I. Background

The State of Connecticut has made a significant commitment to shifting its current service delivery system for persons affected by substance use disorders to one that is more recovery oriented and has embarked upon a number of processes to define the processes, strategies, values, principals and services that will need to be implemented to accomplish this shift. Additionally, the State has been proactive in issuing policy guidance in this matter, has worked with the recovery community and others to develop and disseminate values and principals to anchor the system and has convened a series of opportunities for stakeholder participation in this developmental process. The Department of Mental Health and Addiction Services has requested Federal Technical Assistance through the Center for Substance Abuse Treatment to assist the State in this matter through the development of a strategic implementation plan.

Initial technical assistance deliverables were developed with the Department and include:

- Sharing of feedback regarding the initiative, the process the State is employing to move towards this shift and concerns expressed by various stakeholder groups.
- Identification of areas that require additional attention
- Participation in the development of a strategic plan for systems change including developing a time frame, developing a set of implementation priorities and identifying models within the State that best reflect the principals, values and operations of a recovery oriented system and that can be built upon .
- Assistance with development of an understanding of the various components of a recovery oriented system.

Rick Sampson, of Faces and Voices of Recovery, a national organization serving the advocacy needs of the recovery community and William White of Chestnut Health Systems have been retained as the federally sponsored consultants for this project. A process was developed to accomplish the required tasks that includes preliminary discussions with DMHAS staff (conducted on December 4, 2002) on site consultant/stakeholder feedback sessions (conducted on December 17 and 18), development of this report and consultant participation in a subsequent strategic planning retreat to be held in Connecticut on or around February 14.

II. Contextual Considerations

National

Across the country, treatment, rehabilitative and supportive services for persons with addictive disorders have undergone massive change within the last 10-15 years. Without reviewing all of the causes and effects associated with this change, a growing number of treatment providers, health care professionals and persons in recovery seem to agree that:

- The current system is not as responsive to the individual needs of the significantly diverse population of persons in need as it must be to support successful and sustainable recovery.

- Public treatment systems often function more as a conglomerate of programs rather than as a system of care, thus creating a dynamic within which negotiating the system becomes an impediment to successful recovery.
- The current system tends to provide acute intervention without the focus on early engagement and/or longer term rehabilitative and community support services that will increase the return on investment of the treatment dollar and reduce human suffering.
- Financial and subsequent program support for the rehabilitative and community integration aspects of the recovery process have eroded over time.
- The gap between the availability of services and the numbers of those who need them is significant and will only be closed by improving the effectiveness and efficiency of the service delivery system in concert with developing new funds for additional capacity.

States and national level organizations have begun to assess these realities and are embarking on a variety of efforts to move the system to a new operating reality.

Additionally, current national and state level fiscal realities are resulting in serious reductions in public funds available for services for persons affected by substance use issues. States, providers and, in many cases, the recovery community, have reacted to this environment in a variety of ways by developing increased advocacy efforts, by trying to do as little damage as possible while further reducing already inadequate service budgets and programs, and by carefully evaluating existing systems of care for efficiency and effectiveness. Indeed, major federal, state and industry investments in the creation of performance oriented data systems can provide ongoing information to support this effort for quality improvement.

In the midst of these challenges, a powerful new opportunity for effective system reform has emerged through the voice of the recovery community. All across America, for the first time in many years, persons in recovery are organizing, are publicly proclaiming and celebrating their own recovery and are coming to the public policy and service delivery negotiating tables as equal partners with real contributions to make. In the Behavioral Health arena, the organized and effective participation of persons in recovery from mental illness and their families has been a reality for some time. For a variety of reasons, including the level of discrimination and stigma attached to active and recovering addicts and alcoholics, their families and those who care about and for them, coupled with sometimes misunderstood traditions of anonymity, the emergence of this community of persons affected by addictive disease represents a fairly new phenomenon.

As the State of Connecticut continues its movement to a recovery oriented system of care, the convergence of its efforts with parallel developments and interests at the national level and in other States, will provide significant opportunities to develop sorely needed resources to support the initiative. For example, given the implementation of a performance oriented approach to Federal Block Grant funding for prevention and treatment services, given the activity of other States also engaged in implementing a process of Continuous Quality Improvement (CQI) and given increasing demand for data based, outcome oriented accountability for public dollars, Connecticut is well positioned to join with other States in receiving federal funding for data system development and use within a CQI paradigm. Conversations between the recovery community and the federal research institutes for addictions also indicate the potential to develop

resources to implement science based system changes while evaluating the long term impact of shifting to a recovery oriented system of care.

State

While a variety of national and state level activities across the country are similar to the State's effort to improve its system of care by incorporating a focus on long term recovery, Connecticut has clearly set a standard of leadership. While a variety of States have recognized a dearth of appropriate clinical, rehabilitative and community support services, none have made a comparable investment in the Recovery Community or have committed themselves to such a comprehensive re-direction in day to day practice. No other State has been as aggressive in adopting a clear statement of policy, endorsed by the right levels of leadership, that articulates a vision of a more responsive, humane and effective system of care grounded in the reality of recovery. Few other States have begun the process of engagement with the spectrum of stakeholders that will be necessary to make such a transition possible.

While the State acknowledges that much work remains to define the components of the proposed system, to identify the resources necessary to effect change and to develop appropriate administrative support for the new approach, "Commissioner's Policy Statement No. 83 clearly sets a tone and direction. "The concept of recovery shall be the guiding principle and operational framework for the system of care provided by the partnership of state and private agencies and consumer run services that comprise the Department's healthcare system. Services within this system shall identify and build upon each recovering individual's strengths and areas of health in addressing his or her needs. The environment for this system shall encourage hope and emphasize individual dignity and respect. A one of its foremost priorities, the Department shall promote recovery for persons at risk of, or who have psychiatric or substance use disorders by creating a recovery oriented system."

Given current fiscal realities, embarking on this mission at this time is not only reflective of sound management based on continuous quality improvement principles, it is reflective of the very concept of recovery towards which the system is striving. Indeed, Connecticut's history of systems improvement through major initiatives such as those in the areas of co-occurring mental health and addictive disorders and cultural awareness and competency, creates an environment in which reform can occur.

Key Stakeholders

State DMHAS Perspectives

DMHAS staff is clearly supportive of and significantly engaged in this shift in system design, operation and approach. They reflect a commitment to improving the delivery system by building on the strengths already in place in all or parts of the State and see this effort as moving the entire system to a revised standard of practice. Key principles emerge from the often referenced and highly regarded initiative related to Cultural Competency that they believe should guide the effort: non-threatening in tone, inclusive and respectful in method and effective in outcome. They see the effort as not being driven by the current fiscal environment, but by an

extant commitment to continuous system improvement that should be occurring in any fiscal environment. Staff is concerned about and dedicated to ensuring that the system of care and all of its component parts treat persons in recovery, regardless of their presenting recovery issues, with dignity and respect. They recognize the need for and benefit of developing the training, administrative, contractual, resource and information and evaluation systems needed to support progress on the task and are committed to providing the leadership and resources necessary to the task. Staff also recognizes that this process is staged, will take some time and that it must address the entire State.

Departmental staff includes a number of significant system improvements as anticipated and desired outcomes. First, persons in recovery will find the continuum of care more responsive to their individual needs. Second, persons in recovery will be able, with care management assistance if needed, to move across levels of care and service types based on an individual recovery plan. The individual recovery plan will include a treatment plan but will also address recovery needs beyond clinical intervention and support. The recovery plan will be "owned" by the person in recovery. Third, appropriate housing, educational, vocational, mentoring and other recovery support system components will emerge. Fourth, the recovery community will itself become increasingly critical both to ongoing systems improvement and to recovery support service definition and delivery. Fifth, persons in recovery will experience the system as respectful, responsive and supportive. Sixth, persons in recovery will experience longer periods of sustained recovery, including reductions in rates and/or negative impact of relapse. Seventh, the shift to a recovery orientation will be supported by the development of system goals, outcome expectations and evaluation criteria necessary to insure accountability and progress. Indeed, the staff's very framework of anticipated outcomes, coupled with those of other stakeholder groups, begins to establish a framework for potential process and outcome performance measures.

As part of the staged approach to system change, DMHAS has begun a process of engaging the community in defining the direction and components of the desired system based on a shared understanding of recovery. Activities include:

- Assessing system readiness and need through a Recovery Self–Assessment of consumers/advocates, family members, provider staff and management.

- Convening a statewide recovery oriented conference involving both the mental health and addictions recovery communities.

- Developing a statewide Recovery Institute to address ongoing training and educational needs for the recovery community, the provider community and other stakeholders in the conceptual model of a recovery oriented system. The Institute will also develop training and support systems for specific skill development to include areas such as: how to develop a recovery plan, care management, understanding recovery from a client perspective, understanding cultural identity as a component of recovery.

- Convening a number of workgroups to promote and implement the effort.

- Identifying evidence based approaches to a recovery oriented system of care.

- Convening opportunities for stakeholder input absent State presence.

- Developing plans for additional communications strategies and community involvement in this phase.

As this phase moves forward, DMHAS has begun to develop methods of identifying the specific skills, services, policies, training and administrative supports necessary to support a continuous quality improvement oriented approach to system reform. The Department anticipates developing timelines for various training, development and implementation activities through a strategic planning retreat and follow up activities.

State Board of Mental Health and Addiction Services

The Board is decisively supportive of the development of a recovery oriented system of care. Reflecting input from the recovery community, the larger community and the concerns of its membership, the Board identifies this initiative as a positive response to a perceived decline in service capacity and performance over time. While clearly recognizing the variety of market forces affecting this decline, members voice clear process and outcome performance expectations that again begin to inform an evaluation framework for the effort. They are:

> The process of system reform is seen as potentially enhancing an emerging "addictions" perspective on the Board itself, with the focus on and language of recovery providing a unifying perspective.
>
> The development of a recovery perspective will enhance services for those with co occurring mental illness and addiction disease.
>
> The emergence of the addictions recovery community is a positive change in and of itself. This movement can benefit the addictions system much as mental health community advocacy and participation have benefited that system over the years.
>
> The recovery community is necessary to accomplishing the type of reform the Board wants to see happen, including increasing provider awareness of and sensitivity to the role of the recovering person in the recovery process.
>
> The recovery community is a critical link to the community at large both to convey the message of recovery and systems change and to develop and support the types of community services and opportunities necessary to sustained individual recovery.
>
> Increased service coordination and improved integration with community resources are seen as critical outcomes of system reform.
>
> Increased availability of housing and employment opportunities is a necessary outcome.

Improved efficiency and effectiveness in a recovery oriented system are seen as helping to address critical resource and service availability issues.

Engagement in system reform and communication of that to the community at large is also seen as inherently increasing the dialogue around issues of drug and alcohol use and addiction, increasing the potential for resource development.

A recovery oriented system and increased engagement with the community at large will serve to reduce the stigma and consequent discrimination attached to persons and families in recovery and to those who support them.

The Board and the recovery community are valuable monitors of what is and isn't working from a family and client perspective.

The development of recovery plans that are inclusive of but not limited to treatment plans, especially if they are "owned" by the recovering person, will help address Board concern about "one size fits all" treatment and service planning.

The implementation of recovery plans will require ongoing assessment and re assessment of recovery needs.

The recovery plan will only be effective if the service delivery system supports it as a ticket to the various opportunities available within the recovery oriented system on a need based real time basis. This support will need to be reflected through empowered care managers for those who require that level of support.

A continuous quality improvement approach to systems change will require an ongoing appraisal of system level and within program level issues and solutions.

The Board looks forward to continued and increased involvement in the definition of the underlying principals and services of a recovery oriented system of care. It indicates that a model of improved service collaboration and community resource engagement exists in Western Connecticut and that it may form a base from which to develop statewide. The targeted care management activities of Advanced Behavioral Health, their proactive engagement of the recovery community and their respectful approach to persons in recovery were also cited as models upon which to build. In short, the Board reflects upon this comprehensive initiative as bringing hope to people in recovery and to the system that serves them at a critical time.

Academic/Research Partners

The State has a unique opportunity to build on its existing strong relationships with the academic and research communities in Connecticut to inform and support systemic and program level quality improvement through field driven research to practice collaboration, through training and through evaluation assistance. The academic/research community is clearly interested in increased involvement in the development and implementation of this initiative. They offer several specific suggestions for improving effectiveness and efficiency:

Improve access and retention by investing in strategies that engage people based on stages of readiness rather than rejecting them if they are not receptive to more intensive intervention. For example, allow low intensity outpatient treatment and increase level of care as the recovering person becomes more engaged in the recovery process.

Improve effectiveness and efficiency by "parachuting in" clinical training based on existing research. Examples include the use of manual based therapies, motivational enhancement strategies based on Miller's work, contingency management.

Improve assessment capabilities to support treatment planning and delivery but also necessary to development of recovery plans.

Develop community based resources for recovery support such as housing and employment opportunities.

Develop systems for supporting providers through regional networks that reflect regional integrated service models.

Establish capacity for rapid research response to field driven questions emerging from program level and system level quality improvement activities.

Use the academic/research communities to help communicate the initiative to the larger community.

Use ongoing research based input during the planning and system definition phases of the shift to a recovery oriented system to help shape system design, identify training needs and develop an evaluation framework. For example, the research community can help inform the adoption of outcome measures that have predictive value in terms of outcome.

Service Providers

Input from addiction treatment providers in many ways mirrors input from mental health providers as summarized in the mental health consultant report. For purposes of this report, their input can be summarized in four areas: process, context, implementation and outcome.

Process: Addiction treatment providers are generally supportive of the Department's effort to improve care, but are unclear as to what a recovery oriented system will look like, how it will operate, how it will be financed etc. They wish to be more involved in the planning, defining and implementing stages and wish to work with the Department to develop a communications strategy so that all potential stakeholders in the system redesign have up to date and consistent information. (Many indicated, for example, that they had not reviewed or were not aware of the Commissioner's Policy Statement or the Recovery Core Values issued by the DMHAS.) They recognize the Department's approach to Cultural Competence oriented systems improvement as effective and as a model for proceeding with this current effort. Providers felt that it was a non threatening, "total immersion" experience that recognized and incorporated a staged change

approach. The provider community would like to help develop specific short term goals and action steps to implement the system reform. In many ways, while not clear about what the Department means by a recovery oriented system, the providers know from experience what their clients need and what they cannot currently provide. They hope that shared frustration related to the differences between what is needed and what is there does not result in a system improvement effort based in the negative. They are open to and supportive of addressing this initiative within a framework of quality improvement in which all stakeholders accept responsibility for positive change. They recognize the need to look within their own programs as part of the process and support the increased involvement of the recovery community.

Context: Treatment providers are acutely aware of the reality of the "Treatment Gap" in the State, indicating that the system has capacity for about 50,000 persons while state estimates indicate that more than 300,000 persons need treatment and other services. Given recent State budget realities, they, like providers in many States, are also aware that reductions are coming. They wish to support DMHAS in this initiative, but are not sure how they can implement new approaches and add new services within the current fiscal context. The provider community recognizes that redirection of funding may be implicit within this effort and are concerned that they be included in decisions as to how to "cut the pie". They are most interested in participating in task groups that are specifically focused on identifying possible cost saving, resource development and community involvement strategies. They agree that certain cost offset and system capability benefits may emerge from increased effectiveness and efficiency, but recognize that these benefits will accrue over time and may not help immediate implementation capabilities. They would like to ensure that dollars saved be reinvested in the addiction recovery system, including for increased treatment capacity. They are especially concerned that fewer persons will be served or that target populations will be prioritized thus removing access for large groups of persons in need. Addiction treatment providers are also concerned that the concept of a recovery oriented system develops within the knowledge and experience base of the addictions recovery community. While acknowledging certain commonalities with a "mental health model" they see clear differences between the two. They endorse the "quadrant approach" to viewing level, type and integration of services that was developed by the National Associations of State Alcohol and Drug and Mental Health Directors and believe that this model can protect the uniqueness of addiction specialty care.

Implementation: The provider network recognizes that it is critical to the recovery oriented system of care and has many questions as to what the system will look like in terms of service components, what they will be required to provide that is different than what it is being provided now and how they will be held accountable. They support a staged and systematic approach to quality improvement that insures that all parties are clear about expectations, decision making authority and system interfaces. They wish to insure consistent state wide implementation. They recognize and support a regional approach to this effort that builds on existing strengths. Again the Western region is seen as providing some experience in a more recovery oriented approach. The care management model used by Advanced Behavioral Health (ABH), with its proactive engagement of the recovery community as a real component of the system of care, is seen as effective, particularly in terms of integrating service components and improving access for persons who require that level of support. (Providers recognize that difficulties with community integration within the ABH model are largely related to the lack of necessary housing and

employment opportunities rather than ineffective care management and mentoring support.) They support the addition of care managers across the state and see the recovery community as having a critical role in these services. The providers acknowledge that funding constraints preclude their providing these services currently and see the potential addition as removing a burden from them that would free up more clinical time. They question how the services would be paid, what the role and authority of the care managers will be and what the subsequent relationship with the provider will be. Providers seek increased involvement in the process to insure that administrative and other requirements that may emerge are consistent with the multiple requirements that they already deal with through CARF or JACHO accreditation, State licensing, HIPAA etc. They would also like to work with the Department to identify areas where revised contracting, reimbursement, data reporting, regulatory or other policies and procedures could be modified to reduce burden and provide incentives to support the system as it develops. They would like to participate in the development of the "Recovery Plan" design and to clarify who is responsible for it, how it relates to treatment plans and the degree to which its contents will drive services. They believe that many of their questions can be dealt with fairly easily and wish to support a strategy for this to occur quickly.

Outcome: The provider community shares the same desires for the system as everyone else involved in stakeholders interviews. They recognize and support increased client involvement and participation as positive and reflective of the values they try to develop within their programs. However, they request an opportunity to discuss and clarify the choice/risk issues involved in areas such as methadone dosing, level of care determination and program discharge. They are open to the reality that any system or program can benefit from a focus on quality improvement and that they will need to address issues within their programs as part of this initiative. Providers are supportive of developing clear performance expectations and measurement systems, particularly if they are developed to support quality improvement and data based management as opposed to being used to punish programs. They wish to insure that unrealistic expectations are not created. Some expected outcomes of moving to a recovery oriented system include: increased periods of sobriety, improved access to housing and employment, reduction in relapse and readmission rates, reduction in stigma, improved system access, increased housing and employment opportunities, increased client satisfaction and improved staff satisfaction and retention.

Persons in Recovery and Recovery Citizen Advocates

One of the unique strengths that Connecticut brings to the process of implementing a recovery oriented system of care is an established, well organized and effective community of persons in addiction recovery, their families, friends and allies. The fact that a recovery organization has been in existence for a while allows it to provide a singleness of voice that would not be possible if they were just forming. This community has clear expectations of the system improvement initiative. This community sees the recovery oriented system of care as grounded in recognition that treatment is a critical part of the recovery process for many who need it. However, this community recognizes the recovery process as broader than clinical intervention and extending into all areas of a persons life based upon individual need. Within this construct, interaction between the service system and the person in recovery is driven by client need and readiness and tends to address one or more of four types of focus at any given time. These include: early

identification and engagement in which interventions are designed to identify a problem and develop strategies to prevent it worsening to the point that increased clinical care is required; clinical or treatment services which focus on chemical withdrawal, stabilization and improvement in level of functioning; rehabilitative services that focus on skill development, including educational, vocational and employment skills, to support the recovering person's ability to have a meaningful and full life in the community; and community support services that help maintain wellness.

The Recovery Community sees the recovery oriented system of care as client driven rather than systems determined, as responsive to the varying level of care needs of individuals over time and as reflective of and responsive to the significant diversity within the community itself. Persons within this system will be treated with dignity and respect, shall be provided opportunities responsive to a holistic assessment of need and shall receive services based on a non paternalistic recovery plan that is owned by the person in recovery just as he or she owns their own recovery. It shifts the systems operant premise from one of "we will help you" to one of "here are the tools to help yourself". This recovery plan will function as a passport to the services available, including treatment services. To the person in recovery, the system should be seamless with the ability to move from program to program and level of care to level of care seen as a major system deliverable. Care management services, modeled after those provided by ABH, shall be made available if needed to expedite these processes. Within this system, recovery oriented outcomes such as successful employment and job satisfaction are considered to be of equal importance to clinical outcomes. State policies, procedures, licensing and certification requirements and business practices shall support the recovery oriented system by incorporating recovery language and principals and by developing incentives that buy outcomes rather than programs.

Further, the recovery community sees the system as grounded in recognition of the value of that community as a resource that increases return on treatment investment. It is a system that employs their skills and tacit knowledge of the recovery needs of its peers to provide effective assistance in carrying forward an individual's recovery plan. Given its day to day involvement with the community at large, the recovery community can effectively engage community support and resources for the system and for the people in it. In fact, many if not most current recovery managers tend to be in recovery themselves. A recovery oriented system will provide competitive salaries and educational and career development opportunities for recovering persons seeking to be part of and advance themselves within the addictions service system. Counselor certification standards and processes should support this agenda. As the concept of what a recovery oriented system looks like emerges, this community should be engaged to help shape it and train it to state staff, the community and programs and providers.

While supportive of the Department's effort to move both mental health and addiction services to an integrated behavioral health partnership based on a recovery oriented systems approach and while they recognize the reality of co-occurring mental illness and addiction as an area of service that requires a major focus, the addictions recovery community is clear about the importance of developing and maintaining clarity about appropriate types of care for persons with addictive disease. They join the provider community as supporting the previously referenced level of severity grid approach to program design. This approach recognizes the value of evidence based

integrated service models for those with severe and persistent mental illness and severe addiction disease, while also recognizing the value of other specialty specific intervention strategies for those with differing levels of presenting severity and type of illness.

While it is difficult to sort out the differences and similarities between the two systems approaches, and while the recovery community supports further discussion on these matters as the recovery oriented model is better defined, both systems are recognized as seeking the same end: supporting the maximum possible quality of life in the community for those afflicted with or affected by mental illness or substance use disorders with the least amount of system intrusion and control possible. However, from this similarity of purpose also stems a picture of important perceived differences. As appropriate, these differences flow from the needs and issue of the persons for whom the systems were created and the context within which they were developed. While risking significant oversimplification, the perception of the addictions recovery community may be summarized as follows. By history and tradition, today's publicly funded mental health system is focused on an identified target population of persons with severe and persistent mental illness, many of whom are dealing with the profound effects of institutional living and significant levels of medication and support necessary to address potentially debilitating symptoms that may persist at varying levels over the course of the illness. Issues of stigma and discrimination further compound these challenges. The current system grew out of efforts to better serve these persons in the community rather than in State institutions and a major goal of the services is to prevent hospitalization. Given that many persons have historically entered this system after significant psychiatric trauma and/or periods of hospitalization, the system often begins its relationship with the recovering individual at a significant and holistic level of care. While current mental health practice is focusing on earlier intervention strategies, generally speaking, the mental health system is seen as having longer term relationships with recovering persons than the addiction system. Movement through a continuum of service levels appears less sequential and distinctive than in addictions recovery absent the presence of severe and persistent mental illness. Recent advancements in the provision of consumer self help and peer operated services and in medications development are shifting the systems paradigm to one that more closely resembles some of the underpinnings of the addictions system.

The addictions system is historically grounded in a different tradition of self help and fellowship that is very cautious about a sustained relationship between recovering person and system of care. Indeed, one of the challenges to implementing a recovery oriented system is to insure that the time tested and effective recovery supports provided through sponsorship, fellowship and other means are honored and preserved. While recognizing the increasing severity and complexity of issues confronting many persons dealing with addictive disorders in today's public health system, the recovery oriented addictions system is seen as providing clinical intervention that leads to significant improvement in client wellness and reducing needs for community support and system involvement. Many presenting symptoms resolve with the removal of chemicals and subsequent healing of the brain and body and do not persist over the course of the disease itself. Relapse may reintroduce previously resolved symptoms and behaviors but can often be dealt with appropriate intervention and without a wholesale reversal in recovery, community integration and symptom management. Other psychiatric issues often associated with addictive disorders such as depression, anxiety and post traumatic stress disorder, often resolve with appropriate treatment and require less and less service and support over time. They

are not the same as severe and persistent mental illness. Finally, many persons in recovery from alcohol and other drug disorders feel that they have been historically victimized by the perception of addiction as a result of mental illness and by inappropriate intervention strategies that address the disease of addiction as if it were mental illness. Paternalism and control of providers are significant issues to both the mental health and addictions recovery communities.

In summary, while differences between the mental health and addictions systems are real, certain realities that will govern Connecticut's reform efforts become apparent. Clearly, research consistently supports the notion that co-present illnesses are most effectively addressed when co-treated. Meanwhile, the addictions treatment system has a unique responsibility to the many addicted individuals who are not mentally ill. Again at risk of oversimplifying, the mental health system seems best prepared for dealing with persons in advanced stages of mental and addictive illnesses. Persons with a primary diagnosis of a substance use disorder are best served in the addictions recovery system. Persons with primary diagnoses of severe mental illness are best treated in the mental health system. The addictions system is best equipped to engage with substance dependent persons with less advanced illness or more advanced addiction absent mental illness. Additionally, both systems have critical relationships with and responsibilities with other public service entities such as the criminal justice, child welfare, welfare and public health systems that are different, hard won and necessary for the continued recovery of persons served. Earlier engagement and intervention are anticipated outcomes for both systems. The movement to a recovery oriented system supports cross discipline learning and similar intervention strategies may emerge from both. For example, recent work in the area of motivational interviewing and engagement that was developed out of the addictions treatment system is being utilized successfully in both arenas. Meanwhile there is much to be learned, for example, about successful mental health developed approaches to vocational and housing services, medication supported treatment for co occurring issues and perhaps case management services. Briefly put, there are clear advantages to approaches that exist within both systems as long as they are governed by accurate and holistic assessment reflected in treatment and recovery plans that reflect the needs and choices of the consumer.

Cross System Perspectives

Criminal Justice System: Due to the legal and criminal issues associated with alcohol and drugs, addictions treatment and recovery services are uniquely involved with criminal justice. Recent loss of the Drug Courts in Connecticut will require renewed efforts to enhance collaboration on behalf of recovering persons. A recovery oriented system of care provides a real opportunity to further this collaboration. Judges and parole and probation agents are well aware, for example, of the need for safe and sober housing to help prevent relapse and recidivism. They are equally aware of the necessity for job placement and success as a critical component of community reintegration for persons released from incarceration. They are concerned about the need for recovery support services that help maintain sobriety and promote wellness and that are not provided through clinical intervention. The State has an opportunity through the recovery community, to build on the existing strong relationship between the Department and the criminal justice network to educate that network about the reality of recovery as a viable solution to the issue of addiction, to work with them to develop support for

the recovery oriented model and to help them see this model and the recovery community as a resource that can help them meet their goals for recovering persons within their system.

Housing: For a variety of reasons, clinically oriented treatment providers, while clearly understanding the need for safe and sober housing opportunities, are not able to focus on this issue to the degree required. The shift to adoption of recovery plans in concert with treatment plans will push the system to better deal with this critical aspect of recovery support. Creative efforts such as the very successful Oxford House program, sober residence programs and faith based housing alternatives are examples of effective approaches that exist across the country. Given the lack of available and affordable housing in Connecticut, the recovery oriented system will need to examine these approaches and develop similar initiatives. Consistent with the addictions recovery model, the goal of such initiatives is to respond to immediate consumer need in a manner that helps access and leverage viable independent housing.

Employment: One of the major ingredients to meaningful community living is the ability to find satisfying and decently paying work. For many persons struggling with long term addictions, a lack of job skills and/or job readiness further exacerbates the challenge to successful recovery. For these persons and for other addicted persons that may possess the necessary skill sets, the ability to actually find and as importantly, keep a job is a significant aspect of personal recovery. Overt employment discrimination further exacerbates the challenges they face, particularly if they have a criminal history. The recovery oriented system will require significant effort to develop a continuum of services that responds to individual need in this area. Resources will be required to incorporate this aspect of wellness into the system.

III. Moving Towards a Systems Change Blueprint

As the shift to a recovery oriented system moves forward, the most immediate task facing the DMHAS is to aggressively pursue the development of a consistent and clear understanding of what is meant by a recovery oriented system. Fortunately, the various stakeholders involved in this initiative express substantial support for what the Department is trying to do. All share some common assumptions about what such a system will look like in terms of its conceptual framework and component parts, but aren't sure what others are thinking. All are eager to join in the work necessary to implement. Additionally, stakeholders have significant questions about this effort that tend to reflect their particular perspectives and their understanding of the current environment in the State. Many however express some sense of being disconnected from the process while acknowledging that such initiatives proceed in stages. They eagerly anticipate their further inclusion as the process unfolds and recognize the need to come to consensus on a range of complex matters.

To avoid repetition, this report references the NASMHPD/NTAC Recovery Consultation Report of November 2002 as providing an accurate and comprehensive discussion of this aspect of development. Certainly, the information in that report accurately reflects stakeholder input and this consultant's perspective.

IV. Next Steps

On site consultation with the various stakeholders in the State provides the basis for addressing the types of actions the State should consider as supportive of the process of systems improvement. Many of these recommendations again mirror the recommendations made in the NASMHPD/NTAC consultant report. These recommendations for action steps are organized as:

Short term: Reflecting current opportunities to move forward quickly and successfully towards the recovery oriented system. (<1 year)

Mid-Term: Reflecting the need to deal with issues, or set processes in place to deal with them, that will require more complex analysis and consensus development. (1-2 years)

Long Term: (2+ years) To address to develop systems and actions that will support the successful implementation of a recovery oriented system over time. (2+ years)

Short Term

Continue, through regional and statewide conferences, work groups and other means to define the meaning and component parts of a recovery oriented system. While often stated as an area of concern among the various stakeholders, the policy work of the Department provides and exceptional philosophical set to begin from. The knowledge of what the component parts are is there to a great degree among the various players- it needs to be teased out and documented and vetted.

Develop a series of time limited stakeholder task groups with specific product expectations. Examples of such groups are described throughout these recommendations. Each of these should include a cross cut of stakeholder participants that represents all of the service system and recovery community components. This composition will reinforce a sense of inclusion and respect that is reflective of the desired system and the recovery process itself. It will reduce the opportunity for inconsistency and splitting that was expressed as a concern in the on site interviews.

Implement a communications strategy task group that will develop a mechanism to provide ongoing, real time information to all interested parties as to the state of development of the initiative through an accessible central clearinghouse specific to this agenda. Task group products, “white papers”, meeting and training schedules, issues discussions and benchmarks of progress could be presented and to some degree vetted through such an initiative. Web site, check notes, newsletters and conference calls are some of the elements that might be included in the task group’s proposal. A recommendation can be made as to where the clearinghouse will reside.

Implement a series of task groups that include all stakeholders in a process of developing clarity and definition about what a recovery oriented system means conceptually and practically. The Department should convene and chair these meetings and utilize the input from these groups to support system wide consensus development to the degree possible.

Implement a task group to recommend a marketing strategy to inform the community at large, including policy and decision makers at the local and State levels, general public and other systems as to the meaning and implementation of the recovery oriented system. Unlike the product of the communications task group which is focused on participatory development, this group will suggest methods of communicating the outcome of all of these efforts to a larger audience. The marketing strategy should be developed early on so the Department will incorporate its operant intent in their planning and product development. The marketing strategy can also develop recommendations as to how to target specific messages to specific groups. Representatives of the various intended audiences can be asked to participate, thus using this process to help broaden support.

Immediately convene a forum to address the issue of treating clients with respect and dignity including language, attitudes, practices and environments within programs, ownership of treatment and recovery plans, empowerment and risk management. This activity is very sensitive within both the recovery and provider communities. Providers perceive that they already treat their clients with respect and dignity, yet input from members of the recovery community suggests a very different perception. The goal of the forum shall be to air out these different perspectives openly and honestly, even if it proves uncomfortable, and to develop some consensus about what constitutes respectful treatment, staff and client roles in that dynamic and strategies for moving forward through training and other means. The State's previous efforts related to cultural competence can provide a useful baseline from which to begin. Given the sensitivity of this issue it is recommended that an outside facilitator be retained to facilitate these discussions. Engagement on this issue is critical to the outcomes that all of the stakeholders involved wish to see resulting from this system reform effort. It needs to be worked through in a neutral and safe environment so that it does not play out in programs or the public. Translate the principals developed into formal client/program rights and responsibilities documents that will be communicated to all system participants.

Continue the development and dissemination of recovery kits while recognizing that they will change as the system provides different opportunities for recovery support.

Immediately engage the recovery community in a discussion of the aspects of recovery support that should be provided by the system of care and those that rest in the traditions and practices of fellowship and self help that should be left alone. Agreement on this issue should be fairly quickly and easily forthcoming but it is critical to establishing some parameters as the definition and components of the recovery oriented system move forward.

Begin training on the development of recovery plans that addresses their relationship with treatment plans. Incorporate strengths-based approaches. Provide this training to mental health and addictions providers at the same time to facilitate cross system learning. Implement recovery planning within the first year.

Work with academic and research partners to identify best practices that will support the model. Begin training these. Develop formal opportunities for quick turn around field driven research information.

Develop and deliver training related to data based decision making and quality improvement for program managers.

Mid-Term

Draw upon the experiences of Advanced Behavioral Health and others to develop position descriptions and qualifications for recovery case managers and protocols for determining which recovering individuals would benefit from their involvement and which persons may not require this level of assistance. Begin to bring them on line in other parts of the State.

As the components of the recovery oriented system become clearer, convene a task group to identify procedural, administrative, program standards and accreditation based and other current or potential barriers to implementation and develop strategies to address these. Administrative barriers may include contracting and purchasing requirements, reimbursement mechanisms, reporting requirements, management information system capabilities and redesign issues and shifting accountability approaches. As part of this process, identify other potential provider oriented incentives such as streamlined contracting and purchasing mechanisms. As the development of an Administrative Services Organization proceeds it will be critical that the performance and reporting expectations of that organization support the recovery oriented paradigm. Issues such as medical necessity determination should be dealt with proactively, not resolved after implementation.

As the components of the recovery oriented system become clearer, convene a task group to identify potential areas for resource development and, where possible, redirection. For example, cost saving and reinvestment opportunities may exist within methadone detoxification services and/or hospital based detoxification services or other areas. Opportunities for revenue development may be available through changes in the State Medicaid plan, Federal and Foundation grant opportunities and relationship development with other systems that may have incentives to purchase services.

Support the development of regionally based Clinical Supervisor networks. Clinical Supervisors are best positioned to effect day to day practice yet they need to have the time for supervision and they require support from colleagues who may be addressing similar issues. Though developed in the second year of the implementation, these networks are recommended for permanent status.

Identify, market and reward programs and practices that already exist or emerge within the State that reflect recovery oriented principals and operations. Create opportunities for these programs to provide technical assistance to others not as far along.

Develop mechanisms to periodically stand back and assess, track and share progress towards implementation at a systemic level. These activities should be grounded in the notion of continuous quality improvement rather than being seen as opportunities for criticism or punishment. Therefore, problems identified should be coupled with recommended approaches to solutions.

Develop and begin to test performance and outcome monitoring and evaluation protocols and information sets and identify MIS requirements to support them, including mechanisms for quick turn around reports to programs, regions and the State that can be used for program improvement. These data sets should include customer feedback related to satisfaction and self perceptions of progress in recovery.

Long Term

Based on Task Group recommendations and system capability, implement administrative and other State level practices to reward progress to date and maintain movement.

Continue to test and implement state-wide performance measurement and quality improvement activities. Convene periodic meetings and trainings of providers to support use of performance feedback and data to make program level management decisions. Experience in other States has demonstrated that even when information is available, program management is often not sure of how to translate this input into practice improvement.

Continue to align other systems with the recovery model. Again the NASMHPD/NTAC report contains an excellent discussion of these matters. The following list of entities to be addressed is somewhat modified:

Educational, vocational and employment services
Income maintenance services
Criminal Justice services including the judiciary
Housing developers and authorities
Transportation services
Childcare and parenting services
Primary care providers
Mental Health services
Private sector behavioral health services
Faith communities
Reimbursement entities including private insurance
Child welfare system

Seek opportunities to communicate Connecticut's experience.

Develop mechanisms for developing new goals and strategies as the system moves forward.

VI. Conclusion

The State of Connecticut has embarked on an extraordinary mission of self assessment and system improvement that reflects the very best in human services thinking, science and practice. It is extraordinary in the courage required to open its system up to the type of introspection that is required for such an effort. It is extraordinary in its foundation in principles of recovery that have been part of the reality of recovering persons for many years but which have seldom found

their way into system philosophy and operations. It is extraordinary in its ability to build upon the State's ongoing commitment to the development of an active and effective recovery advocacy community. It is extraordinary in its commitment to a long term, staged process of change that is reflective of the very principals of recovery it seeks to incorporate through inclusion, problem solving and empowerment. It is extraordinary in its willingness to commit the resources necessary to the task despite a difficult fiscal environment. It is most extraordinary in its message of hope to the people it serves, the providers it employs and the community as a whole.

As it progresses, this initiative will go through the necessary cycles of need for clarity, dynamic tension, problem identification and resolution and implementation that mark a real change agenda. The process will be linear at times and non linear most of the time. It will be marked by movement forward, re assessment and readjustment. It will be noteworthy in its emphasis on quality improvement rather than heavy handed dictum. Yet, Connecticut is fortunate to have a history of positive engagement of stakeholders in such efforts to build upon. The amount of anticipation of and commitment to this process from all involved will provide the necessary human capital and investment to make a recovery oriented system a reality. As many systems try to figure out what addictions recovery services will look like in the future, Connecticut is clearly providing a vision for tomorrow.