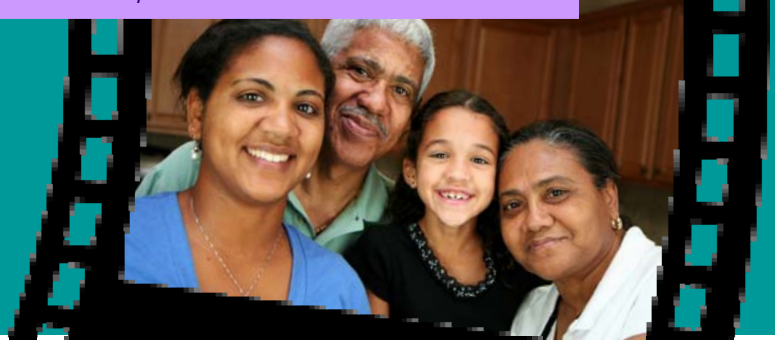
Michigan's Recovery Oriented System of Care

An Implementation Plan for Substance Use Disorder Service System Transformation



Bureau of Substance Abuse and Addiction Services
Behavioral Health and Developmental Disabilities Administration
Michigan Department of Community Health

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Acknowledgments

Michigan's ROSC Transformation Steering Committee Members

Sonia Acosta, Easter Seals/Centro Latino
Ronald Brown, Odyssey Village
Thomas Combs, Department of Corrections
Ann Comiskey, Troy Community Coalition
Patricia Degnan, MDCH
Norm Delisle, MI Disability Rights Coalition
Sue Eby, MDCH
Joyce Foster-Hartsfield, M.D., Bio Med Behavioral Health Care
Yarrow Halstead, Certified Peer Support Specialist, Washtenaw County
Michael Head, MDCH
Denise Herbert, network 180
Deborah Hollis, MDCH
Mike Jensen, New Day Treatment Substance Abuse Program
Steve Logan, List Psychological Services
Lisa Miller, MDCH
Eva Petoskey, Intertribal Council of Michigan
Pamela Pellerito, Kalamazoo Community Mental Health and Substance Abuse Services
Yisrael Pinson, Daniel B. Sobel Friendship House
Elke Plescher, network 180
Sam Price, 1016 Recovery Network
Dawn Radzioch, Macomb County Community Mental Health
Larry Scott, MDCH
Joe Sedlock, Riverhaven Coordinating Agency
Marci Scalera, Washtenaw Community Health Organization
Felix Sharpe, MDCH
Laura Shue, Graduate Student
Harry Simpson, Point of Change, Inc.
Angela Smith-Butterwick, MDCH
Kim Stapert, Living Waters Ministry
Mark Steinberg, MDCH
Gary VanNorman, Mid-South Substance Abuse Commission
Brad VanZanten, 59th District Court Probation
Joyce Washburn, MDCH
Pamela Werner, MDCH
Jeff Wieferich, MDCH
Steve Wiland, MDCH
Grady Wilkinson, Sacred Heart Rehabilitation Center
Mark Witte, network 180
Jackie Wood, MDCH
Cathy Worthem, Arbor Circle Corporation
Roscoe Wright, Detroit Recovery Project

ROSC Transformation Professional Consultants

Ijeoma Achara-Abrahams, PsyD, Behavioral Health Consultant
Joan Kennerson King, APRN, BC, Consultant

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Message from the Bureau of Substance Abuse and Addiction Services and the Transformation Steering Committee

We are in the midst of an extraordinary time in the history of healthcare in the United States. The recently enacted healthcare reform legislation is changing the landscape for all health-related systems and services. In addition, over the past few years a recovery revolution has gained momentum and is now sweeping the country. This movement has its roots in the voices of people in recovery, and their family members, who are increasingly calling for services that support people to not only initiate their recovery, but also sustain recovery in their communities of choice. Calls for change are also championed by prevention and treatment providers, researchers, recovery advocates, and system administrators, who are advocating for more flexible, holistic, and integrated systems of care that can more effectively promote community health, resilience, and long-term recovery.

As a result, Michigan's substance use disorder (SUD) service system is undergoing, and is committed to, radical changes. These changes entail strengthening our focus on the prevention of substance use disorders before they begin, as well as shifting the focus of treatment from acute stabilization to long-term recovery, promoting an enhanced quality of life for individuals, families, and communities directly and indirectly affected by alcohol and other drugs.

During the past twelve months, community members, people in recovery, family members, providers, and coordinating agencies have met at various symposia and focus groups to discuss the implications of developing a recovery-oriented system of care (ROSC) in Michigan. As a result, a shared vision of a ROSC for Michigan is beginning to emerge. This implementation plan represents the work of these partners, and outlines an initial roadmap to guide us as we strive to make our vision a reality. The plan describes the guiding principles that will direct Michigan's transformation efforts, documents Michigan's definition of a ROSC, reviews practices to be prioritized in the early phases of this transformation process, and details our initial goals and strategies for advancing our collective vision of recovery and resilience for our communities. We believe that developing a ROSC in Michigan will not only provide a framework for successful navigation of the significant changes in the national health delivery system resulting from the passage of healthcare reform, but also effectively address all of the Substance Abuse and Mental Health Service Administration's (SAMHSA) newly developed strategic initiatives.

We are extremely fortunate, because we are building on Michigan's long history of innovation in the prevention and treatment of substance use disorders. Nevertheless, while our collective accomplishments have been tremendous, there remain individuals, families, and communities in Michigan that have yet to experience the reality and hope of recovery. This process of system change is really a process of community change. It will require the united passion, critical thinking, and collaboration of partners in all communities across the state. United we can make sustained wellness and recovery a reality for individuals, families, and communities in Michigan. We are deeply committed to this goal, and we look forward to working with you to make it a reality.

Bureau of Substance Abuse and Addiction Services (BSAAS)
and the ROSC Transformation Steering Committee

Preface

The Nature of Transformational Change and the Implications for Michigan

There has been much discussion in recent years about the importance of transformation and reform in behavioral health. Perhaps one of the most significant reform efforts seen in decades is the national response to the passage of the Affordable Care Act (ACA), more commonly known as healthcare reform. Transformation is a concept that states and providers are working hard to define. What is understood about behavioral health transformation is that the system changes required for its implementation are profound. The scope of change needed to improve the quality and effectiveness of these services may be most clearly articulated in the Institute of Medicine's (IOM) "Quality Chasm" series of reports. In this series, the IOM launched a critical examination of American healthcare delivery and subsequently sounded an urgent call for a fundamental, sweeping redesign of the entire healthcare system.

The Federal Action Agenda (DHHS, SAMHSA, 2005) developed by the New Freedom Commission also described the degree of change needed in behavioral health systems, declaring:

> Mere reforms are insufficient…transformation is not accomplished through change on the margins, but instead, through profound changes in kind and degree. Applied to the task at hand, transformation represents a bold vision to change the very form and function of the…service delivery system…Transformation is nothing short of revolutionary (pp.1, 5, 18).

These federal reports have underscored the fact that systems change is absolutely critical to the future of the behavioral health system and that change needs to be complete and all encompassing. There are three components of transformational change that one must consider:

- First, in transformational change, the future is unknown and only through forging ahead does one discover it. This requires entering the process without a clearly defined outcome, guided instead by values and an emerging vision.
- Second, in transformational change, the future state is so different from the current state that shifts in attitude are required to create it (Ackerman, 1997).
- Third, given that transformational change requires shifts in culture and mindset, the process and human dynamics are much more complex and can therefore be experienced as more chaotic (Ackerman, 1997).

So what are the implications for recovery-focused transformation? Changes in practice that are not accompanied by profound changes in attitudes and beliefs are meaningless. Transformation does not occur simply because new services have been added to the existing service system. For example, one cannot bring about recovery-oriented care by replacing treatment planning with recovery planning. Recovery planning is not about a change in language; the forms utilized, or even the final product. It is about the process, and the shift in power dynamics that occurs when clinicians move from an expert orientation to one of collaboration and partnership with people receiving services. In short, with

transformational change, the process is as important as, if not more important than, the product or outcome (Achara-Abrahams, Evans, & King, 2011).

There are also several specific implications for the recovery transformation process in Michigan. First, transformational change requires specific strategies and distinct leadership in order to be successful. Rather than providing highly prescriptive practice guidelines as mandates for the service system, the Bureau of Substance Abuse and Addiction Services (BSAAS) is committed to setting the overall direction for the system and facilitating processes so that stakeholders can develop a shared vision of a ROSC in Michigan.

Second, there will be a significant investment in examining and aligning the attitudes, beliefs, and values that underlie the system, to make certain that they are consistent with a recovery orientation. This will ensure that transformation efforts do not become a series of superficial practice changes layered on top of the existing system.

Finally, Michigan's approach to advancing the development of a system of care that promotes recovery and resilience will be transparent and will continue to evolve over time. This will be a complex, long-term process that will entail changes, not only for providers, but also in all aspects of the system, including fiscal, policy, regulatory, and administrative. Transformation will also involve changes within the communities in which these systems are embedded.

A holistic and effective service delivery system has long been a goal of many coalition members, providers, advocates, individuals receiving services, and system administrators. However, efforts to create such systems have been thwarted by nonintegrated regulations and funding streams. The process of developing a ROSC in Michigan is an opportunity to break down those silos and build on the intersection of healthcare reform legislation, the advocacy of diverse system stakeholders, and emerging research documenting the most effective strategies for supporting long-term recovery and promoting healthy communities. This implementation plan represents our initial thinking, our emerging vision, and the first steps in an exciting journey of rediscovery.

Purpose and Scope of the Implementation Plan

While this implementation plan serves as an initial roadmap for advancing the vision of a ROSC in Michigan, it is not intended to be prescriptive or exhaustive. In the absence of a rigid model and specific requirements, stakeholders are free to take more risks, be more innovative, and discover what works best for the people being served. This plan continually references the "stakeholders" that are critical to transforming Michigan's SUD service system. These individuals represent diverse sectors of communities throughout Michigan. They include people who are directly receiving SUD services, their family members, providers of prevention and treatment services, county administrators of substance use disorder systems, state administrators, and individuals working in and served by other systems such as mental health, criminal justice, housing, education, and public health, along with innumerable community members.

This implementation plan is designed to:

- Describe the background and rationale for transforming Michigan's SUD service system;
- Provide an overview of the principles guiding Michigan's system-transformation efforts;
- Define what a ROSC means for Michigan;
- Recognize recovery-oriented practices identified by stakeholders as initial priorities;
- Articulate initial goals and strategies to advance the transformation process; and
- Describe the processes that will be developed to ensure that a broad range of peers, individuals and families have the opportunity to participate in a transparent process.

The timeframe of this initial plan is limited to three years, which began in February of 2010, when the Transformation Steering Committee (TSC) convened its first meeting. It is anticipated that as additional individuals are engaged in the transformation process, this plan will be expanded and further refined. It should not be considered a static blueprint, but rather an initial plan to set the direction, create a common language, stimulate dialogue, and promote innovation.

The primary focus of this plan is the recovery transformation process within the SUD service system. While the principal focus of this plan is on those services for which BSAAS has direct oversight, BSAAS and the TSC recognize that many other institutions and organizations also influence the type and quality of SUD services in the state. For example, these include Medicaid and managed care companies. In addition, the individuals and families who receive SUD-related services often interact with other service sectors such as criminal justice, child welfare, mental health and physical health systems. As all of these service systems are closely interconnected, this transformation effort cannot successfully occur in a vacuum. It must unfold as a partnership among relevant systems and organizational entities. Although BSAAS and the TSC members do not have any oversight responsibilities within these multiple systems, they do recognize their ability to influence, and their responsibility to lead. As such, the "system" in this plan is broadly defined. It refers to the vision of developing an overarching network of coordinated services that is philosophically aligned with the vision of promoting recovery and resilience. As a result, this implementation plan identifies opportunities for increased collaboration, planning, and service integration across multiple systems, particularly between behavioral, primary care, housing, employment, transportation and the criminal justice systems.

Overview of a Recovery-Oriented System of Care: Background and Rationale for Development

The Need for an Organizing Framework

With the passage of healthcare reform legislation, addiction services are poised for unprecedented changes. While the details associated with healthcare reform can be daunting to sort through, the goals are relatively simple. The ACA is designed to:

- Increase access to healthcare;
- Improve the quality of services and manage associated costs by:
    - Expanding the availability of prevention and early intervention services to prevent acute health conditions from developing into chronic health conditions;
    - Dramatically improving the management of chronic health conditions;
    - Diminishing errors and waste in healthcare systems; and
    - Reducing incentives for expensive services that have low value or effectiveness (DHHS, SAMHSA, 2010a).

Four strategies for reaching these goals are embedded in healthcare reform. These strategies include provisions related to: 1) insurance reform, 2) coverage expansion, 3) service delivery system redesign, and 4) payment reform (DHHS, SAMHSA, 2010a). Some of the implications for specialty addiction services are:

- A greater focus on the promotion of wellness and prevention.
- An increased focus on the coordination between and integration of specialty addiction treatment services and primary care.
- Inclusion of mental health and substance use disorders in chronic disease-prevention efforts, increasing the need for collaboration between SUD prevention specialists and primary care;
- A greater focus on "whole health" approaches that address the comprehensive needs of individuals receiving prevention and treatment services.
- An increased shift toward value-based services (in which reimbursement is tied to effective outcomes) rather than volume-based services (in which payment is tied to the delivery of service units), resulting in a need among providers for the capacity, technology, and ability to measure and report outcomes that demonstrate quality and effectiveness.
- A greater attention to provider accountability.
- Infrastructure enhancements (service systems and providers) to support the delivery of effective services (e.g., greater utilization of health information technology).
- New funding streams that will encourage competition, promote choice, and increase the need for culturally relevant services that are effective for diverse populations.
- An increased demand for services requiring more efficient processes.
- Prevention services that focus on health promotion in a broader context, which may require prevention specialists to expand their reach into non-traditional environments and widen their focus to address mental health promotion.

Healthcare reform will significantly affect the current service delivery system on all levels. In addition to the healthcare reform priorities, SAMHSA recently prioritized eight strategic initiatives to focus their

efforts. SAMHSA is reviewing the feedback from the field on the proposed eight initiatives and will finalize its priorities very soon. Although the process of finalizing these priorities is not yet complete, SAMHSA previously communicated that "recovery-oriented systems of care should be the gold standard" (DHHS, SAMHSA, 2009). SAMHSA has demonstrated its commitment to recovery-oriented approaches by continuing to fund projects such as Access to Recovery, Recovery-Oriented System of Care Development, Recovery Community Support Programs, and it's Partners for Recovery Initiative.

> "Whether one's health conditions are from physical, mental or substance use conditions, recovery-oriented systems of care should be the gold standard. Every consumer should have a health home that comprises a strong partnership between the patient and his or her family and the full range of involved health professionals to ensure comprehensive and continuous care that takes into account the whole person rather than just physical health. To that end, ultimately, every medical practice should have a prevention specialist who focuses specifically on wellness and who is trained in mental health and addictions to support general practitioners in making appropriate referrals and coordinating care."
> (DHHS, SAMHSA, 2009, p. 16)

With all the changes underway in the healthcare arena, a comprehensive framework is needed to plan and organize related efforts. Change-management experts contend that, without such a framework, change efforts can be reduced to a number of disparate, well- intentioned projects that serve only to increase fragmentation and confusion (Kotter, 1996). ROSC provides this comprehensive framework because of its focus on addiction as a chronic illness, the whole-health approach to services, the focus on improving outcomes and the quality of services, and the emphasis on community wellness. The core principles of ROSC create a roadmap to guide the transformation of prevention and treatment services.

Aligning Treatment Services

Current addiction treatment services have undoubtedly played a critical role in the healing and restoration of countless individuals, families and communities across our nation. For example, a 12-year follow-up study of individuals treated for cocaine dependence found that 52 percent of them were in stable recovery (Hser et al., 2006). Other research has documented a 60 percent decrease in substance-related problems during the months following treatment, along with reductions in illegal activity, illegal income, risk of HIV infection, and other health-related problems (Dismuke et al., 2004; Scott et al., 2003; Hubbard et al., 2002; Longshore, Hsieh, Danila, & Anglin, 1993; Moss et al., 1994).

While it is clear that current addiction treatment services have saved countless lives, there is also compelling research that indicates, for many individuals with chronic and complex alcohol and other drug use (AOD) problems, treatment systems have not been as effective as they could be. On a national level, more than half of those admitted to treatment do not complete it, and 18 percent are administratively discharged due to relapse and other infractions that take place while they are receiving services (White, 2008). Unfortunately, research indicates that those who are least likely to complete treatment are not those who want it the least, but rather those who need it the most. They are the individuals with the most severe and complex problems; the fewest individual, family and community supports and assets; and the most severely disrupted lives (Stark, 1992; Meier et al., 2006; White, 2008).

In addition, although systems are currently built on an acute care model of treatment characterized by brief treatment episodes that focus on helping people stabilize and achieve abstinence, research actually

indicates that addiction is a chronic illness. An individual does not reach stability in alcoholism recovery (i.e., when the risk of future lifetime relapse drops below 15 percent) until he or she has attained four to five years of sustained remission (Dawson, 1996; Vaillant, 1996; Nathan & Skinstad, 1987; Jin et al., 1998; Dennis et al., 2007; Schutte et al., 2001). Despite the anecdotal and scientific evidence supporting the chronicity of addiction, those who are fortunate enough to complete treatment rarely receive continuing support. Only 1 in 5 adults receive continuing care in the United States (McKay, 2001). In recent years, several data sources have converged to document the types of services and supports that are effective in building healthy communities and promoting sustained recovery. Specifically, research indicates that sustained recovery is best facilitated when treatment services focus on developing strong therapeutic alliances, incorporate peer and community-based supports, address global health, promote life skills, include families and/or other significant allies, and adopt a chronic-care approach to treatment (Barber et al., 2001; Meier et al., 2006; Klein et al., 1998; McKay, 2005; Isaacson, 1991; White, 2008).

Recognition of the disparity between what we know about addiction and recovery and the ways in which our service systems are currently configured has led to a paradigm shift in the addiction treatment arena. The emerging recovery management paradigm represents a chronic care approach to addiction treatment in which services move beyond serial episodes of stabilization to the assertive management of long-term recovery. In this transition, recovery is emerging as the organizing construct for addiction treatment (White, 2008).

As a result, in a ROSC, services are much broader in scope. The focus moves beyond symptom reduction and helping people achieve abstinence to assisting people with building individual, social, and community resources to promote long-term recovery. These resources are diverse and unique for each individual. In traditional systems of care, services are often delivered "programmatically" and are seldom individualized. However, in a ROSC, services are flexible and adapted to fit the needs and preferences of each person. Despite the numerous health problems of people presenting for addiction treatment and the high rates of post-treatment morbidity and mortality (Mann et al., 2005; Hser et al., 2001; Hser et al., 2006), historically SUD service systems have had a singular focus on AOD problems. Recovery-oriented systems of care however, offer integrated primary healthcare and addiction treatment from assessment through ongoing healthcare management. Also, one of the fundamental shifts that take place within a ROSC is the empowerment of the people receiving treatment services. Rather than functioning as passive recipients of services, they are in a much more active role, and work collaboratively with service providers to direct the course of treatment (White, 2008).

Furthermore, while recovery can be initiated in a treatment setting, it is maintained and sustained in the natural environment of a person's community (White, 2008). As such, a ROSC goes beyond the individual to help strengthen the surrounding community, by integrating treatment efforts with the services and supports available in a person's natural environment. Within a ROSC, this expanded focus on the promotion of community health and wellness is a critical component of, not only treatment services, but also prevention services.

Broadening Prevention Services

Just as dramatic changes are occurring in the treatment arena, the prevention field is also undergoing a radical shift. This shift involves moving from a primary focus on changing individual behavior to the development of more comprehensive community- and population-based approaches. While prevention

specialists have long recognized the importance of broad-based community health, prevention strategies have often targeted only individual change. More recently, prevention advocates have called for a broader focus on universal prevention strategies that target the environment as well as individual behavior (Cohen & Chehimi, 2007).

This shift is evident in the recently released National Drug Control Strategy from the Office of National Drug Control Policy (ONDCP). This plan stresses the importance of moving away from a:

> Focus on individual settings (e.g., the school)[to] entire communities, and [from those that] seek to prevent specific youth problems (e.g., bullying, depression, or school failure) to shared risk factors that contribute to a range of problems…The first step in building a national prevention system based on current, effective programs and activities…is to prepare communities to efficiently and effectively assess the unique nature of their local drug problems and to deliver evidence-based prevention targeted specifically toward those problems (White House, 2010a).

Consistent with this broader community-based approach to prevention, the IOM also called for a multifaceted approach to prevention in its 2000 report, stating, "it is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change" (IOM, 2000, p. 4). This reality may be particularly relevant when one attempts to prevent or intervene early in the development of alcohol and other drug problems. Research has clearly documented the power that family and community protective factors have in promoting resilience, along with the influence that community-based variables have in tipping the delicate balance between substance use or non-use, relapse, and sustained recovery.

Thanks to the efforts of prevention specialists over the past few years, Michigan is already poised to lead this transition to include more population-based approaches. Consistent with this community-based approach, SAMHSA's Strategic Prevention Framework has been utilized throughout Michigan.

The development of a ROSC in Michigan provides an opportunity for increased collaboration and partnership between prevention and treatment around shared goals. For the first time, both prevention and treatment efforts are geared at a common goal – helping people build healthy lives in the community.

A Shared Goal for Treatment and Prevention

People are only as healthy as the communities in which they are embedded. This truth is as important for people who are in treatment trying to maintain their recovery as it is for people receiving prevention support who have never used alcohol or drugs.

Despite this commonality, the predominant approach to healthcare in the United States has focused primarily on the provision of services after the onset of illness and has fostered an unproductive tension between prevention and treatment services. On a national level, this has led to minimal coordination between the two. The development of a ROSC in Michigan provides an opportunity for increased collaboration and partnership between prevention and treatment around shared goals. For the first time, both prevention and treatment efforts are geared at a common goal – helping people build healthy lives in the community. Given the expertise that prevention specialists have in this area, they are critical to the development of a ROSC.

A ROSC expands the focus of services to include prevention, early intervention, treatment, and continuing care, all within the ecological context of the community. The development of a ROSC presents a unique opportunity to align and coordinate prevention and treatment efforts more effectively. The focus of both is now on promoting community health and wellness for all and equipping people with the resources, opportunities, and support they need to live meaningful lives in the community.

A Common Framework for Prevention and Treatment

In addition to a shared goal, developing a ROSC in Michigan provides a common framework around which to organize both prevention and treatment service systems. On a national level, discussions about ROSC to date have focused primarily on treatment services. As a result, prevention specialists are less clear about the implications for prevention and their potential role in a ROSC. In addition, the word "recovery" is most commonly associated with individuals who have some connection to treatment services, so the use of this language has led many prevention specialists to assume that developing a ROSC is irrelevant to their work. However, stakeholders in Michigan are working through these language barriers to develop a shared vision for prevention and treatment services organized around ROSC principles.

This level of collaboration is possible because there is a growing understanding that a ROSC is not merely a model for treatment services or systems. ROSC is a value-driven approach to organizing all behavioral health services. Values such as holistic services, strength-based approaches, family and community involvement, culturally responsive services, and continuity of services have equal applicability to prevention and treatment. This is exemplified in the IOM 2009 landmark report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* (National Research Council & IOM*)*. This report describes many of the principles and services that reinforce effective prevention services for youth, and the principles it identified are consistent with the guiding principles of a ROSC. For example, the IOM report documents that ongoing, community-based, comprehensive approaches to prevention are most effective. This was also reiterated by the ONDCP, which stated:

> The evidence suggests that instead of the current set of short-term, primarily educational "programs," what is needed are continuing prevention systems of evidence-based components, selected, implemented and integrated to protect adolescents, continuously throughout the pre-teen and teenage years; and not just from schools or police, but instead from many sources of influence within the community (e.g. parents, schools, peers, healthcare, etc) (White House, 2010b)

In addition, the IOM report indicates that programs designed to prevent substance use disorders have increased effectiveness when they are delivered by peer leaders (Gottfredson & Wilson, 2002; Cuijpers, 2002) and that prevention strategies must target individuals, families, and the broader community. The concepts of peer support, continuing support, community-based services, and comprehensive approaches are all core values of a ROSC.

Connecticut was the first state to explore the implications of these values for their treatment system. That action, along with advocacy from providers, researchers, and community members, initiated a transformation of the Connecticut treatment system that has had significant impact on the federal government, and communities around the country. Like Connecticut, Michigan is now poised to be one of the first state systems to explore the implications of these values for prevention services. Healthcare

reform necessitates increased collaboration between treatment and prevention, and between behavioral health and primary care. A ROSC provides a framework for increasing collaboration and coordination between prevention and treatment, and thereby positions the entire system for other successful collaborations with primary care and beyond.

Benefits of Developing a ROSC for Individuals and Families Involved with the Criminal Justice System

The criminal justice and the SUD service systems are inextricably linked. Nationally, the criminal justice system is the largest referral source for SUD treatment (Robertson, 2008). Data from the Arrestee Drug Abuse Monitoring program documents that a high proportion of people who are arrested use illicit drugs (DHS, Office of Applied Studies, 2005). In fact, it is estimated that the rate of substance abuse or dependence among adult offenders on probation or parole supervision is more than four times that of the general population (38.5% vs. 9.0%) (DHS, Office of Applied Studies, 2005). Similarly, adults arrested in the past 12 months for a serious offense were more likely to have used an illicit drug in the past year than those who were not arrested (60.1% vs. 13.6%) (DHS, Office of Applied Studies, 2005). Data also shows that arrests related to substance use are not confined to urban areas. Nationally, the percentage of drug related arrests in urban areas (40.8%) is now equivalent to the percentage in suburban areas (40.6%) and rural areas are not far behind (35.4%) (Robertson, 2008). Clearly, substance use in the criminal justice population is a problem that impacts all communities.

It is not surprising then that across the country, criminal justice systems are overloaded and overwhelmed. A 2008 study conducted by the Pew Charitable Trust indicated that 1 in every 100 adults in the United States is now behind bars. Because of the burgeoning criminal justice population, state systems are facing enormous challenges related to the re-integration of ex-offenders into their communities. In 2008 alone, 735,454 people were released from prisons in the United States (Department of Justice, BJS, 2009) and it is estimated that millions are released from jails (Department of Justice, BJS, 2006). Unfortunately, recidivism rates among this population are high: approximately two thirds of those released from prison are rearrested within three years of their release (Department of Justice, OJP, 2007).

Individuals released from prison in Michigan encounter some of the same challenges mentioned above. In 2009, the Michigan Department of Corrections (MDOC) released 13,541 individuals to parole from the state prison system (MDOC, 2010a). During 2009, there were 4104 individuals returned to prison due to violating the terms of their parole. Of those returned, 590 or 14.4% were returned due to alcohol or drug use violations (MDOC, 2010b).

> "When individuals are given a chance to attain and sustain recovery from addiction and mental illness, the revolving door between incarceration and (the) community can stop spinning." (Terry Cline, Administrator, SAMHSA, in Robertson, 2008)

Michigan is one of several states that have made a commitment to offer additional supports and services to individuals released from prison to decrease the recidivism rate. The Michigan Prisoner Re-Entry Initiative (MPRI) is a statewide program that is designed to assist individuals who are in prison to be successful when released on parole. The program prepares the individual for release while still in prison and then provides assistance and support in the community-setting while on parole. The goals of this program are to promote public safety and increase the success rates of offenders (MDOC, 2006). In 2009, the MPRI program supervised over 13,000 individuals on active parole throughout the year. Even

with the additional supports offered with this program, and that include SUD treatment services, over 6400 individuals had a positive drug test during that time. Over 3500 of those individuals tested positive two or more times (MDOC, 2009a, 2010b).

Individuals encounter numerous challenges as they attempt to rebuild their lives in their communities. These include challenges related to securing housing, finding employment, dealing with stigma, reuniting with family, and coping with multiple health issues. The stress related to navigating these issues coupled with complying with criminal justice supervision requirements can contribute to relapse and the high recidivism rates (DHHS, NIDA, 2007).

Consequently, experts contend that a holistic approach to SUD treatment is critical for individuals involved with the criminal justice system (DHHS, NIDA, 2007). The unique challenges of individuals re-entering the community from prison or jail, suggest that acute care approaches that focus solely achieving abstinence, are likely to have minimal long-term success. By contrast, ROSCs are particularly beneficial for this population because of their focus on creating a network of diverse services and supports designed to meet the holistic needs of individuals. Within this approach, treatment is recognized as only one of many resources that will help individuals to successfully initiate and sustain their recovery. Moreover, as recovery-oriented approaches embrace a chronic care model for treating substance use disorders, ROSCs are positioned to provide ongoing support to individuals involved with the criminal justice system over longer-periods of time and to assist them in building their own natural support systems in their communities. Based on what we know works, both of these strategies seem more likely to promote sustained recovery and reduce recidivism with regard to both substance use and criminal activity.

Recent research findings of the DHHS, National Institute on Drug Abuse (NIDA) have included principles of drug abuse treatment for criminal justice populations (2007). Included among these principles are the delivery of individualized services that meet the unique needs of each person, including family and other allies in the treatment process, implementing a chronic-care approach that includes the necessary dose and duration of treatment as well as ongoing management and support over time, and providing integrated mental and physical health services when needed. These principles are all consistent with recovery-oriented care. As such, developing a ROSC in Michigan presents an exciting opportunity to partner with the criminal justice system and address many of the obstacles to successful re-integration encountered by people with SUDs in the criminal justice system.

The Significance of Cultural Competence in a Recovery Oriented System of Care

While people of color currently account for 20 percent of Michigan's population, it is estimated that, within the next 35 years, ethnic and racial minorities will represent 50 percent of the state's population (MDCH, BSAAS, 2009). In addition to the rapidly changing demographics in Michigan, experts project that the Affordable Care Act will increase diversity throughout the nationwide healthcare system as 23 million more individuals gain access to care. Historically, behavioral health services have not been tailored to meet the needs of ethnic and racial minorities (DHHS, Office of the Surgeon General, 2001). This has resulted in many individuals of color either refusing services or receiving substandard care (DHHS, Office of the Surgeon General, 1999).

Client satisfaction is higher in programs attuned to cultural competence and diversity (Bernstein et al., 2005). Unfortunately, within SUD service systems, studies examining the experiences of people of color indicate that they are less likely to seek treatment (Rebach, 1992; Longshore, Hsieh, Anglin, & Annon, 1992), receive fewer treatment services (Jerrell & Wilson, 1997; Schmidt & Mulia, 2009), and are less likely than Caucasians to believe that treatment will be effective for them (Longshore, Hsieh, & Anglin, 1993). Ethnic and racial minority groups who do enter treatment for substance use disorders are less likely to complete treatment (King & Canada, 2004; Agosti, Nunes, & Ocepeck-Welikson, 1996; Mertens & Weisner, 2000; Tonigan, 2003) and are less satisfied with treatment (Schmidt & Mulia, 2009; Tonigan, 2003; Bluthenthal et al., 2007). Experts contend that these disparities are explained by the cultural divide that exists between the practices in behavioral health systems and the needs of minority clients (La Roche, 2002).

BSAAS Definition of Cultural Competence:

A set of behaviors, attitudes, polices, and practices that come together in a substance use disorder service system that includes BSAAS, coordinating agencies (CAs), providers, and professionals working effectively to serve Michigan's culturally diverse population.

Stakeholders in Michigan are committed to developing a system of care that promotes health equity and reduces disparities. As a result, BSAAS will continue the Cultural Competence Workgroup as a part of their ongoing transformation efforts. Rather than limiting diversity to ethnic and racial differences, The Cultural Competence Workgroup views diversity along multiple dimensions. It is understood that, given the changing demographics throughout Michigan, providers will be increasingly called upon to serve those with diverse characteristics in the areas of language, physical disabilities, economic, gender, age, and various religious affiliations, characteristics that often affect recovery (MDCH, BSAAS, 2009).

Developing a ROSC in Michigan provides a framework and concrete strategies to promote health equity. For example, rather than embracing universal, one-size-fits-all approaches, a ROSC requires that all services and supports be individualized based on the needs, preferences, and cultural context of the individual, family or community. In addition, the principle of person-, family-, and community-directed services is central to recovery-oriented care. Rather than limiting the direction of services to experts, a ROSC embraces a partnership-consultation approach in which treatment and prevention professionals work in collaboration with individuals and community members to address the concerns that are most important to them, in the manner that is most relevant and effective for them.

The Emerging Vision of a ROSC in Michigan

A ROSC Integrates Strategies to:

- Prevent the development of new substance use disorders;
- Reduce the harm caused by addiction;
- Help individuals make the transition from brief experiments in recovery initiation to sustained recovery maintenance via diverse holistic services; and
- Promote good quality of life and improve community health and wellness for all (Adapted from White, 2008).

Michigan's Definition of a ROSC

Based on significant input from stakeholders, Michigan defines a ROSC as follows:

> Michigan's recovery-oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life-enhancing recovery and wellness for individuals, families and communities.
>
> *Adopted by the ROSC Transformation Steering Committee, September 30, 2010*

Bureau of Substance Abuse and Addiction Services Vision

We envision a future for the citizens of the state of Michigan in which individuals and families live in healthy and safe communities that promote wellness, recovery, and a fulfilling quality of life**.**

Elements of Michigan's ROSC

Based on stakeholder feedback, the Transformation Steering Committee (TSC) has identified several core values and beliefs to guide Michigan's transformation process. The cornerstone of these values is the recognition that people recover, and individuals and families maintain their wellness, in healthy communities. Also, people with both substance use disorders and serious mental illnesses can and do recover. The recovery process can be facilitated by professional intervention, but professional services are not equally important for everyone, since in some cases recovery occurs outside the context of professionally based services.

While only a small segment of people with SUDs need specialized addiction treatment services to support recovery, all members of the community benefit from prevention activities that promote resilience and community health for all. The TSC believes that the promotion of community health must be a foundational element of Michigan's transformation process. The overall health of the community improves when fewer people develop SUDs, when the burden of substance use is reduced, and when recovery is effectively facilitated. As such, both prevention and treatment services play a critical role in promoting community health and building community recovery capital.

The TSC further recognizes that recovery exists on a continuum of improved health and function. Along this continuum, there are diverse roles through which people can provide support. These roles include prevention and treatment providers, peer support specialists, and community-based support services. All of these roles are equally appreciated, valued, and needed to promote sustained health and wellness in our communities.

Finally, the TSC believes the people who are receiving services must have opportunities to assume leadership roles and participate in guiding the development of the system. At an individual level, rather than services being professionally directed, peers, family and community members are valued for their lived experiences, and collaborate with professionals to identify the most effective treatment or prevention approaches for their unique needs and preferences.

Guiding Principles of Michigan's ROSC

In addition to these core beliefs articulated by the TSC, stakeholders throughout Michigan have customized, expanded, and endorsed the elements of a ROSC that were developed during a SAMHSA-sponsored National Summit on Recovery in 2005. The first 15 elements below are described in descending order of importance, based on a voting process in which approximately 80 stakeholders in Michigan participated. Number 16, the promotion of community health and wellness, was not prioritized as part of the original list; it was added as an additional priority based on stakeholders' belief that universal prevention approaches benefit everyone in the community. These elements of a ROSC will be utilized by BSAAS and the TSC to support and guide the development of a ROSC in the state of Michigan:

1) **Adequately and flexibly financed**

   Our system will be adequately financed to permit access to a full continuum of services, ranging from prevention, early intervention, and treatment to continuing care and recovery support. In addition, we will strive to make funding sufficiently flexible to enable the establishment of a customized array of services that can evolve over time to support an individual's and a community's recovery.

2) **Inclusion of the voices and experiences of recovering individuals, youth, family, and community members**

   The voices and experiences of all community stakeholders will contribute to the design and implementation of our system. People in recovery, youth, and family members will be included among decision-makers and have oversight responsibilities for service provision. Recovering individuals, youth, family, and community members will be prominently and authentically represented on advisory councils, boards, task forces, and committees at state and local levels.

3) **Integrated strength-based services**

   Our system will coordinate and/or integrate efforts across service systems, particularly with primary care services, to achieve an integrated service delivery system that responds effectively to the individual's or the community's unique constellation of strengths, desires, and needs.

4) Services that promote health and wellness will take place within the community

Our system of care will be centered within the community, to enhance its availability and support the capacities of families, intimate social networks, community-based institutions, and other people in recovery. By strengthening the positive social support networks in which individuals participate, we can increase the chances for successful recovery and community wellness.

5) Outcomes-driven

Our system will be guided by recovery-based process and outcome measures. These measures will be developed in collaboration with individuals in recovery and with the community. Outcome measures will be diverse and encompass measures of community wellness as well as the long-term global effects of the recovery process on the individual, family, and community – not just the remission of biomedical symptoms. Outcomes will focus on individual, family, and community indicators of health and wellness, including benchmarks of quality-of-life changes for people in recovery.

6) Family and significant other involvement

Our system of care will acknowledge the important role that families and significant others can play in promoting wellness for all and recovery for those with substance use challenges. They will be incorporated, whenever it is appropriate, into needs-assessment processes, community planning efforts, recovery planning and all support processes. In addition, our system will provide prevention, treatment, and other support services for the family members and significant others of people with SUDs.

7) System-wide education and training

Michigan will seek to ensure that concepts of prevention, recovery, and wellness are foundational elements of curricula, certification, licensure, accreditation, and testing mechanisms. The workforce also requires continuing education, at every level, to reinforce the tenets of ROSC. Our education and training commitments are reinforced through policy, practice, and the overall service culture.

8) Individualized and comprehensive services across all ages

Our system of care will be individualized, person/family/community-centered, comprehensive, stage-appropriate, and flexible. It will adapt to the needs of individuals and communities, rather than requiring them to adapt to it. Individuals in treatment will have access to a menu of stage-appropriate choices that fit their needs throughout the recovery process. The approach to SUD services will change from an acute, episode-based model to one that helps people manage this chronic disorder throughout their lives. Prevention services will be developmentally appropriate and engage the multiple systems and settings that have an impact on health and wellness. Prevention efforts will be individualized based on the community's needs, resources, and concerns.

9) Commitment to peer support and recovery support services

Our system of care will promote ongoing involvement of peers, through peer support opportunities for youth and families and peer recovery support services for individuals with substance use disorders. Individuals with relevant lived experiences will assist in providing these valuable supports and services.

10) Responsive to cultural factors and personal belief systems

Our system of care will be culturally sensitive, gender competent, and age appropriate. There will be recognition that beliefs and customs are diverse and can impact the outcomes of prevention and treatment efforts.

11) Partnership-consultant relationship

Our system will be patterned after a partnership/consultant model that focuses more on collaboration and less on hierarchy. Systems will be designed so that individuals, families, and communities feel empowered to direct their own journeys of recovery and wellness.

12) Ongoing monitoring and outreach

Our system of care will provide ongoing monitoring and feedback, with assertive outreach efforts to promote continual participation, re-motivation, and re-engagement of individuals and community members in prevention, treatment, and other support services.

13) Research-based

Our system will be informed by research. Additional research on individuals in recovery, recovery venues, and the processes of recovery (including cultural and spiritual aspects) will be essential to these efforts. Research related to SUDs will be supplemented by the experiences of people in recovery. Prevention efforts will use the Strategic Prevention Framework and epidemiologically-based needs-assessment approaches to identify behavioral health issues and community concerns. Individual, family, and environmental prevention strategies will be data-driven.

BSAAS recently received a State Epidemiological Outcome Workgroup (SEOW) grant from the Center for Substance Abuse Prevention to expand and enhance the current substance abuse needs assessment collection and tracking processes by incorporating mental health data. This will allow us to create state and community profiles that share common indicators, intervening variables and consequences related to mental, emotional and behavioral disorders. The SEOW will support the work of the ROSC TSC and will inform the implementation of the ROSC in the Michigan.

14) Continuity of care

Our system will offer a continuum of care that includes prevention, early intervention, treatment, continuing care, and support throughout recovery. Individuals will have a full range of stage-appropriate services to choose from at any point in the recovery process. Prevention services

will involve the development of coordinated community systems that provide ongoing support, rather than isolated, episodic programs.

15) Strength-based

Our system of care will emphasize individual strengths, assets, and resiliencies.

16) Promote community health and address environmental determinants to health

Our system will strive to promote community health and wellness through strategic prevention initiatives that focus on building community strengths in multiple sectors of our communities.

Building Momentum in Michigan

To demonstrate commitment to developing a ROSC, BSAAS has engaged in the following efforts to advance the integration of recovery-oriented services within the system:

- In July 2006, the Administrative Rules for Substance Abuse Services were modified for the first time since their development in 1981. These changes resulted in addition of integrated treatment, case management, early intervention, and peer recovery/recovery support as approved services.
- Recovery support services have been made allowable activities for Medicaid and Community Grant funds, and BSAAS has established the use of the appropriate encounter codes.
- BSAAS developed an initial technical assistance document for the field, to assist in the implementation of peer recovery/recovery support services.
- BSAAS has re-designed its website. Along with making the site more user-friendly, BSAAS has included information on the importance of recovery and recovery support services.
- BSAAS supported the HBO project on addiction recovery, so that program recommendations could be implemented throughout the state.
- Several ROSC symposia and focus groups have been hosted to provide forums for ongoing dialogue about developing a ROSC in Michigan.
- The ROSC TSC has been established to guide the transformation process.
- BSAAS has hosted focus groups and symposia for prevention specialists, to explore the contributions of prevention to Michigan's developing ROSC.
- A work group has been created to outline the various types of formal and informal peer support services that will be available within Michigan's ROSC.
- A workgroup has been created to redesign the state benefit plan.
- A SEOW has been established to expand and enhance the current substance abuse needs assessment data collection and tracking processes by incorporating data on mental, emotional and behavioral disorders that informs the implementation of the ROSC in Michigan.

Initial Practice Priorities

Stakeholders throughout Michigan have participated in a number of ROSC symposia. These included three meetings hosted by BSAAS in Lansing, in addition to regional symposia hosted by the Detroit Department of Health and Wellness Promotion, network 180, Northern Michigan Substance Abuse Services, Riverhaven Coordinating Agency, Southeast Michigan Community Alliance and Washtenaw Community Health Organization. More than 1000 individuals, including people in recovery, family

members, prevention and treatment providers, county administrators, cross-system stakeholders, and state staff have participated in this ongoing dialogue focused on promoting a recovery-oriented environment in Michigan.

As a result, five areas of initial practice priorities have emerged from the discussions. These include:

1. integrated behavioral health and primary healthcare;
2. promotion of community health;
3. peer-based recovery support services;
4. environmental and population-based prevention services; and
5. expanded focus of services and supports, including both the continuum of care (from pre-treatment services to post-treatment check-ups and support) and the content of care (expanding the focus beyond supporting abstinence to promoting community health and helping people build meaningful lives in the community).

For additional information about these prioritized practices, refer to the Appendix.

Framework Guiding the Recovery Transformation Process

The framework that Michigan is adopting to guide its recovery transformation process is the transformation framework used to guide Philadelphia's ongoing recovery transformation process (Achara-Abrahams, Evans, & King, 2011). It involves three primary strategies that must be implemented in a way that promotes a culturally competent service delivery system.

> **Conceptual Alignment:** This alignment targets the promotion of conceptual and philosophical clarity regarding the system's collective vision of transformation. During this process, the core values, principles, and ideas upon which a ROSC will be built are defined through an inclusive process.
>
> **Practice Alignment**: This focuses on changing stakeholder behaviors and processes across the system, so that they are consistent with the stated vision of recovery and resilience. Change leaders are focused on developing mechanisms to translate the theoretical concepts of recovery and resilience into concrete practices at various levels and in diverse parts of the system.
>
> **Contextual Alignment:** Activities are designed to sustain the transformation over time. While practice changes constitute a necessary part of the process, these changes cannot be implemented in a vacuum. To be sustained over time, they must be accompanied by contextual changes that will facilitate their long-term success. Many of these changes in context include policy, regulatory, and fiscal changes; increased political advocacy; activities that increase community support for people in recovery; and efforts that address stigma and strengthen the health of the community for all people.

These strategies are not linear, and at each phase of the transformation process there will be a continued need to align thinking, practices, and the fiscal/policy environment with the vision for the system. During some phases, however, certain strategies play a more prominent role. For example, in the initial stages of the transformation process, it is critical that sufficient time be invested in developing a shared vision for the system. It is also important to clarify what a ROSC in Michigan will look like before we attempt to implement any practice changes. If practice and/or policy changes are made prior to this clarification, it is highly likely that the resulting efforts will be fragmented or out of alignment with a recovery orientation. Table 1 details the initial phases of these transformation efforts and provides a high-level overview of some of the associated activities.

Table 1: Initial ROSC Framework Timeline for the Transformation Process

	Phase I (0 – 12 months)	Phase II (12 – 24 months)	Phase III (24 – 36 months)
Conceptual Alignment (Develop consensus; promote an in-depth understanding of a culturally competent ROSC)	Increase awareness of the need for the development of a ROSC in Michigan Develop a shared vision for change among all stakeholders Develop ROSC definition and guiding principles that apply to treatment and prevention Increase stakeholder understanding of the differences between a ROSC and a traditional system, including implications for treatment and prevention	Increase awareness of the implications of a ROSC for other systems (e.g., criminal justice, child welfare) Increase stakeholder understanding of effective ways of implementing recovery-oriented services and supports	Increase awareness of the types of services and supports within Michigan that are leading to better outcomes Realign the vision for the system based on lessons learned, successes, and challenges
Practice Alignment (Align services and supports with a recovery, resilience and culturally competent orientation)	Identify initial recovery-oriented practices that will be prioritized in the transformation process Disseminate information about practices throughout the system Conduct baseline assessments Identify/initiate potential pilots Mobilize the recovery community and other community stakeholders	Support the implementation of recovery-oriented practices through the development of technical advisories, training, technical assistance, relevant work groups, etc. Support the implementation of pilot projects Conduct rapid-cycle change projects Collaborate across systems to promote practice alignment	Conduct outcome assessments Disseminate lessons learned Provide advanced training and technical assistance Increase collaboration with other systems around the provision of recovery-oriented services Identify additional recovery-oriented practices that will be prioritized
Contextual Alignment (Change policy, fiscal, regulatory and administrative infrastructure so that it supports the sustainability of Michigan's culturally competent ROSC)	Identify fiscal, policy and regulatory barriers to delivering services and supports that promote recovery and resilience Identify strategies for addressing barriers to implementation Develop strategies to engage the community to support ROSC	Align fiscal and policy infrastructure to support recovery-oriented services Identify and address contextual challenges that arise within the pilot projects	Conduct cost/benefit analyses in various parts of the system Identify ongoing policy/fiscal challenges Increase expectations around the delivery of recovery-oriented care, through changes in contract language, inclusion in RFPs Actively address regulatory barriers to the full implementation of practice changes

Initial Transformation Goals for the Next 36 Months

Goal I: To Increase Understanding of a System that Promotes Recovery and Resilience in Michigan.

Goal II: To Develop a Shared Vision for ROSC in Michigan.

Goal III: To Increase Stakeholders' Understanding of Ways in Which Services and Supports that Promote Recovery and Wellness May be Similar to or Different from Current Services.

Goal IV: To Enhance our Collective Ability to Support the Health, Wellness, and Resilience of All Individuals by Developing Prevention-Prepared Communities.

Goal V: To Promote Health Equity in Michigan's SUD Service System.

Goal VI: To Enhance the Ability of People with SUDs to Both Initiate and Sustain Their Recovery.

Goal VII: To Ensure that Michigan Residents in Need of SUD Treatment Receive Effective Services and Supports, Regardless of the Systems They Enter.

Goal VIII: To Mobilize the Recovery Community and Increase the Hope that Recovery is a Reality in Michigan.

Goal IX: To Ensure that Transformation Efforts Are Sustainable and Become Embedded in Systems and Communities Throughout Michigan.

The initial objectives and strategies associated with each goal are outlined below. These were developed by the TSC in partnership with BSAAS and were influenced by input from stakeholders across the state. As transformational change is a complex and long-term process, the TSC is aware that not all of the strategies identified can be implemented simultaneously or immediately. As a result, those that are deemed most time-sensitive have been prioritized as the first four strategies under each objective and the text is highlighted in **bold**. The remaining strategies are equally important, but will not be the focus of BSAAS' and the TSC's immediate attention.

It is important to reiterate however, that this plan is not static nor set in stone. Based on changes within the general healthcare environment, the shifting needs of the people and communities being served, unanticipated circumstances, or the preferences of stakeholders, the plan will be adjusted accordingly. This serves only as an initial roadmap to guide the process of developing a ROSC in Michigan. Based on the collective experiences with transformation across the state and the subsequent lessons learned, this implementation plan will be modified and further refined. To get started however, the goals are organized within the three elements of the change framework; conceptual alignment, practice alignment and contextual alignment.

While the strategies that follow are primarily focused on the state's efforts to lead the development of a ROSC in Michigan, many of them are equally relevant to local communities. For example while the state may sponsor regional symposia to increase stakeholder's understanding of a ROSC and promote the development of a shared vision, regional CAs may choose to implement a similar strategy at a more local level to promote the development of a shared vision in a particular community. As such, this implementation plan should be viewed as a resource to assist CAs and their stakeholders in the planning and implementation of their recovery transformation processes.

CONCEPTUAL ALIGNMENT

Goal I: To Increase Understanding of a System that Promotes Recovery and Resilience in Michigan.

Objective A: To make the majority of stakeholders aware of the intention to develop a ROSC in Michigan.

Potential Strategies:

1. **Support regional symposia designed to increase awareness of recovery transformation. Include opportunities for regions to begin developing local plans during these symposia.**
2. **At the local, regional and state levels create opportunities to involve multiple stakeholders (e.g., focus groups, community meetings, etc.).**
3. **Develop a PowerPoint presentation that managers, supervisors, change agents and other stakeholder can use with their staff.**
4. **Conduct conference calls and webinars that stakeholders statewide can access, providing an overview of the recovery transformation underway in Michigan. Use assistive technology for storage to enable stakeholders to access the material at their convenience.**
5. Develop a recovery transformation newsletter that will be distributed statewide.
6. Develop fact sheets to orient stakeholders to the purpose of the recovery transformation.

Goal II: To Develop a Shared Vision for ROSC in Michigan.

Objective A: To develop a ROSC definition, guiding principles, and consensus regarding the types of services and supports that will be a part of Michigan's ROSC.

Potential Strategies:

1. **Through multiple mechanisms, clearly articulate how existing initiatives and priorities fit into Michigan's transformation process, in order to minimize fragmentation.**
2. **Document Michigan's evolving transformation process in articles for publication.**
3. **Explore and document the implications of recovery transformation for other systems such as criminal justice, child welfare, and primary care.**
4. **Facilitate stakeholder involvement in developing ROSC guiding principles (some of which overlap with mental health recovery transformation) via symposia, focus groups, and community meetings.**
5. Promote the development of a clear and simple common language, through the dissemination of a document that describes relevant language, to promote understanding through consistent language in all forums, documents, etc.
6. Conduct focus groups and symposia with prevention specialists, to provide opportunities for them to create a vision of a ROSC in Michigan that reflects their values and goals. Build on 2010 focus groups and symposia to continue to build conceptual clarity and commitment.

Goal III: To Increase Stakeholders' Understanding of Ways in Which Services and Supports that Promote Recovery and Wellness May be Similar to or Different from Current Services.

Objective A: To enable stakeholders to distinguish current practices which are consistent with a recovery orientation from those that are not consistent.

Potential Strategies:

1. **Give people in recovery opportunities and training to share their recovery stories in public settings and publicly accessible venues, thereby increasing stakeholders' understanding of what helps support recovery and increasing the hope that recovery is real.**
2. **Develop clear technical advisories/practice guidelines to assist people in understanding what services that promote recovery and resilience actually look like.**
3. **Examine mechanisms for increasing the integration of behavioral health services with primary care services along with increasing the understanding of the need to integrate/coordinate services with primary care.**
4. **Use webinars to provide concrete examples of services and supports that promote recovery and resilience.**

PRACTICE ALIGNMENT

Goal IV: To Enhance our Collective Ability to Support the Health, Wellness, and Resilience of All Individuals by Developing Prevention-Prepared Communities.

Objective A: To develop systems that provide continuing prevention services which promote individual, family and community health.

Potential Strategies:

1. **Continue to implement the Strategic Prevention Framework in the development of the role of prevention within a ROSC that includes an expanded continuum of health and wellness strengthened by prevention-prepared communities.**
2. **Conduct focus groups with prevention providers, to clarify their perspectives of the role in creating prevention-prepared communities within a ROSC.**
3. **Engage and mobilize stakeholders in multiple systems and sectors of the community to play identified roles in the development of prevention- prepared communities throughout Michigan.**
4. **Identify, prioritize and implement evidence-based and promising prevention practices that are consistent with ROSC. These include evidence-based practices which:**
    a. **Strengthen families by targeting substance abuse and associated aggressive behavior, teaching parenting skills, improving familial communication, and helping families respond effectively to disruption and adversity including divorce, removal of children from the home, parental mental illness, and poverty.**
    b. **Strengthen individuals by building resilience, life skills and improving cognitive processes and behaviors.**
    c. **Promote mental health among children in school settings encountering risk factors affecting social behavior, decision-making skills, self-awareness, positive relationships, and potential for violence, aggressive behavior, suicide risk and substance abuse.**
    d. **Promote mental health through primary health and community programs for the purpose of fostering and supporting pro-social behavior, coping skills and lifestyle changes that can affect mental, emotional and behavioral health.**
5. Provide training and technical assistance on prioritized prevention practices and strategies to providers and coalitions for the purpose of implementing prevention-prepared communities' essential in implementing the recovery-transformation process.
6. Increase cross-system stakeholders' understanding of prevention-prepared communities and their role in implementing a ROSC.
7. Increase the effectiveness of existing coalitions in creating prevention- prepared communities that are essential in implementing a ROSC.
8. Seek additional funding to support the development of prevention-prepared communities throughout Michigan.

Objective B: Reduce the development of SUDs among those at high risk by providing early intervention services to individuals and families with an increased risk of developing substance use challenges or disorders.

Potential Strategies:

1. **Identify frameworks that help to facilitate community change and guide stakeholders in building protective environments that foster the health and wellness of young people.**
2. **Identify an array of evidence-based early intervention programs. Examples include:**
    a. **Evidence-based and environmental change programs designed to reduce youth access to alcohol by applying social organizing techniques to address effectively legal, institutional, social and health issues, and to communicate to the community that underage drinking is not acceptable behavior.**
    b. **Group and individual school-based programs designed to reduce posttraumatic stress disorder, depression and behavioral problems; improve parent support and improve coping skills of students exposed to trauma such as community and school violence.**
    c. **Computer-based programs geared to promote mental health and prevention of substance abuse by increasing communication and disciplinary skills of parents of high-risk school-aged children.**
    d. **Prenatal and infancy home nursing programs geared to promote mental health and prevent substance abuse among high-risk and first-time parents and their children.**
    e. **School-based programs designed to prevent and reduce substance abuse among middle and high school students experiencing problems related to truancy, academic failure, discipline, and parental substance abuse.**
    f. **Programs that support family reunification, reduce intergenerational SUDs, promote mental health, increase parental participation, support pro-social behavior and improve academic performance.**
    g. **Family skills development programs designed to enhance school success, prevent substance use, and promote mental health by reducing aggressive behaviors.**
3. **Collaborate with primary care and mental healthcare settings to increase the likelihood that people receive an annual screening for at-risk drinking and substance use problems:**
    a. **Increase healthcare providers' knowledge of screening and brief intervention techniques.**
    b. **Identify additional opportunities to collaborate with primary care settings and expand early intervention opportunities.**
    c. **Educate current prescribers regarding appropriate prescribing practices for pain and other medications that may be misused.**
4. **Provide training to professionals in multiple systems, to assist them in identifying risk factors in individuals and families that can lead to the development of SUDs.**

Objective C: To prevent suicides and attempted suicides among those at risk.

Potential Strategies:

1. **Examine the prevalence of suicide and attempted suicide among various groups in Michigan and the cultural disparities associated with suicide along with at risk age groups.**

2. **Educate stakeholders in multiple systems including primary care, behavioral health, education, and the public at large about the risk and protective factors that contribute to a person's ability to manage effectively adverse life situations.**
3. **Encourage the development of culture-specific suicide prevention programs for those in cultures that have disproportionately high rates of suicide or suicide attempts.**
4. **Educate the public on the warning signs for suicide and appropriate actions to take in response to those warning signs.**

Goal V: To Promote Health Equity in Michigan's SUD Service System.

Objective A: To reduce health disparities in Michigan's SUD service system.

Potential Strategies:

1. **Continue the cultural competence workgroup as a subgroup of the TSC. The workgroup will provide oversight around efforts to eliminate disparities and increase the provision of culturally competent care. Some of the initial tasks of the workgroup will include:**
    a. **Establishing baseline data by Coordinating Agencies (CAs) for retention and penetration rates using fiscal year 2005 data.**
    b. **Sharing data/information/policies/outcomes (NOMS, PIs), including data on specific populations to identify and track health disparities.**
    c. **Surveying providers and CAs to assess what resources or support they need to eliminate health disparities in their communities.**
    d. **Surveying the regions to identify existing promising practices for providing culturally competent care and disseminating the information throughout the system.**
    e. **Providing the system with resources (training and information summarizing best practices) to promote the development of culturally competent practices.**
    f. **Developing a cultural competence technical advisory.**
2. **Align current policies, technical advisories and transformation strategies with the provision of culturally competent care.**
3. **BSAAS will provide direction and support to the CAs to increase the provision of culturally competent care.**
    a. **Establish relevant performance indicators.**
    b. **Monitor CA plans related to the elimination of health disparities and promotion of cultural competence during site visits.**

Goal VI: To Enhance the Ability of People with SUDs to Both Initiate and Sustain Their Recovery.

Objective A: To increase the number of people in treatment who successfully initiate and sustain recovery, through the implementation of integrated, recovery-oriented services and supports.

Potential Strategies:

1. **Expand the availability of peer-based support services and ensure that peer-support is an integrated and valued component throughout the service system:**

a. **Provide statewide webinars to support the implementation of peer support services in prevention and treatment.**
b. **Establish provider incentives for the successful integration of peer supports.**
c. **Create opportunities throughout Michigan for people in recovery, youth, and family members to serve in leadership roles and to have increased visibility in the system and in their communities.**
d. **Increase the number of identified people in recovery on the statewide transformation steering committee (and regional transformation steering committees)**
e. **Establish a workgroup to refine further the vision of peer-based recovery supports in Michigan.**
f. **Explore the role that peer-based recovery support services might play within an integrated service-delivery setting, or in promoting collaboration between primary care and the SUD service system.**
g. **Expand the role of peers in prevention services.**
h. **Increase the peer support available to adolescents and transition-age youth.**
i. **Update the technical advisory on peer-based recovery support services.**
j. **Highlight treatment programs and prevention efforts that are successfully integrating peer support, and share lessons learned.**

2. **Broaden the focus of treatment services and supports:**
   a. **Encourage providers to develop a diverse menu of service options from which people can select. This menu of services should include diverse services that are provided within treatment settings as well as those that are available in the community from existing community resources. As such providers should focus on building partnerships with individuals and organizations that represent different sectors of the community (e.g., employment, education, housing, spiritual support).**
   b. **Provide technical assistance and support for the integration of global assessments that focus on multiple domains including physical health and for the integration of recovery planning into service settings. These plans should be self-directed, individualized and focus on the broader life goals of people receiving services.**
   c. **Revise the technical advisory on provider-based ancillary recovery support services (e.g., life skills groups, assistance with basic needs, etc.) and on stage-based services and supports.**
   d. **Clarify ways in which providers can be reimbursed for providing ancillary recovery support services and/or for brokering these services using existing community resources.**
3. **Increase the implementation of post-treatment check-ups and supports:**
   a. **Identify and address policy and fiscal barriers to providing post-treatment check-ups and supports.**
   b. **Discuss post-treatment check-ups and supports within the context of care management as it is being discussed in healthcare reform.**
   c. **Develop and disseminate practice guidelines that describe diverse types of post-treatment check-ups and supports and describe what post-treatment check-ups and supports might look like in the context of a chronic-care management framework.**

    d. **Clarify the need for and sense of urgency around providing post-treatment check-ups and supports, via webinars, symposia, newsletters, etc.**
    e. **Encourage CAs to change contractual language with providers, so that post-treatment check-ups and supports are an expectation.**
4. **Develop learning communities among treatment providers who are working to integrate similar recovery-oriented services and supports:**
    a. **Utilize technology (e.g., webinars, conference calls, etc.) to share successes, challenges and lessons learned across systems and among stakeholders, including peers.**
5. Create a multi-layered training and workforce development approach that is inclusive of individuals who are still in training and preparing to enter the field, as well as those who are already working in the field and require continuing education.
    a. Engage existing workforce development committees in identifying relevant strategies to increase understanding of recovery-oriented services.
    b. At the local level, identify ways to build strong partnerships with local colleges and universities to incorporate more material regarding recovery-oriented services into existing curricula.
    c. Develop a broad range of strategies to support the ongoing development of all individuals currently providing behavioral health services in Michigan:
        i. Develop and/or provide self-assessment tools for providers.
        ii. Utilize conference calls and web-based training.
        iii. Focus on preparing the SUD services workforce for integration with primary care.
        iv. Facilitate training for diverse stakeholder groups, including people in recovery, prevention specialists and their stakeholders, treatment providers, family members, and stakeholders in other systems.
6. Develop pilot projects to demonstrate effectiveness and benefits**:**
    a. Identify local systems that have the necessary strengths and leadership to be early adopters in the transformation process.
    b. Identify areas of focus that can generate short-term wins and in which there exist interest and/or urgency.
    c. Disseminate lessons learned and describe developing best practices throughout the state. Use this as a marketing opportunity to bring others onboard.
    d. Assess the strengths and recovery orientation along multiple domains of local systems.
    e. Identify the type and duration of support needed to demonstrate meaningful outcomes.
    f. Align existing resources such as NIATx coaches to support system-transformation efforts.
7. Engage natural supports (e.g. faith community, community based organizations, mutual aid organizations, families, libraries, recreational centers, community-based businesses, etc.) in promoting community wellness and sustained recovery:
    a. Develop expectations for prevention and treatment providers to identify and partner with natural supports in their communities beyond the traditional institutional partnerships. These partnerships need to be real and mutually beneficial.
    b. Identify the barriers (e.g. lack of transportation) that providers and people in recovery encounter in attempting to connect with natural supports and identify potential solutions using lessons learned across the state.

c. Increase the focus on collaborating with families in both prevention and treatment efforts. Identify concrete strategies to increase the involvement of families in individual's recovery processes and to increase the support available to families.
d. Highlight examples of the integration of natural supports with prevention and treatment efforts throughout the system.
e. Identify the supports that providers need to engage successfully natural supports in the community.
f. Encourage the development of community coalitions.

Goal VII: To Ensure that Michigan Residents in Need of SUD Treatment Receive Effective Services and Supports, Regardless of the Systems They Enter.

Objective A: To increase cross-system collaboration and coordination between public health, child welfare, mental health, criminal justice, education, the Department of Corrections, primary care, recovering communities and the SUD service system.

Potential Strategies:

1. **Form a workgroup to focus on cross-system collaboration generally. Some of the tasks of the workgroup might include:**
    a. **Identifying the most pressing concerns in other service systems and articulating how recovery-oriented services assist with addressing those concerns.**
    b. **Developing a network of ROSC ambassadors who are embedded in other systems and who can influence the practices in their respective systems.**
    c. **Developing a communication process that will increase cross-system awareness of the recovery-oriented services and supports that are being implemented in different communities.**
    d. **Facilitating opportunities to engage other systems in a dialogue to identify potential areas of collaboration.**
    e. **Identifying, documenting, and disseminating information about the implications that the recovery-transformation process will have for other systems.**
    f. **Identifying opportunities for SUD prevention services to expand the role and increase stakeholders' awareness of the role of prevention services in overall health promotion.**
    g. **Identifying the areas of intersection between the recovery-transformation process underway in mental health and addiction, and highlighting opportunities for increased collaboration and coordination.**
2. **Develop an aggressive education campaign directed at the state legislature that highlights the outcomes and cost-effectiveness of recovery-oriented approaches.**
3. **Develop other strategies at both state and regional levels to increase collaboration and cooperation to advance the goals of ROSC transformation.**

Objective B: To ensure that individuals in need of care receive comprehensive services that address both their addiction as well as their physical health needs.

Potential Strategies:

1. **Increase the integration and coordination of specialty addiction and primary healthcare services:**
    a. **Perform a comprehensive statewide environmental assessment to identify current local models of integrated services, promising practices, local leaders, lessons learned that can be disseminated throughout the state, the status of health information technology utilization and potential obstacles to service integration in Michigan.**
        i. **Identify strategies for addressing obstacles to integration and collaboration, such as policies that impede information sharing across systems and policies that prohibit payment to multiple providers for services provided on the same day.**
        ii. **Identify strategies to advance the integration of health information technology to facilitate care coordination.**
    b. **Identify ways in which different roles within the SUD service system can be expanded to address both physical and behavioral health issues in primary care and behavioral health settings. For example:**
        i. **What roles might prevention specialists play within a primary care setting?**
        ii. **How might the roles of peers be expanded to include assertive connections to primary care settings?**
        iii. **How might SUD service providers play an expanded role in providing brief intervention services within primary care settings?**
    c. **Expand providers' concepts of care coordination to include both physical health and behavioral health services, by providing new guidelines for effective care coordination and by aligning reimbursement strategies (e.g. providing reimbursement for care coordination conferences).**
    d. **Identify strategies to ensure that primary care providers have timely access to specialty SUD services for their patients.**
    e. **Provide stakeholders with brief summaries of models of bi-directional SUD service and primary care integration in the literature.**
    f. **Create opportunities for dialogue with stakeholders across systems about developing person-centered healthcare homes in Michigan.**
    g. **Form partnerships with other systems to explore the development of a standard consent form that can be used across an integrated continuum of care.**
    h. **Examine strategies for streamlining paperwork to match the fast-paced environment of primary-care settings.**
    i. **Use a variety of communication strategies to highlight the need for providers to expand partnerships with primary care services and develop memoranda of agreement.**

Person-Centered Healthcare Homes

1. Health screening and registry tracking in MH/SU settings as well as primary care
2. Nurse practitioner or PCP in MH/SU settings as well as primary care
3. Behavioral health consultants in primary care, competent in MH/SU disorders
4. Nurse care managers in MH/SU settings as well as primary care
5. Evidence-based preventive care in all settings
6. Wellness programs in all settings

(NCCBH, 2010)

Objective C: To assist the criminal justice system in aligning their approaches, resources and philosophical framework with that of recovery-oriented services and supports.

Potential Strategies:

1. **Seek opportunities to provide education about ROSC to stakeholders in the following organizations and institutions:**
    a. **Drug Treatment Courts;**
    b. **Family Courts;**
    c. **Michigan District Judges Association;**
    d. **Michigan Court Administrators Association;**
    e. **Michigan Judicial Institute; and**
    f. **Michigan Association of Drug Court Administrators.**
2. **Work with criminal justice representatives to identify the implications of developing a ROSC for criminal justice services.**
3. **Identify opportunities for increased collaboration and coordination between the criminal justice system and the SUD service system.**
4. **Develop or identify models of criminal justice and SUD service system collaboration within a ROSC and disseminate lessons learned throughout the state.**
5. **Increase the participation of criminal justice representatives on the TSC.**

Objective D: To increase access to services, promote retention in services, and improve the financial health of providers through the use of tele-health technologies.

Potential Strategies

1. **Assess the current use of tele-health technologies throughout the state.**
    a. **Form a stakeholder workgroup focused on the use of tele-health technologies.**
        i. **BSAAS will submit a request for technical assistance from SAMHSA/CSAT to guide state officials in establishing a statewide tele-health system.**
        ii. **Identify the relevant individuals, groups, and organizations to be represented on the workgroup along with the relevant competencies and expertise needed to ensure that the group is productive.**
        iii. **Identify an individual who will serve as the advisor to the stakeholder workgroup regarding technology capabilities and configuration options.**
2. **Charge the workgroup with the responsibility of developing and implementing a tele-health strategic plan for SUD services in Michigan:**
    a. **By August 2011, the TSC sponsored stakeholder workgroup will identify the systemic requirements for the implementation of a statewide tele-health system. This will include an internal assessment of the goodness-of-fit with the other responsibilities and objectives of BSAAS.**
    b. **The stakeholder workgroup, in collaboration with its IT advisor and the Department of Information Technology, will establish and publish minimum compatibility standards to permit the field to move forward.**
    c. **The stakeholder workgroup will survey licensed SUD service providers and community mental health service providers to determine the current capacity and needed resources.**

3. **Coordinate the use of tele-health efforts throughout the state for individuals with SUDs:**
    a. **Issue a technical advisory to encourage and permit the use of tele-health approaches to SUD treatment services.**
    b. **Determine whether or not relevant state policies exist, and the degree to which they apply or may need to be revised.**
    c. **Develop an implementation and/or training plan to support the technical advisory.**

Goal VIII: To Mobilize the Recovery Community and Increase the Hope that Recovery is a Reality in Michigan.

Objective A: To increase the number of people in recovery who are visible in leadership positions, within the system and throughout Michigan's communities.

Potential Strategies

1. **Develop pathways of opportunity for people to assume leadership roles (e.g., involvement in advisory structures, boards, co-facilitators of training, etc.).**
2. **Create relevant leadership training for people in recovery.**
3. **Identify additional strategies to increase the visibility of current formal and informal leaders who are in recovery.**
4. **Promote the development of recovery advocacy organizations at local and state levels.**
5. **Ensure that people in recovery participate in all existing and new workgroups and committees.**

Objective B: To expand the voice of people in recovery in communities throughout Michigan.

Potential Strategies

1. **Develop storytelling training for people in recovery and increase their visibility in the system.**
2. **Identify strategies to honor the contributions of traditional recovery communities.**
3. **Create opportunities for people in recovery to share experience, strength and hope.**
4. **Implement efforts to increase the number of participants in the annual recovery walk.**

Objective C: To reduce stigma and discrimination against people in recovery in Michigan.

Potential Strategies:

1. **Expand and build more peer-based recovery support services.**
2. **Identify and implement a wide range of strategies to highlight that sustained recovery is a reality.**
3. **Educate the public about the factors that help people to initiate recovery and those that hinder people from attaining long-term recovery.**
4. **Educate the public about the fact that SUDs are chronic illnesses.**

CONTEXTUAL ALIGNMENT

Goal IX: To Ensure that Transformation Efforts Are Sustainable and Become Embedded in Systems and Communities Throughout Michigan.

Objective A: To align fiscal, policy, regulatory, and community contexts with the provision of services and supports which promote recovery, resilience, and community health.

Potential Strategies:

1. **Create a workgroup to focus on policy, fiscal, and regulatory barriers that treatment/prevention providers may face in implementing services and supports that promote recovery and resilience. Some of the tasks of that group might include:**
    a. **Establishing a benefit package of services that will represent ROSC in Michigan.**
    b. **Conducting an e-survey to assess some of the current barriers to implementation.**
    c. **Identifying strategies to increase collaboration among funding sources, to reduce the influence of silos and promote shared funding and requirements around service delivery.**
2. **Identify strategies to support providers in enhancing their infrastructure to provide recovery-oriented services and monitor related outcomes, such as through the use of electronic health records.**
3. **Develop an evaluation strategy to document the outcomes and benefit of the transformation process.**
    a. **Conduct cost/benefit analyses.**

Quality of Care in a ROSC

As systems begin to grapple with the practice changes required to move more fully toward a recovery orientation, questions often emerge around whether these changes "aren't just good clinical care." The principles of practice in a recovery orientation are not distinct from those of good care; rather, they now define what good-quality care really is. High-quality services are those that are effective in, not only reducing illness, but also improving quality of life. High-quality care is also geared to the current stage of an individual's recovery journey, with careful attention to the person's culture in the broadest sense of the word. Such care is equitable, in the sense that it does not fluctuate based on personal characteristics such as gender, race, ethnicity, sexual orientation, and religious affiliation. In addition, the provision of high-quality behavioral health services entails attending to the trauma-related issues that often underlie behavioral health challenges.

The recovery transformation in Michigan will focus on different aspects of quality of care at different points in time. These include using evidence-based and informed practices, increasing the availability of trauma-informed services, and addressing health disparities by enhancing cultural competence throughout the system, and developing specific programs for cultural groups. While it is recognized that the multiple dimensions of the provision of quality services cannot always be addressed simultaneously, the transformation process will work continuously toward these ends.

Mechanisms to Ensure that the Transformation Process is Participatory, Inclusive, and Transparent

BSAAS and the TSC are committed to facilitating a participatory, transparent process. To that end, the following mechanisms will be used to facilitate such a process:

- BSAAS will host regional ROSC symposia to increase stakeholder awareness of efforts to promote a ROSC in Michigan and obtain feedback and ideas.
- A transformation newsletter will be developed and disseminated throughout the system.
- Notes from the TSC meetings will be posted on the Michigan Department of Community Health website.
- Changes in policies and technical advisories will be facilitated through workgroups with diverse stakeholder representation.

How You Can Become Involved in the Transformation Process

Creating a more recovery-oriented system of behavioral healthcare in Michigan will require the commitment and talents of many people. If you would like to be a part of this transformation process, we invite your participation through such activities as the following:

- Acquaint yourself with the classic papers on recovery advocacy and key recovery-related research, and with research-to-practice articles. Many of these can be found at www.attcnetwork.org/greatlakes and www.williamwhitepapers.com.
- Encourage service recipients and their family members to participate in storytelling trainings.
- Offer your ideas and feedback by participating in community forums hosted by BSAAS and your local CA.
- Expand the role of people in recovery at your service-delivery setting.
- Use the tools that will be provided by BSAAS to begin the process of aligning your organizational structure and service-delivery practices with the initial priorities for recovery transformation.
- Develop an internal change-management team, to begin exploring ways in which concepts of recovery-oriented care can be applied at your service setting, and to shepherd this change successfully. Include on these teams key agency leaders, people in recovery, and all levels of staff.
- Expand and develop new partnerships with natural supports in the community.
- Increase activities aimed at the cultivation of non-clinical recovery support services outside the treatment agency.
- Find opportunities to listen to the stories of people in recovery and learn from them what helps and what hurts.
- Participate in any of the workgroups that are developed to advance the transformation process.

We welcome your feedback regarding this implementation plan. If you would like any additional information regarding any of the transformation activities mentioned above, please send your inquiries to mdch-bsaas@michigan.gov.

The state of Michigan is already on the cutting edge of behavioral health service delivery due to the hard work, innovation, and dedication of stakeholders throughout the system. The transformation process currently underway builds on the existing strengths in the system and continues that tradition of leadership into the future. We invite you to join us in shaping the future, not only for people in recovery, but ultimately for us all.

Appendix

Recovery-Oriented Practices within a ROSC

The guiding principles outlined in this document have far-reaching implications for Michigan's prevention and treatment efforts. To date the SUD services field at the national level has focused primarily on the implications for treatment services. That focus is reflected below. As we continue the development of a ROSC in Michigan however, prevention specialists are articulating the implications for their work. As such, what follows will be expanded to include a greater emphasis on prevention in the near future.

Implications for Recovery-Oriented Services in Michigan's ROSC

Assessment: Greater use of holistic, culturally relevant, strengths-based assessment procedures and interview protocols; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stage of recovery.

Dose/Duration of Services: Provide the proper doses of services across levels of care that are associated with positive recovery outcomes. Facilitate continuity of contact in a primary recovery support relationship over time, and across levels of care.

Focus of Services and Supports: Focus of services and supports expands beyond sobriety to assisting individuals with building lives in the community and promoting community health. Treatment and prevention efforts are focused on life goals, and what people want to become, rather than what we want them to stop doing. Services and supports also extend to strengthening the family and community contexts so that individuals have increased access to long-term recovery supports and protective factors. Focus of treatment is expanded to include the development of recovery maintenance skills rather than limited to recovery initiation.

Peer-based Recovery Support Services: Expand the availability of non-clinical, formal (paid) and informal (non-paid) peer-based recovery support services and integrate them with professional and peer-based services.

Post-treatment Checkups and Support: Shift the focus of service intervention from acute stabilization to sustained recovery management via post-treatment recovery check-ups, stage-appropriate recovery education and, when needed, early re-intervention. Shift from passive aftercare to assertive approaches to continuing care.

Promotion of Community Health: Encourage greater focus on prevention, and community wellness through targeted community education, strategic community partnerships, efforts geared at strengthening/building community recovery capital or community protective factors, reducing community risk factors, and implementing effective prevention programming along with other strategies.

Relationship to Community: Collaborate with indigenous recovery support organizations (e.g., faith communities); assertively link clients to local communities of recovery; participate in local recovery education/celebration events in the larger community and advocate on issues that effect long-term recovery (e.g., issues of stigma and discrimination), as well as general community health. Mobilize and increase collaborations amongst community resources. Prevention and treatment efforts approach the community from a collaborative stance that values and integrates the knowledge, expertise and strengths of community members.

Retention: Enhance rates of service retention and reduce rates of service disengagement and administrative discharge by utilizing outreach workers, enhancing peer-based recovery support services in the treatment context, providing culturally competent services, providing a menu of service options so that care is individualized, and incorporating family members and other important allies as desired. Also focus on assertive approaches to keeping people connected to community-based supports.

Role of Client: Shift towards philosophy of choice rather than prescription of pathways and styles of recovery, greater client authority and decision-making within the service relationship, emphasis on empowering clients to self-manage their own recoveries and identify their personal life and treatment goals.

Service Delivery Sites: Increase the delivery of community integrated services and supports and expand recovery support services in high-need areas. Utilize and link clients to existing community-based resources rather than duplicating efforts and re-creating resources within segregated, institutional environments. Assist community members in developing a network of natural recovery supports in order to increase their recovery capital.

Service Relationship: Shift the primary service relationship from a hierarchical expert/patient model to a partnership/consultant model. The helping stance changes from "this is what you must do" to" how I can help you?"

Strengths-Based Community Asset Mapping: Rather than focusing primarily on needs assessments, gaps and identified problems, prevention efforts also take a strategic approach to assessing the strengths and assets within communities.

System Access: Assure rapid access to services and supports with minimal wait times. During unavoidable wait times, clients in treatment are engaged through peer-based supports. Ensure that there are no limitations to accessing treatment based on past utilization and/or treatment outcomes.

System Engagement: Promote early engagement in treatment- and community-based recovery supports via outreach and community education. Emphasize removing personal and environmental obstacles to recovery and wellness through meeting basic needs. For those in treatment, the responsibility for motivation to change is shared by service providers, and inclusive admission criteria are utilized rather than an emphasis on exclusionary criteria.

References

Achara-Abrahams, I., Evans, A., & King, J. (2011). Recovery-focused behavioral health system transformation: A framework for change and lessons learned from Philadelphia. J. Kelly, W. White (Eds.). *Addiction Recovery Management: Theory, Research and Practice*, pp. 187-208

Ackerman, L. (1997). Development, transition, or transformation: The question of change in organizations. D. Van Eynde, J. Hoy, E. Van Eynde (Eds.). *Organization Development Classics*, pp. 45-58.

Agosti, V., Nunes, E., & Ocepek-Welikson, K. (1996). Patient factors related to early attrition from an outpatient cocaine research clinic. *American Journal of Drug and Alcohol Abuse, 22*, pp. 29-39.

Barber, J., Luborsky, L., Gallop, R., Crits-Christoph, P., Frank, A., Weisss, R., Thase, M., Connolly, M., Gladis, M., Foltz, C., & Siqueland, L. (2001). Therapeutic alliance as a predictor of outcome and retention in the National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Journal of Consulting and Clinical Psychology*, *69*(1), 119-124.

Bluthenthal, R, Jacobson, J., & Robinson, P. (2007). Are racial disparities in alcohol treatment completion associated with racial differences in treatment modality entry? Comparison of outpatient treatment and residential treatment in Los Angeles County, 1998 to 2000. *Alcoholism: Clinical & Experimental Research, 31*, pp. 1920-1926.

Cohen, L., & Chehimi, S. (2007). Beyond brochures: The imperative for primary prevention. L. Cohen, V. Chavez & Sana Chehimi (Eds.). *Prevention is Primary. Strategies for Community Well-being*, pp. 3-23.

Cuijpers, P. (2002). Peer-led and adult-led school drug prevention: A meta-analytic comparison. *Journal of Drug Education, 32*, pp. 107-119.

Dawson, D. (1996). Correlates of past-year status among treated and untreated persons with former alcohol dependence: United States, 1992. *Alcoholism: Clinical and Experimental Research, 20*(4), 771-779.

Dennis, M, Foss, M, & Scott, C. (2007). An eight-year perspective on the relationship between the duration of abstinence and other aspects of recovery. *Evaluation Review*, *31*(6), pp. 585-612.

Dennis, M., & Scott, C. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*(1), pp. 45-55.

Department of Health and Human Services. (2000). *Healthy People 2010: Understanding and Improving Health*. 2nd ed.

Department of Health and Human Services, National Institute on Drug Abuse. (1998). *The Economic Costs of Alcohol and Drug Abuse in the United States - 1992* (#BKD265).

Department of Health and Human Services, National Institute on Drug Abuse. (Rev 2003). *Drug Use Among Racial/Ethnic Minorities*. NIH # 03-3888. Retrieved from www.drugabuse.gov.

Department of Health and Human Services, National Institute on Drug Abuse. (Rev 2007). *Principles of Drug Abuse Treatment for Criminal Justice Populations*, NIH # 06-5316. Retrieved January 6, 2010, from www.drugabuse.gov.

Department of Health and Human Services, Office of Applied Studies (2005). *National Survey on Drug Use and Health*. Retrieved from http://oas.samhsa.gov/2k5/arrests/arrests.htm.

Department of Health and Human Services, Office of the Surgeon General. (1999). *Mental Health: A Report of the Surgeon General*. Retrieved from http://www.surgeongeneral.gov/library/reports.

Department of Health and Human Services, Office of the Surgeon General. (2001). *Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General*. Retrieved from http://www.surgeongeneral.gov/library/reports.

Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2005). *Federal Action Agenda: First Steps*.

Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2009). *Ensuring U.S. Health Reform Includes Prevention and Treatment of Mental and Substance Use Disorders – A Framework for Discussion: Core Consensus Principles for Reform from the Mental Health and Substance Abuse Community*. SMA 09-4433.

Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2010a). *Healthcare Reform: Implications for Behavioral Health Providers* Webinar presented by: J. O'Brien , C. Ingoglia, & D. Jarvis.

Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2010b). *Leading Change: A Plan for SAMHSA's Roles and Actions 2011 – 2014*. Retrieved from http://www.samhsa.gov/about/sidocs/SAMHSA_SI_paper.pdf.

Department of Justice, Bureau of Justice Statistics. (2006). *Prison and Jail Inmates at Midyear 2005*. NCJ 213133. Retrieved from http://bjs.ojp.usdoj.gov/content/pub/pdf/pjim05.pdf.

Department of Justice, Bureau of Justice Statistics. (2009). *Prisoners in 2008.* NCJ 228417. Retrieved June 1, 2010, from http://bjs.ojp.usdoj.gov/content/pub/pdf/p08.pdf.

Department of Justice, Office of Justice Programs. (2007). *Reentry*. Retrieved January 27, 2007, from http://www.reentry.gov.

DeSoto, C., O'Donnel, W., & DeSoto, J. (1989). Long-term recovery in alcoholics. *Alcoholism: Clinical and Experimental Research, 13*, pp. 693-697.

Dismuke, C., French, M., Salome, H., Foss, M., Scott, C., & Dennis, M. (2004). Out of touch or on the money: Do the clinical objectives of addiction treatment coincide with economic evaluation results? *Journal of Substance Abuse Treatment, 27*(3), pp. 253-63.

Gottfredson, D., & Wilson, D. (2003). Characteristics of effective school-based substance abuse prevention. *Prevention Science,* 4(1), pp. 27-38.

Hser, Y., Evans, E., Huang, D., & Anglin, M.D. (2001). Relationship between drug treatment services, retention and outcomes. *Psychiatric Services, 55,* pp. 767-774.

Hser, Y., Stark, M., Paredes, A., Huang, D., Anglin, M., & Rawson, R. (2006). A 12 year follow-up of a treated cocaine-dependent sample. *Journal of Substance Abuse Treatment, 30,* pp. 219-226.

Hubbard, R., Craddock, S., & Anderson, J. (2002). Overview of 5-year follow-up outcomes in the Drug Abuse Treatment Outcome Studies (DATOS). *Journal of Substance Abuse Treatment, 25,* pp. 125-134.

Institute of Medicine. (2000). *Promoting Health: Intervention Strategies from Social and Behavioral Research*. B. Smedley, L. Syme (Eds.). Committee on Capitalizing on Social Science and Behavioral Research to Improve the Public's Health.

Isaacson, E. (1991). Chemical addiction: Individuals and family systems. *Journal of Chemical Dependency Treatment, 4*(1), pp. 7-27.

Jerrell, J., & Wilson, J. (1997). Ethnic differences in the treatment of dual mental and substance disorders: A preliminary analysis. *Journal of Substance Abuse Treatment, 14*(2), pp. 130-140.

Jin, H., Rourke, S., Patterson, T., Taylor, M., & Grant, I. (1998). Predictors of relapse in long-term abstinent alcoholics. *Journal of Studies on Alcohol, 59,* pp. 640-646.

King, A. & Canada, S. (2004). Client related predictors of early treatment dropout in a substance abuse clinic exclusively employing individual therapy. *Journal of Substance Abuse Treatment, 26*(3), pp. 189-195.

Klein, A., Canaan, R., & Whitecraft, J. (1998). Significance of peer social support for dually diagnosed clients: Findings from a pilot study. *Research on Social Work Practice, 8,* pp. 529-551.

Kotter, J. (1996). Leading Change.

La Roche, M. (2002). Psychotherapeutic considerations in treating Latinos. *Harvard Review of Psychiatry*, 10(2), pp. 115–22.

Longshore, D. Grills, C., & Anon, K. (1999). Effects of culturally congruent intervention on cognitive factors related to drug-use recovery. *Substance Use and Misuse, 34*(9), pp. 1223-1241.

Longshore, D., Hsieh, S., & Anglin M. (1993). Ethnic and gender differences in drug users' perceived need for treatment. *International Journal of the Addictions, 28,* pp. 539-558.

Longshore, D., Hsieh, S., Anglin, M., & Annon, T., (1992). Ethnic patterns in drug abuse treatment utilization. *The Journal of Mental Health Administration, 19*(3). pp. 268-277.

Longshore, D., Hsieh, S., Danila, B., & Anglin, M. (1993). Methadone maintenance and needle/syringe sharing. *International Journal of the Addictions, 28,* pp. 983-996.

Mann, K., Schafer, D., Langle, G., Ackermann, K., & Croisaant, B. (2005). The long-term course of alcoholism, 5, 10, and 16 years after treatment. *Addiction, 100,* pp. 797-805.

McKay, J. (2001). Effectiveness of continuing care interventions for substance abusers: Implications for the study of long-term treatment effects. *Evaluation Review, 25*(2), 211-232.

McKay, J. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction, 100*(11), 1594-1610.

Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services. (2009). *Cultural Competence Conceptual Framework.*

Michigan Department of Corrections. (2006). *The MPRI Model: Policy Statements and Recommendations*. Retrieved from www.michigan.gov/corrections.

Michigan Department of Corrections. (2009a). *Report to the Legislature, Pursuant to P.A. 245 of 2008 Section 403(6), MPRI Parolees Tested Positive for Substances and Department Imposed Sanctions, September 2008 – February 2009.* Retrieved from www.michigan.gov/corrections.

Michigan Department of Corrections. (2009b). *Report to the Legislature, Pursuant to P.A. 245 of 2008 Section 403(6), MPRI Parolees Tested Positive for Substances and Department Imposed Sanctions, March 2009 – August 2009.* Retrieved from www.michigan.gov/corrections.

Michigan Department of Corrections. (2010a). *Report to the Legislature. Pursuant to P.A. 114 of 2009 Section 401, Prison Population Projection Report, January 2010.* Retrieved from www.michigan.gov/corrections.

Michigan Department of Corrections. (2010b). *Report to the Legislature. Pursuant to P.A. 487 of 2006 Section 40(3) - M.C.L. 791.240, Parolees Returned for Violations Involving Alcohol or Controlled Substances, April, 2010.* Retrieved from www.michigan.gov/corrections.

Meier, P. Donmall, M., McElduff, P., Barrowclough, C., & Heller, R. (2006). The role of the early therapeutic alliance in predicting drug treatment dropout. *Drug and Alcohol Dependence, 83,* pp. 57-64.

Mertens, J. & Weisner, C. (2000). Predictors of substance abuse treatment retention among women and men in an HMO. *Alcoholism Clinical and Experimental Research, 24*(10), pp. 1525-1533.

Moss, A., Vranizan, K., Gorter, R., Bachetti, P., Watters, J., & Osmond, D. (1994). HIV seroconversion in intravenous drug users in San Francisco 1985-1990. *AIDS, 8*(2), 223-231.

National Council for Community Behavioral Healthcare. (2010). *Substance Use Disorders and the Person-Centered Healthcare Home*. Retrieved from http://www.thenationalcouncil.org.

National Research Council & Institute of Medicine. (2009). *Preventing, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions*. M. O'Connell, T. Boat, T. Warner (Eds.). Board on Children, Youth and Families.

Nathan, P., & Skinstad, A. (1987). Outcomes of treatment for alcohol problems: Current methods, problems and results. *Journal of Consulting and Clinical Psychology*. *55*, pp. 332-340.

Pew Charitable Trust. (2008). *One in 100: Behind Bars in Americ*a. Retrieved January 6, 2011, from www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/sentencing_and_corrections/one_in_100.pdf

Rebach, H. (1992). Alcohol and drug use among American minorities. J. Trimble, C. Bolek, S. Niemcryk (Eds.). *Ethnic and Multicultural Drug Abuse: Perspectives on Current Research*.

Robertson, K. (2008). Recovery-oriented systems of care and their relationship to criminal justice. Conference presentation at *15th National TASC Conference on Drugs and Crime*. Retrieved January 5, 2011, from http://www.nationaltasc.org/wp-content/conference/data/papers/P001.pdf.

Schmidt, L., & Mulia, N. (2009). *Policy Brief on: Racial and Ethnic Disparities in Substance Abuse Treatment*. Retrieved from Robert Wood Johnson Foundation's Substance Abuse Policy Research Program, http://saprp.org/knowledgeassets/knowledge_detail.cfm?KAID=11.

Schutte, K., Byrne, F., Brennan, P., & Moos, R. (2001). Successful remission of late-life drinking problems: A 10-year follow-up. *Journal of Studies on Alcohol, 62*, pp. 322-34.

Scott, C., Foss, M., Lurigio, A., & Dennis, M. (2003). Pathways to recovery after substance abuse treatment: Leaving a life of crime behind. *Evaluation and Program Planning, 26*(4), pp. 403-12.

Stark, M. (1992). Dropping out of substance abuse treatment: A clinically oriented review. *Clinical Psychology Review*, *12*, pp. 93-116.

Tonigan, J. (2003). Project Match treatment participation and outcome by self-reported ethnicity. *Alcoholism: Clinical and Experimental Research 27*, pp. 1340-1344.

Vaillant, G. (1996). A long-term follow-up of male alcohol abuse. *Archives of General Psychiatry, 53*(3), pp. 243-249.

White House, Office of National Drug Control Policy (2010a). *National Drug Control Strategy*. *Data Supplement*.

White House, Office of National Drug Control Policy (2010b). New directions in drug control policy: White House office of national drug control policy demand reduction priorities. Document provided at the *Addiction Technology Transfer Center Directors Meeting* held March 2010.

White, W. (2008). *Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices*. Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, and Philadelphia Department of Behavioral Health and Mental Retardation Services.