



Adoption of Recovery-Oriented Care Systems Growing: A Look at the 'State of the Nation'



The 'state of the nation' in recovery-oriented systems of care (ROSC) is a moving target with a mass of anecdotal information but little hard data. An ROSC is a system designed to meet the needs of the consumer with recognition that each person must either lead or be the central participant in his or her own recovery. The integration of an ROSC will involve many changes to current systems of care, requiring different state and federal agencies to work together and rethink goals and priorities. A common question I hear from provider organizations is, "How do we know this can work and what are others doing across the country?"

States are at different stages in conceptualizing and implementing recovery-oriented systems change, according to "Partners for Recovery," a 2008 report issued by Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse (CSAT). While the report primarily focuses on substance abuse, it can be utilized as a good indicator of the pace of development in both substance abuse and mental health fields. According to the report, five states have begun planning, actively adapting, and re-engineering their systems of care to become more recovery-oriented; eighteen states are implementing system elements and are beginning to plan implementation of ROSCs; twenty-two states are implementing one or more system elements; and six states are considering implementation of ROSCs.

The participants in the report demonstrate the diversity of ROSC development and interest. Those in attendance included 17 Single State Authorities (SSA) and 34 SSA designees; 50 treatment providers or treatment provider association representatives; 48 representatives of recovery organizations or of the recovering community; eight faith-based providers; two recovery/faith-based providers; one treatment/faith-based provider; 20 research representatives; and 30 other types of stakeholders. Such diversity in representation and geography demonstrates the pervasively high level of interest in the development of ROSCs. However, a few states and tribal nations have endorsed the ROSC model and are setting the pace: Arizona, Connecticut, Michigan, Oregon, the city of Philadelphia, and the Native American Wellbriety Movement.

In 2001, the Arizona Department of Health Services, Division of Behavioral Health, shifted its system to include the reliance on licensed provider agencies and the development of non-traditional support providers. The transformation goals included diversification and expansion of the workforce through non-traditional providers, the maximization of Medicaid reimbursement for a growing entitled population, employing the Health Care Common Procedures Coding System's "H" codes for substance abuse, mental health, and behavioral health services for reimbursement by the Centers for Medicare and Medicaid Services, and developing an 80-hour class in skill and competencies of peer support specialists.

Connecticut's ROSC integration strategy included a multi-year implementation process including consensus building; technology transfers to utilize 'best practices'; incorporating existing initiatives; re-orientation of systems to support recovery; the transition of providers to recovery-oriented performance outcomes; the

development of "Practice Guidelines for Recovery-Oriented Behavioral Health Care" that include instructions on participation, promoting access and engagement, continuity of care, identifying barriers, and individualized recovery.

In 2006, a Michigan Administrative Rule change went into effect to add four new licensing categories including case management, early intervention, integrated treatment, and peer recovery support services. This rule change served as the groundwork for larger system change efforts in the state. Michigan is working to integrate a wide range of systems, including corrections, child welfare, state police, and education into their recovery-oriented activities. Next steps for Michigan include forming ROSC workgroups, continuing policy development, enhancing monitoring at various levels, and integrating technical advisory group recommendations.

Since 2006, Oregon has planned to gradually phase in a ROSC. The Addictions and Mental Health Division (AMH) at Oregon's Department of Human Services has devised the *Resilience and Recovery Policy Statement*, which places more of an emphasis on the consumer and provider experience, focus groups, data analyses of their programs and policies, and evidence-based practices. It also promotes the use of Recovery Homes/Oxford Houses—group homes throughout various metropolitan areas that allow for self-run/self-supportive drug-free recovery environments. AMH essentially aims to create a holistic, self-directed recovery process that allows each client to take control of every aspect of his or her life. AMH's outcomes involve success in school, work, and personal relationships; improved health; community involvement; and an overall increased quality of life for both the individual and family involved. Oregon is further examining payment strategies and regulatory issues (e.g. administration rules and processes). Main concerns for the development of Oregon's ROSC is peer-delivered services as well as the inclusion of case management into the Medicaid benefit package.

The city of Philadelphia's Department of Behavioral Health and Mental Retardation Services (DBH/MRS) is also undergoing a transformation in their system. DBH/MRS has begun a process of systems change with early identification and increased use of assessment tools as well as service retention. The ability of clients to take control of their own recoveries is now emphasized, as well as a natural learning environment and welcoming attitude towards re-admitted clients. DBH/MRS also plans on improving the quality of service relationships; increasing total services (while decreasing acute care episodes); and on providing post-treatment checkups and support. Philadelphia has collaborated with various organizations with these goals in mind and has formed community coalitions, awarded grants to community-based organizations and providers, and has supported faith-based initiatives.

The Wellbriety Movement in Native American communities is based on the Four Laws of Change for community development as well as on the traditional 12-step program from Alcoholics Anonymous; this integration represents culturally specific healing in the development of a ROSC. Recovery-oriented elements of the Wellbriety Movement include peer recovery support networks, ongoing monitoring and outreach, education and training, and an emphasis on cultural responsiveness, family involvement, and person-centered treatment elements.

This article has taken a look at the state-of-the-nation, and although ROSC implementation is presently limited, we can all encourage their growth and development through exploration and discussion.

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Aune, Dan M. (2009, July). Adoption of Recovery-Oriented Care Systems Growing: A Look at the 'State of the Nation'. OPEN

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