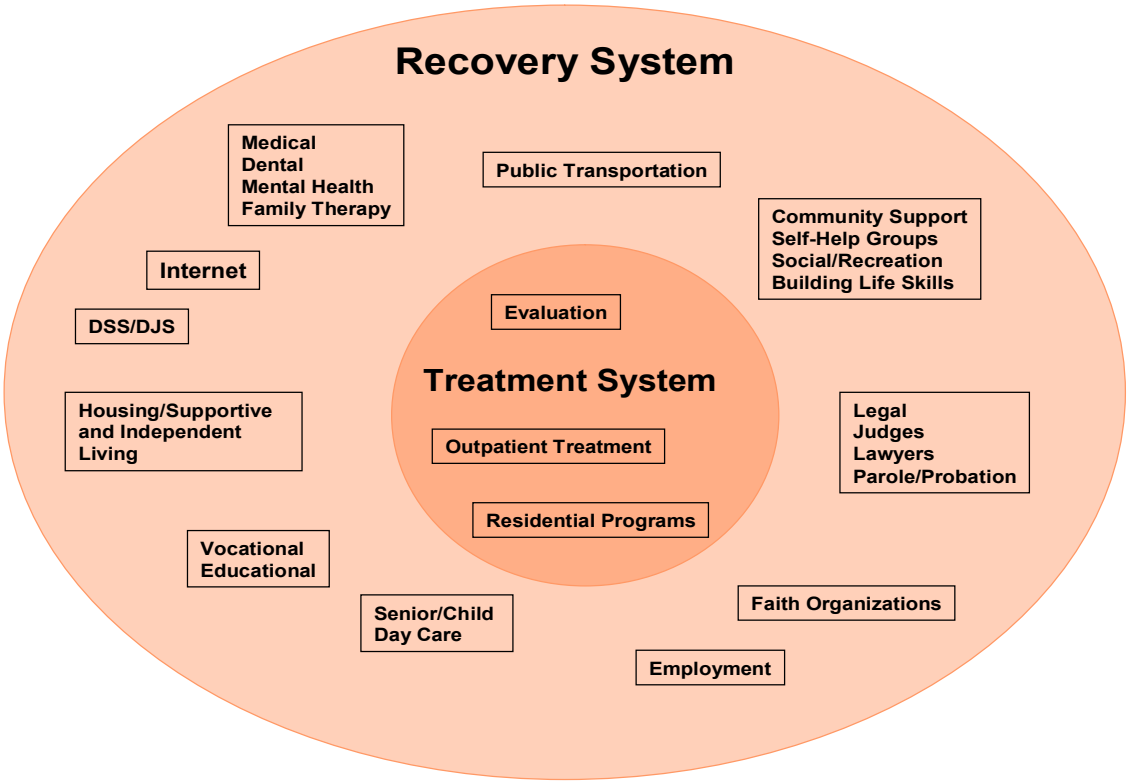
Recovery Oriented Systems of Care
Implementation Plan



Maryland Recovery Workgroup
January 2009

Introduction
In November 2007, the Director of ADAA, Dr. Peter F. Luongo, appointed a workgroup comprised of county coordinators, addiction treatment providers, members of the recovery community, a recovery advocacy organization, and ADAA staff to create an implementation plan that would guide ADAA in developing a Recovery Oriented System of Care (ROSC) in Maryland.

The workgroup members are:
Thomas Cargiulo– Director, Bureau of Substance Abuse Services, Howard County Health Department
David Ennis – ADAA Western Region Manager
Carlos Hardy – Executive Director, Maryland Chapter of the National Council on Alcoholism and Drug Dependence
Susan Jenkins – ADAA Central Region Manager
Yngvild Olsen – Acting Deputy Health Officer, Harford County Health Department
Arnold Ross – Chief of Administration, Baltimore Substance Abuse Systems
Rebecca Ruggles – Special Projects Director, Mid-Atlantic Association of Community Health Centers
William Rusinko – ADAA Research Director
Suzan Swanton – Executive Director, Maryland State Drug and Alcohol Abuse Council
Christina Trenton – Director, Carroll County Long-Term Treatment Facility.

The Task
In order to establish a common ground to accomplish our task, the workgroup agreed upon a definition of recovery and adopted the guiding principles and elements that characterize a Recovery Oriented System of Care established by the Center for Substance Abuse Treatment's National Summit on Recovery (see appendix A). The workgroup conceptualized the development of a recovery oriented system of care as containing two major components:

1. transforming the addiction treatment system to reflect a chronic disease management model; and
2. developing systems of recovery support services within communities.

The need to obtain information from community stakeholders regarding current community services, barriers to accessing those services, and gaps in services was addressed by inviting every jurisdiction in Maryland to convene focus groups.

Focus Group Summary
Baltimore County, Garrett County, Harford County and Howard County held focus groups comprised of treatment providers, members of the recovery community and their families, and support service providers who were asked to identify treatment and recovery support services that exist in their communities, barriers to accessing those services, and services that are needed. Common themes revealed by their discussions are as follows:

- Services universally available included outpatient addiction treatment, parole and probation, and internet access.

- Services available in varying degrees included medical care, mental health services, family therapy, vocational/employment, legal services, self-help groups, connection with faith organizations, DJS, and substance abuse evaluation.

- Services universally identified as high need and not available included supportive housing, senior/child day care, social/recreational activities (particularly for youth), public transportation, and local residential addiction treatment.

- Multiple focus groups identified the need for service providers to connect more effectively with the citizens in their communities through outreach programs and public awareness activities, to help reduce the stigma associated with substance use disorders, enhance public knowledge of resources available, and publicize how services can be accessed.

- Themes focusing on service delivery included inadequate quantities of services, services exhausting funds prior to the end of the fiscal year, long waiting lists to access some services, and uneven access to services throughout a jurisdiction. Some services were identified as requiring complicated application processes and having exclusionary eligibility criteria. A need for improved collaboration between service providers to serve patients with multiple problems was emphasized, as was the need for "braided" funding for mental health and substance abuse treatment.

- Additional service needs included intervention, support for families who have someone in treatment, case management, centralized resource centers, and mobile treatment.

Goals and Objectives

Based on the information received from these focus groups and the results of our analysis of the service delivery systems' strengths, weakness, threats and opportunities, the workgroup identified the following goals that would facilitate the development and implementation of a recovery-oriented system of care for Maryland's citizens.

1. Engage stakeholder groups in the process of planning, implementing, and evaluating recovery oriented systems of care in Maryland.
2. All partners in Maryland's recovery oriented system of care will have the appropriate and necessary skills, attitudes, and knowledge to promote recovery and wellness.
3. Guide the transformation to a Recovery Oriented System of Care in Maryland.
4. Define standards for services.
5. Change funding priorities.
6. Collaborate with other agencies.
7. Measure recovery outcomes.

Goal 1: Engage stakeholder groups in the process of planning, implementing, and evaluating recovery oriented systems of care in Maryland.

Objective 1: Involve stakeholder groups in planning services.

Objective 2: Involve consumers and other stakeholders in evaluation of services.

Objective 3: Enhance the capacity of the recovery community to provide recovery support services.

Objective 4: Support the development of leadership capacity within the recovery community.

Strategies:

1. Assess the ability of local alcohol and drug abuse councils to elicit a broad range of stakeholder input in the development of their strategic plans.
2. Develop a list of questions for survey, focus group or structured interview to assess consumer satisfaction with services.
3. Contact the Alcoholics Anonymous General Service Board and the Narcotics Anonymous World Services Organization for help with eliciting information from persons in recovery – i.e. What services do you need currently; what services did you need in the past.

Goal 2: All partners in Maryland's recovery oriented system of care will have the appropriate and necessary skills, attitudes, and knowledge to promote recovery and wellness.

Objective 1: Develop a common language for recovery-oriented systems of care that reflects our understanding of addiction as a chronic disease and includes concepts of prevention, intervention, treatment and recovery support.

Objective 2: Develop recovery-oriented curricula and clinical practice standards, considering at least three different groups of individuals:

a. Substance abuse service workforce;
b. Human service and medical providers; and
c. Recovery support providers.

Objective 3: Implement recovery-oriented practices and standards using a technology transfer model.

Objective 4: Develop and provide an educational program on ROSC to promote cooperation and alignment among ROSC stakeholders.

Strategies:

1. Convene a multi-disciplinary workgroup to define recovery-associated terms and concepts, formulate revised language, and create a framework for curricula and clinical practice standards.
2. Engage representatives from Maryland's undergraduate and graduate training institutions in recovery-oriented system education.
3. Identify and partner with expert consultants to develop recovery-oriented curricula and clinical practice standards.
4. Present white papers from workgroups and consultants to state alcohol and drug abuse council for review and approval to disseminate.
5. Identify change agents within each jurisdiction, programs, and other ROSC-associated settings to participate in dissemination plan.
6. In conjunction with workgroups, change agents, and state council, develop a dissemination plan to include practical learning exchanges, formalized trainings and courses, incentive-based programming.

Goal 3: Guide the transformation to a Recovery Oriented System of Care in Maryland.

Objective 1: Create senior staff level authority and accountability for the transformation process within ADAA.

Objective 2: Involve other administrations within the Department of Health and Mental Hygiene in the ROSC transformation process.

Strategies:

1. Consider developing an ongoing Recovery Workgroup to help guide the transformation process.
2. Explore the possibility of the Deputy Secretary for Behavioral Health establishing a committee bridging the administrations to encourage and monitor recovery "friendly" activities.
3. Explore if State General funds can be used to fund recovery support services.
4. Establish benchmarks to measure the status of transformation to a recovery oriented system.
5. Establish a time line for transformation to a recovery oriented system.

Goal 4: Define standards for services.

Objective 1: Identify structural system changes needed to implement recovery oriented programs and business practices for prevention, intervention and treatment (Example: Closing cases after 30 days; no mechanism for reimbursement of family sessions in treatment programming**).**

Objective 2: Identify program practice standards that constitute recovery oriented facilities and programming within prevention, intervention, treatment, and recovery support services.

Objective 3: Develop clinical practice standards that constitute recovery oriented practices.

Strategies:

1. Identify barriers that exist within programs and systems that prohibit the implementation of ROSC.
    a. promote access and engagement
2. Develop standards of practice for programs and clinical practices for ROSC.
    a. primacy of participation – recovering Individuals and family members
    b. community mapping and development –promote active involvement of community stakeholders and holistic involvement of community resources (formal and informal).
3. Provide technical assistance to programs to evaluate existing practice standards and adapt program practice standards developed for ROSC that are appropriate to level of care.
4. Identify the knowledge and skills needed to implement recovery oriented care.
    a. strength based assessments
    b. individualized recovery planning
    c. ensuring continuity of care
5. Prioritize training and staff development to increase individual practitioners' competencies.
6. Develop ongoing mentor support, enhanced supervision, recovery oriented case conferences and opportunities for peer consultation.

Goal 5: Change funding priorities.

Objective 1: Provide new funding for selected recovery support services.

Objective 2: Incorporate recovery oriented system requirements into conditions of grant/contract award, for both existing treatment services and for newly funded recovery support services.

Objective 3: Use incentive funds to encourage providers to achieve recovery oriented outcomes.

Objective 4: Re-evaluate funding allocations annually, based upon conformance to recovery oriented standards of care and recovery oriented outcomes.

Strategies:

1. Apply for SAMHSA Access to Recovery grant to obtain additional funding for recovery support services.
2. Explore whether State General Funds can be used to fund recovery support services.
3. Form a System Planning subcommittee of the Recovery Workgroup to:
    a. research recovery support service delivery systems in other states and consider local jurisdictional needs assessments in order to recommend what recovery support services should be prioritized for funding, and
    b. develop a system blueprint, including costs for recovery oriented treatment and support services by level of care.
4. Explore Connecticut's recovery self assessment tool and vendor contract conditions for guidance in identification of recovery oriented conditions of grant/contract award to be used for existing treatment services and recovery support services.
5. Determine what recovery oriented outcomes can be encouraged through use of incentive funding.
6. Develop recovery oriented systems evaluation criteria for grant review process.

Goal 6: Collaborate with other agencies.

Objective 1: Identify existing resources available through public and private human services agencies/entities that support and sustain recovery.

Objective 2: Facilitate a coordinated effort by public and private human services agencies/entities to:

a. deliver a continuum of effective and efficient services at local and state levels, and
b. secure necessary resources to provide a full continuum of care at local and state levels.

Objective 3: Increase ease of access to human services that support and sustain recovery through coordination and collaboration by state and local public and private agencies/entities.

Strategies:

1. Meet with members of the Maryland State Drug and Alcohol Abuse Council, and at the local level, with representatives of human services agencies to:
    a. Educate them on the principles of a recovery-oriented system of care
    b. Raise their awareness of the mutual benefits of coordination and collaboration in service provision and the value of shared outcomes.
    c. Identify those services each department offers that support and sustain recovery
    d. Identify access barriers to those services
    e. Explore possibility of memoranda of agreements to facilitate referral and access to services
    f. Identify opportunities for additional funding and resources needed to address gaps in service delivery.
2. Develop a resource guide that includes admission criteria, referral phone number, staff contact, etc.
3. Explore how the Maryland Community Services Locator can be used /expanded to facilitate referrals to access to a full continuum of recovery-oriented services.

Goal 7: Measure recovery outcomes.

Objective 1: Assess readiness of ADAA to measure recovery outcomes.

Objective 2: Develop and define outcomes that are indicators of progress in recovery.

Objective 3: Define intervals and a system for collecting longitudinal data on people who have accessed services.

Strategies:

1. Convene an interdisciplinary group to consider outcome measures that reflect stability in housing, social connectedness, and participation in self-help groups.
2. Recommend revision of existing treatment indicators to better address recovery status.
3. Charge the interdisciplinary group with identifying settings adaptable to reporting of data.
4. Identify other states that routinely collect follow-up data and assess the effectiveness of methods.
5. Recruit service providers and other parts of the service system to participate.
6. Address confidentiality issues and freedom of choice of person in recovery to refuse follow-up contact or to assist with tracking.

Appendix A

Definition of Recovery:
Recovery from alcohol and drug addiction is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life. Abstinence includes use of medication as prescribed by an authorized health care provider.

Guiding Principles:

- There are many pathways to and through recovery
- Recovery is self-directed and empowering
- Recovery involves a personal recognition of the need for change
- 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
- Recovery is a reality

Elements of a Recovery Oriented System of Care:

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