of trust and system-wide buy-in from providers and organizations. Though there are still providers and organizations that have reservations about the changes, the majority of the system stakeholders support the process and are active participants in the transformation effort. Additionally, the city felt it was important to inform stakeholders from the very beginning that the change process will evolve over time. However, ambiguity can increase stress and resistance to systems change. It is critical to the success of these efforts that any issues that could impede the process be addressed as soon as possible in the planning process.

Summary

The City of Philadelphia has instituted an inclusive process of systems transformation that emphasizes building on existing resources to develop recovery-oriented systems of care.

The city's efforts generally reflect 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 the City of Philadelphia's work and the Summit's elements is particularly marked. They include:

Person-centered by making the individual in recovery the center of the transformation process. Recovering individuals have been central at each phase of planning and implementation, helping to design the city's recovery-oriented system of care. The city is also developing a menu of services that will meet the needs of the individual, whether the person is seeking support from a recovery-support provider, a community organization, a treatment program, or a peer support specialist.

Family and other ally involvement by bringing families and other support networks to the table as a part of the transformation process. Families are an important part of the city's system, and that is reflected in the various roles they continue to play in the system and in the change process.

Individualized and comprehensive services across the lifespan by changing the system to enhance chronic care approaches and rely less on approaches that reflect acute care practices. The city has also focused on developing comprehensive services that are stage-

appropriate and can be accessed by individuals at any point in their treatment or recovery.

Systems anchored in the community through the inclusion of community-based organizations. The city also supports community-based organizations in transformation efforts. This enhances the community support systems and makes them a viable and valued part of the system of care.

Continuity of care by identifying those organizations that are providing pretreatment and recovery support services and enhancing their programs through mini-grants in an effort to develop models for pretreatment and recovery maintenance.

Strength-based by redesigning the system to support treatment and recovery efforts that capitalize on an individual's strengths.

Culturally responsive by reaching out to ethnically diverse populations and supporting recovery in settings where they are most comfortable.

Responsiveness to personal belief systems by including faith-based organizations in the transformation process and in the request for proposals (RFP) process for mini-grants.

Commitment to peer recovery support services by including peer recovery support services in the principles of the transformation as well as by devising strategies to expand those services.

Inclusion of the voices and experiences of recovering individuals and their families by including them throughout the transformation process, as well as by training recovering

individuals and their families in peer support and family support activities.

Integrated services by creating an integrated behavioral health care system and by exploring strategies for making behavioral health care available in city-run health clinics.

System-wide education and training through the provision of training and education opportunities from the outset of the process. System-wide education and training will continue as a part of the transformation efforts as the city brings together model programs for conferences and workshops, trains recovering individuals to partner with providers to create systems and services that embody the vision and the mission of the transformation, and provides education to recovering individuals and their families.

Ongoing monitoring and outreach by developing a system that is designed to reach out consistently to individuals and their families and to reengage them in the recovery process through training opportunities, education, and community-based support.

Arizona: Statewide Systems Change Through Medicaid Expansion

Background

Since the early 1990s, substance use disorders services in the State of Arizona have been provided as a part of a behavioral health Medicaid carve-out. Service eligibility is contingent upon financial eligibility for Medicaid. Coverage of all behavioral health services under Medicaid allows the State to offer the same level of services regardless of whether someone presents with a substance use disorder or a severe mental illness. In 2000, Arizona redesigned the State's behavioral health system to shift the provision of service from delivery solely in traditional treatment settings to delivery in treatment and other recovery-based community settings. This system redesign included an expansion of person- and family-centered support and rehabilitation services. A number of factors motivated Arizona to undertake this systems-change effort, including:

- A Federal Medicaid waiver that allowed services to be defined and reimbursed in a new way;

- A statewide ballot initiative that significantly increased the number of individuals eligible for Medicaid; and

- A class action lawsuit settlement that required the State to substantially improve behavioral health services for children.

Peer and Family Support Services

With an expanded array of services covered by Medicaid, Arizona was able to offer a full array of person- and family-centered, recovery-oriented services. Both recovering individuals and their family members were hired to work in the behavioral health system in a variety of capacities. Under Arizona's system redesign effort, recovering individuals play a critical role in providing peer support services (PSS).

Arizona began offering PSS in 2000. Initial PSS efforts focused on services to individuals with serious mental illnesses. However, beginning in 2003, Arizona expanded the focus to create PSS positions to support those with substance use disorders. Peer support specialists serve as mentors and recovery coaches and team with alcohol and drug treatment providers to support individuals in their long-term recovery efforts. A statewide training for peer support specialists was piloted in 2003 and expanded in 2005 to train 65 peer support specialists working in 17 agencies. In 2006, the State achieved its goal of doubling the number of peer support staff, and it continues to expand PSS.

Although the State does not require certification for peer support specialists, several training and certification programs exist. A new training program to expand PSS for people with co-occurring disorders provides training for both treatment providers and people interested in becoming peer support specialists. The 2-day training for treatment providers serves as a guide

for including peer support specialists on service teams and trains existing staff to work with peer staff on service teams. Other training targets individuals interested in becoming peer support specialists and provides a mechanism for earning college credit.

Family members are also an important part of the Arizona recovery support service redesign. Many family members are hired by community service agencies (CSAs), which may be nontraditional faith-based organizations and/or community-based organizations. The CSAs provide support services (e.g., health promotion groups, living skills, other family supports) under the Medicaid waiver. Other family members (approximately 181 at this time) provide family and PSS in both licensed behavioral health agencies and CSAs statewide.

The CSAs were added to Arizona's funded continuum of care in 2001. They were created as part of the system redesign to expand access to recovery support services. The CSAs are not licensed and do not conduct assessments or provide treatment, but they are certified through an application process overseen by the Arizona Department of Health Services/Division of Behavioral Health Services, the Single State Authority for substance use services. They are described in Arizona's Medicaid Covered Services Guide as a "natural community support" that uses practical and informal approaches to provide support and rehabilitation services. While many of the services can be provided by a clinician, nontraditional providers often bring personal experience in recovery, shared cultural experience, and other assets that clinicians may not be able to offer.

The CSAs receive both block grant and Medicaid funding. There are currently 12 consumer-operated organizations providing peer services, including depression and alcohol screening, employment training, and educational services for behavioral health consumers and family members. Their efforts have reinforced the focus on recovery-oriented efforts, increasing awareness of what it takes for people to be successful in recovery.

Recovery-Oriented Approaches at the Point of Entry

Within the new system, Arizona implemented recovery-oriented approaches at the front door. In many agencies, when someone enters a treatment facility, the first person they see is a peer, not a clinician. This first contact can be instrumental in fostering engagement with the behavioral health system. This approach has proved successful in Arizona's detoxification programs. Many detoxification clients come into the program with no intention of staying longer than the 24 hours it will take to stabilize. However, when the first person they meet is a peer, they find themselves in conversation and interaction with someone who can relate to what they are going through. This often leads to a discussion about what is next for them, and many find themselves talking about treatment and recovery as something they want or need in their life.

> Arizona's person-centered approach to recovery-oriented services begins when an individual initiates contact with the system.

The assessment process also reflects recovery-

oriented approaches. A uniform assessment and service-planning process has been adopted statewide. It concurrently assesses substance use and mental health issues and utilizes a team approach to develop a recovery plan, which reflects the individual's goals and focuses on building a system of support around him or her. The planning team focuses on helping individuals identify strengths and supports in their lives and also puts in place a plan to ensure that they will be able to attend the next appointment.

This same planning process is in place for adolescents, utilizing a child and family support team. The team may consist of a variety of social service providers, family members, or a guardian, who provide support for the adolescent. The child and family support team also identifies any urgent issues that must be addressed immediately, such as concerns about the child's safety or a need for prescription medication. There are about 14,000 child and family support teams operating in Arizona, serving a little over one-third of the adolescents in the system.

Community Reintegration

Ongoing recovery support also involves assisting individuals in locating housing and employment. The State of Arizona has worked with provider organizations to provide employment opportunities within the behavioral health system for recovering individuals. It has also provided seed money for consumer-run businesses, including a candle-making company and a bee-keeping business. The State is also collaborating with the business community to create job development programs to support employment for individuals in recovery.

The State has developed methods to help individuals secure housing as well. If an individual cannot afford housing, the block grant will pay for supported housing for individuals and their families while they are participating in treatment. When an individual moves from residential treatment to outpatient services, the State covers the cost of an apartment for the duration of treatment.

Planning for Recovery-Oriented Services

Initially, minimal strategic planning informed systems-change efforts in the adult substance use disorders service system. Systems change was driven by changes in Medicaid that expanded the service availability for eligible clients. The change meant that providers had to provide reimbursable services to Medicaid-enrolled individuals. Providers were challenged with determining how to make available this expanded array of services. The State assisted by offering technical assistance, monitoring utilization rates, setting network goals, and assessing network capacity.

At the time this case study was written, Arizona State officials, consumers, providers, and advocates were in the process of developing a strategic recovery plan for adolescents. The document is currently in draft form. The systems-change process for the adolescent service system has been more structured than the effort to transform the adult system. The process includes the development of a plan with the support of stakeholder workgroups and defined goals.

Implementing Recovery Support Services

Through utilization review, the State learned that providers were not comfortable with PSS and therefore had not implemented them despite available funding. To increase utilization of PSS, the State convened eight providers to design a peer support model. In 2003, the State requested technical assistance from SAMHSA to help adapt the successful peer support model used for those with serious mental illnesses to a model that could be used for individuals with alcohol and drug use disorders. The eight providers piloted the adapted model. The State highlighted the work of the eight providers by scheduling trainings and workshops in which they presented their work. The State also provided $650,000 to expand the availability of PSS, which then became Medicaid-covered services. Finally, the State developed a protocol for PSS designed to help organizations develop and implement their own PSS.

> This creative and flexible approach to funding substance use disorders services has allowed the State to serve more than 89,000 people, up from only 8,000 in the late 1990s.

Funding Recovery-Oriented Approaches

Arizona has been able to successfully blend its block grant and Medicaid funding to provide a wide range of recovery-oriented services. While Medicaid accounts for over 75 percent of the Arizona substance use disorders budget, block grant funds cover critical components not covered by Medicaid, including transitional housing for individuals completing treatment. According to State officials, Arizona had the ability through a waiver to expand their Medicaid service coverage since the early 1990s, but did not systematically identify gaps and explore how Medicaid funds could fill these gaps until 2000.

Challenges and Barriers

One of the greatest challenges Arizona encountered was dealing with clinicians' beliefs that they could control the treatment and recovery process. Medicaid-eligible services could no longer be denied for an individual deemed "not ready" for treatment. Clinicians were accustomed to making many decisions regarding treatment for individuals, including whether or not an individual was ready for treatment. With the change to the Medicaid-covered services array, providers were now required to provide services for anyone eligible to receive them.

Ambivalence and hesitation among providers regarding the provision of peer services was also a significant challenge. Under the Arizona model, peer support specialists have access to clinical records and take part in clinical staffing. Some clinicians initially attempted to exclude them from the staff room and also attempted to prevent them from reviewing medical records. Some clinicians also attempted to hold service-planning meetings at a time when the peer support specialist was unavailable. Additionally, in rural agencies, a challenge was encountered when a peer support specialist was receiving

services at the same agency where they were providing peer support. Previously there was nothing in a clinician's training that addressed overcoming some of the ethical and clinical issues that they were facing in dealing with peers/consumers as full and participatory members of the service delivery staff. In response to this, the State developed a protocol to help agencies and clinicians overcome these challenges.

Lessons Learned

Other organizations attempting the same level and scope of system redesign must undertake the effort with recognition that change is a long-term and evolving process. A philosophical shift like Arizona's systems-change effort can be daunting for all parties involved and should be recognized as such. Any major system shift should include input from all key stakeholders from the beginning. It is also important that all parties—the State, providers, advocates, and individuals in recovery—be flexible and at times accommodating as the process will be continuously revised and adjusted. Cultural barriers can also pose a challenge to systems change.

Summary

The Arizona recovery-oriented change process is an example of how a State can develop innovative approaches to address the needs of individuals and can implement those changes through a long-term and evolutionary process involving multiple parties.

The State's efforts generally reflect 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 the State of Arizona's work and the Summit's elements is particularly marked. They include:

Person-centered by implementing team-based recovery-focused approaches from an individual's initial contact with the system.

Family and other ally involvement by involving families in the recovery process from the point of assessment through recovery. Families provide support services and are valued members of organizational support staff.

Individualized and comprehensive services across the lifespan by making available an individualized, stage-appropriate, and flexible menu of options for adults and adolescents. The systems change reflected the knowledge that the system must change to meet the needs of the individual, as opposed to requiring the individual to change to meet the needs of the system.

Systems anchored in the community through involving CSAs in the recovery support process, as well as involving community members in community reintegration efforts.

Strength-based by developing an assessment that focuses on the strengths an individual brings to his or her own recovery.

Commitment to peer recovery support services by the creation and funding of CSAs.

Inclusion of the voices and experiences of recovering individuals and their families by giving peer support specialists a prominent role in the system, employing them in agencies where they are the first contact a client may have

with the system, and by valuing their input in the system redesign.

Integrated services by implementing the use of an integrated behavioral health assessment. The Arizona system also focuses on assisting individuals in gaining access to community supports following treatment, including housing and employment.

System-wide education and training by making such efforts a cornerstone of the Arizona systems-change effort. The introduction of peer

services required extensive training of provider organization leaders and managers, clinicians, and peers.

Adequately and flexibly financed by creatively expanding the range of Medicaid-covered services and the number of individuals eligible for Medicaid and using block grant funding to provide services not covered by Medicaid.

Michigan: An Evolving Process to Implement Recovery-Oriented Approaches

Background

Michigan's substance use disorders system is operated through a regional structure. The State offices for substance use disorders—the Office of Drug Control Policy and the Bureau of Substance Abuse and Addiction Services—contract with 16 regional coordinating agencies (CAs). The CAs in turn contract with providers in their region and manage the regional provider network. All direct services are provided by licensed community-based organizations. In 2006, the State completed a 3-year restructuring process. This process culminated with the issuance of new administrative rules governing substance use disorders treatment services. The rule change was particularly significant because the State had not modified its rules since they were first promulgated in 1981. Prior to the issuance of the revised administrative rule, State substance use disorders policy and regulation had been driven largely by the requirements of the Federal Substance Abuse Prevention and Treatment Block Grant, which was the primary funding source for substance use disorders services in the State.

Implementing Recovery-Oriented Approaches

State officials began the systems-change effort by reviewing the substance use disorders services and infrastructure with the goal of expanding the service array for licensed provider agencies. Prior to the rule change, the State funded outpatient, intensive outpatient, sub-acute residential, detoxification, residential, and methadone services. With the implementation of systems-change efforts, that standard service array was expanded to include case management, co-occurring mental illness, recovery, and PPS, as well as early intervention. (Previously early intervention only existed within the prevention system.)

The initial change process did not include a vision statement or plan for strategic systems change. The State's environment for the past several years had been one of little or no growth or change. However, community stakeholders pressed for systems evolution. Discussions began to move forward with modest goals. A vision and a strategy began to emerge. When State officials convened a workgroup consisting of providers and other stakeholders to discuss improvements to addictions treatment, consensus emerged that the system needed to be strength-based and recovery-focused. From this consensus, the stakeholders developed values and principles to guide the State's vision and authored a plan to create such a system.

Although Michigan did not make a conscious decision to implement recovery management as defined by the Behavioral Health Recovery Management project and the work of William White, the principles and practices of this project informed the implementation process. Many providers and CAs across the State were familiar with White's work and the concepts of recovery management.[2] Through the multiple trainings he

had conducted in the State, many of his ideas had caught on at the local level. Through discussions between the State, CAs, and local providers, the elements of recovery management made their way into State-level systems-change efforts.

To realize the vision that had emerged for Michigan's addictions system, barriers to implementing systems change had to be addressed. First and foremost, the administrative rule had to be changed to allow for reimbursement of an expanded array of services, including case management, early intervention, peer support, and other recovery support services. A State workgroup that includes State staff, providers, and consumers is currently establishing standards for these services.

> Among the challenges the State of Michigan faced were fostering understanding and acceptance of new approaches and philosophies and managing the process of change through which they were implemented on a program and system level.

In addition to designing standards for the State's expanded recovery-focused services, State officials have made a concerted effort to include strength-based and recovery-focused approaches and philosophies throughout the State system. Planning guidelines and documents reflect this effort. Examples include proposed requirements that consumers and families be included in treatment and recovery planning and in decision-making processes at all levels. In addition, the State law governing the advisory council requirements for CAs has been updated to require greater consumer and family participation on the advisory councils.

Training is a critical component of Michigan's systems-change efforts. It serves not only to equip clinicians, providers and other stakeholders to implement new practices but also to support them in adopting new philosophies. Training is an important tool to secure widespread support of the change process. The State has funded several training opportunities for providers, including a motivational interviewing workshop with William White. As part of their ongoing training plan, State officials have requested support from the Great Lakes Addiction Technology Transfer Center (GLATTC). GLATTC provides technical assistance and training on systems-change efforts and technology transfer and continues to work with the State, providers, and consumers on skills training to enhance and support systems-change efforts.

Finally, the State and providers are striving to close the gap between prevention and treatment in Michigan. Historically, prevention and treatment services existed in separate and distinct silos. However, several organizations across the State are working to break down those silos and capitalize on preventionists' community capacity–building skills to support community-focused recovery and relapse prevention efforts.

Funding Systems-Change Efforts

Despite the efforts to create systems change in Michigan, State funding is not available to support new services. The State is asking providers to examine their business practices and identify creative ways to reallocate or more effectively fund recovery-oriented services. Additionally, the State is developing strategies to address engagement and retention issues. They have discovered that a significant percentage of addictions treatment funding supports services provided to individuals who enter the system, receive limited treatment services, and then are discharged prior to treatment completion or without linkage to recovery support services. Often a significant percentage of these individuals return within weeks or months. Such "revolving door" services cost the State money but typically do not result in positive outcomes.

Michigan recognized that systems could be put into place that would increase engagement and retention rates, reducing the number of clients cycling in and out of the system. To address these issues, the State has been involved in the Network for the Improvement of Addiction Treatment (NIATx) study to determine which combinations of services produce the greatest improvement in treatment services.[3] This involvement resulted in the State's establishing a policy to facilitate access to treatment by making the initial intake process less intensive and overwhelming for individuals seeking treatment. By implementing practices to increase engagement and retention, thereby reducing the revolving door effect, Michigan believes that it will be able to reallocate resources that

have historically funded repeat treatment episodes.

Many CAs have applied for grants to fund recovery support services, and one Michigan CA was awarded a Recovery Community Services Program (RCSP) grant. Providers and CAs will continue to apply for grants to fund recovery-oriented approaches in the State. The State is also looking at how existing, nontraditional community services can be used to support recovery-oriented approaches. State officials believe that even if no new funds become available, changes can be made within organizations to support ongoing systems-change efforts.

Barriers and Challenges

Funding has been identified as the greatest barrier to implementing a recovery-oriented approach in Michigan. However, the State and providers have worked collaboratively to reallocate existing funds to support recovery-oriented services. Additionally, barriers created by the State's infrastructure and administrative codes were addressed through a collaborative process.

Lessons Learned

It is important to identify a vision for the system. Once a vision has been established, values and principles need to be articulated and a structure to support them needs to be developed. It is also important to identify and analyze regulatory, funding, and philosophical barriers to implementation of practices that reflect the new values and principles. A plan should be developed to address specific barriers. The plan may require a multipronged approach that includes statutory and rule changes and

statewide training efforts. Without such a plan, systems-change efforts may stall. Finally, the change process will require incremental steps over an extended period of time to implement.

Summary

Systems-change efforts in Michigan continue to evolve incrementally as State workgroups create recommendations to address gaps and barriers. Michigan's ongoing work is an example of systems-change efforts in support of a recovery-oriented approach. It demonstrates how a planning and change management process can become a feature of a State system, providing a mechanism for system improvement.

The State's efforts generally reflect 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 the State of Michigan's work and the Summit's elements is particularly marked. They include:

Person-centered by expanding the array of services to include a broader menu of choices. The service system now includes case management, recovery and PPS, and early intervention.

Continuity of care by closing the gap between early intervention and treatment.

Strength-based by infusing strength-based principles and concepts into all systems-change efforts.

Commitment to peer recovery support services by adding PPS to the array of covered services in the State system. Additionally, the State has developed a workgroup to design peer support standards.

Inclusion of the voices and experiences of recovering individuals and their families through administrative and regulatory changes. Recovering individuals and their families are now included in many of the decision-making and planning processes, including CA advisory councils.

Integrated services by including co-occurring disorders services in the new administrative rule. Providers are now able to provide these services to consumers in the substance use disorders programs.

System-wide education and training by providing training on systems change and technology transfer. Michigan also conducts a yearly statewide training conference that for the past 2 years has been focused on recovery-oriented approaches.

Ongoing monitoring and outreach by increasing retention rates. Michigan will be able to use money previously spent on "revolving door" clients on recovery-oriented approaches.

Conclusion

The three case studies presented here document innovative approaches that a city and two States have taken to implement recovery-oriented approaches. Systems-change efforts were motivated by different factors in the jurisdictions. In 2004, the City of Philadelphia hired a new director of the Department of Behavioral Health and Mental Retardation Services who transferred lessons learned from a similar effort in another jurisdiction. The State of Arizona, in 2000, redesigned the State's behavioral health system based on several factors: a Federal Medicaid waiver that provided an expanded funding stream; a Statewide ballot initiative that increased the number of individuals eligible for Medicaid; and a class action lawsuit settlement requiring the State to improve behavioral health care for children. In 2006, the State of Michigan began its change process by promulgating an administrative rule change, which expanded the service array. Further, a broader vision for systems change was inspired by community stakeholders.

Implementing recovery-oriented systems of care is an evolutionary process, and the city and States discussed in this paper are at different stages in that process. In each case, the city or State faced unique challenges and barriers which it was able to overcome by collaborating with key stakeholders, including consumers and their families, providers, and other community-based organizations. Despite differences, all three studies concluded that collaboration among stakeholders was required for success. In each study the leaders were able to create buy-in for a common vision and a process for change by maintaining open communication and including multiple stakeholders in the planning and implementation process. The city and States found that entrenched attitudes and beliefs by those involved in the systems created barriers to change and had to be addressed immediately.

Leadership, innovative thinking, flexible planning, and analysis of existing system strengths and weaknesses emerged as key elements of each change process. Another theme that emerged was that change can begin with small amounts of funding or by reexamining current business practices. Additionally, in each case, contributors stressed the need to recognize and commit to a long-term and often difficult process. However, once that commitment is made and all parties recognize that the city or State is prepared to follow through with change efforts, momentum increases.

Despite the long-term nature of the process, these jurisdictions stated that their efforts to move people and systems toward a recovery orientation were worthwhile.

References

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Endnotes

[1] The Behavioral Health Recovery Management project is a partnership of Fayette Companies, located in Peoria, Illinois; Chestnut Health Systems, headquartered in Bloomington, Illinois; and the University of Chicago, Center for Psychiatric Rehabilitation, in Chicago, Illinois. The project seeks to apply the principles of disease management to assist individuals with chemical dependency and/or mental illness to engage in a process of recovery from these illnesses.

[2] Recovery management approaches place greater emphasis on supports within the family and the community that can be capitalized on to enhance recovery initiation and maintenance. Recovery management focuses on the life of an individual and not just the disease. Recovery management recognizes that recovery is an incremental process in which an individual moves through a series of five zones of personal experience and that there is an "ebb and flow" through and across each of the five zones. The zones of personal experience are physical, psychological, relational, lifestyle, and spiritual. The recovery management model uses "progress in one zone to prime improvement in other zones." Additionally, recovery management recognizes three stages in the recovery process: 1) engagement and recovery priming (pre-recovery/treatment), 2) recovery initiation and stabilization (recovery activities/treatment), and 3) recovery maintenance (post-treatment recovery support services). See Boyle et. al. (2000, June 28), *The Behavioral Health Recovery Management Project: Project Summary and Concept*, at http://www.bhrm.org/bhrmpsummary.pdf.

[3] The Network for the Improvement of Addiction Treatment (NIATx) is a partnership between the Robert Wood Johnson Foundation's Paths to Recovery program, the CSAT Strengthening Treatment Access and Retention (STAR) program, the National Institute on Drug Abuse, and a number of independent addictions treatment organizations. NIATx works with addiction treatment providers to make more efficient use of their capacity and shares strategies for improving treatment access and retention.

Appendix

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