
OPERATIONALIZING RECOVERY-ORIENTED SYSTEMS

EXPERT PANEL MEETING REPORT
May 22 – 23, 2012

Prepared for the
Substance Abuse & Mental Health Services Administration
August 17, 2012

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Acknowledgements

This summary of proceedings and policy and practice guidelines meeting report was co-authored by Kelly Stengel, Ede Schwartz, and Chacku Mathai. Thanks also to Ann Winger, Lee Chapman, and Cathy Crowley of JBS International who worked on the background paper for this meeting. Special thanks go to the Center for Social Innovation team, especially Jeff Olivet, Livia Davis, Cheryl Gagne, Rebecca Stouff, Kathy Hanlon, and Steven Samra. Additionally, the BRSS TACS team would like to thank Cathy Nugent, Deepa Avula, and Marsha Baker for their guidance and support of this project. Finally, a very special thanks to all Expert Panel participants for working together to assure that recovery-oriented systems of care are developed not in name only, but that they are based on a solid foundation of the guiding principles and values of recovery and include integrated, person-centered, recovery-based, and culturally competent services.

Disclaimer

This document was developed by the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS), under Contract No. HHSS280201100002C from the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. The views, policies, and opinion expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

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About BRSS TACS

In September 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) to encourage the widespread adoption of recovery-oriented services and systems of care across the United States. BRSS TACS serves as a coordinated effort to bring recovery to scale, leveraging past and current accomplishments by SAMHSA and others in the behavioral health field. These efforts are an important mechanism for coordinating and implementing SAMHSA's Recovery Support Strategic Initiative. Through the Recovery Support Strategic Initiative and other efforts, SAMHSA supports a high quality, self-directed, and satisfying life in the community for all people in recovery, and includes health, home, purpose, and community.

The BRSS TACS contract was awarded to the Center for Social Innovation (C4), who established the BRSS TACS Team:

- ◆ Abt Associates
- ◆ Advocates for Human Potential
- ◆ Boston University Center for Psychiatric Rehabilitation
- ◆ Faces and Voices of Recovery
- ◆ JBS International
- ◆ National Coalition for Mental Health Recovery
- ◆ National Federation of Families for Children's Mental Health
- ◆ National Association of State Alcohol and Drug Abuse Directors
- ◆ National Association of State Mental Health Program Directors
- ◆ New York Association of Psychiatric Rehabilitation Services
- ◆ Pat Deegan Associates

INTRODUCTION

Over the past decade, behavioral health systems across the United States have begun to move toward more recovery-oriented approaches to help people with mental health and substance use conditions recover and gain access to important community roles. In a time of national health reform, state and local behavioral health systems have the opportunity to transform service systems, realign resources, and improve the quality of services and systems to meet the needs of the people they serve. This transformation process, while widespread, is challenging systems to make sweeping changes to the structure and function of their services.

Many stakeholders recognize that it is insufficient to offer recovery-oriented services within a traditional service system. Instead, it is necessary to change the service system structure to bring about a truly recovery-oriented service system. The Recovery-Oriented System of Care (ROSC) framework is one such approach for transforming behavioral health service systems. A ROSC is a framework for organizing and coordinating multiple services, supports and systems to deliver person-centered services and to adjust to support the person's or family's chosen pathway to recovery (Kaplan, 2008). A system that supports person-centered, self-directed approaches to services, A ROSC builds on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness, and recovery. A ROSC offers a comprehensive menu of prevention, treatment, and support services that can be combined and readily adjusted to meet an individual's needs. ROSC is timely and responsive, effective, equitable and efficient, safe and trustworthy, and maximizes use of natural supports and settings.

Despite general approval of the ROSC concept, the term itself is controversial. The substance use disorder service system coined the term *ROSC*, and stakeholders from the mental health service system take issue with the word *care* because, for them, it conjures images of a paternalistic system dedicated to long-term maintenance. Many stakeholders in the mental health field prefer using *Recovery-Oriented Systems (ROS)* because it does not emphasize care. This document uses the term *recovery-oriented systems* when describing recovery-oriented systems in a general way, and uses the term *ROSC* when discussing the specific model of system organization.

To facilitate the implementation of State and local recovery-oriented systems, SAMHSA has funded 33 discretionary grant programs to implement recovery oriented systems of care at the local level. To further understand how to operationalize recovery-oriented systems, SAMHSA, through its Bringing Recovery Support to Scale Technical Assistance Center Strategy (BRSS TACS), convened an Expert Panel on May 22 – 23, 2012. The purpose of the Expert Panel was to explore areas of consensus and differences surrounding ROSC values, to identify implementation barriers, and to establish strategies to overcome these barriers. Specifically, the panel worked to:

1. Identify key ingredients of a recovery-oriented systems
2. Understand how mental health and substance use disorders systems tend to support or impede implementation of recovery-oriented systems
3. Develop strategies to put key recovery-oriented elements into operation across State and local systems

Panelists consisted of experts from mental health and addictions services, state behavioral health administrators, peer-run recovery organization leaders, and behavioral health researchers. During the meeting, the BRSS TACS team facilitated small and large working group discussions with invited experts (see Appendix 1 for the panelist roster).

In preparation for the meeting, SAMHSA created a background paper, *SAMHSA's Expert Panel on Operationalizing Recovery-Oriented Systems of Care*, to present the issues and foster panel discussion. The document outlines current approaches to recovery-oriented systems, identifies essential elements, summarizes points of consensus and differences in the mental health and addiction fields around ROSC values and principles, and describes how state and local systems are operationalizing the ROSC framework. The paper includes three state and local ROSC initiatives (i.e., Texas, Connecticut, Philadelphia), and offers lessons learned during these system redesigns. The paper is included below.

During the Expert Panel Meeting, participants worked to identify the current areas of consensus and disagreement in the substance use disorder and mental health systems on the principles and values of recovery-oriented systems. They discussed three ROSC initiatives and how they can inform the development and implementation of other recovery-oriented systems. From this work, the panel established essential ingredients required to operationalize recovery-oriented systems. Panelists discussed actions taken by local and State initiatives to operationalize recovery-oriented systems and made recommendations related to policy, workforce development, research and outcomes, peer leadership, community inclusion, and cross-systems collaboration. Panelists examined their own guiding vision and principles, and collaborated to blend them under a recovery-oriented system. The panel concluded its work by proposing concrete ways of operationalizing recovery-oriented systems of care for both the mental health and substance use disorder systems.

Based on the Expert Panel discussions, this Meeting Report discusses frameworks of recovery-oriented systems and their advancement in the mental health and addiction fields. It identifies the key ingredients of recovery-oriented systems, examines how the mental health and substance use disorder systems can support or impede implementation or recovery-oriented systems, and offers strategies to operationalize recovery-oriented systems across State and local service systems.

BACKGROUND

Recovery-oriented systems of care (ROSC) is a framework for coordinating multiple systems, services and supports that are person-centered and designed to readily adjust to meet the individual's needs and chosen pathway to recovery (Kaplan, 2008). One of the essential elements of ROSC, as outlined in the 2005 *National Summit on Recovery: Conference Report*, is that ROSC integrates services between mental health, substance use disorders, and physical health care (CSAT, 2005). Currently, these systems are not designed integrated way although systems integration, including integration with systems such as criminal justice and family support services, is ideal to help support a person in recovery (Gagne, White & Anthony 2007). Effective implementation of ROSC requires realignment of policy, administrative, and fiscal practices, within and between these systems.

To achieve this, substance use disorder and mental health systems need to establish a common vision, based on shared values and principles, for operationalizing recovery-oriented systems. Furthermore, a framework for operationalizing these principles and values throughout the system needs to be developed. Understanding how the mental health and substance use disorder systems support or impede the implementation of recovery-oriented systems is essential for developing this framework.

VALUES AND PRINCIPLES OF RECOVERY-ORIENTED SYSTEMS

At the 2005 National Summit on Recovery, a working definition of recovery, 12 guiding principles of recovery, and 17 elements of recovery-oriented systems of care were proposed to serve as a conceptual framework to guide SAMHSA and other stakeholder groups as the treatment and recovery fields move towards operationalizing recovery-oriented systems.

The 12 principles outlined in SAMHSA's 2005 *National Summit on Recovery: Conference Report* to guide the implementation of recovery-oriented systems of care, developing measures, and establishment of evidence-based practices are:

1. There are many pathways to recovery
2. Recovery is self-directed and empowering
3. Recovery involves a personal recognition of the need for change and transformation
4. Recovery is holistic
5. Recovery has cultural dimensions
6. Recovery exists on a continuum of improved health and wellness.
7. Recovery emerges from hope and gratitude
8. Recovery involves a process of healing and self-redefinition
9. Recovery involves addressing discrimination and transcending shame and stigma
10. Recovery is supported by peers and allies
11. Recovery involves (re)joining and (re)building a life in the community
12. Recovery is a reality

The 17 essential elements of a recovery-oriented system identified at the *National Summit on Recovery* are:

1. Person-centered
2. Family and other ally involvement
3. Individualized and comprehensive services across the lifespan
4. Systems anchored in the community
5. Continuity of care (pretreatment, treatment, continuing care, and recovery support)
6. Partnership/consultant relationship, focusing more on collaboration and less on hierarchy
7. Strengths-based (emphasis on individual strengths, assets, and resilience)
8. Culturally responsive
9. Responsive to personal belief systems
10. Commitment to peer recovery support services
11. Inclusion of the voices of individuals in recovery and their families
12. Integrated services
13. System-wide education and training
14. Ongoing monitoring and outreach
15. Outcomes-driven
16. Based on research
17. Adequately and flexibly financed

In 2006, SAMHSA convened the *National Summit on Mental Health Recovery* (CMHS, 2006). Over 110 experts, including people in recovery, family members, practitioners, advocates, researchers and others participated in the summit. They articulated 10 fundamental components of recovery, which overlap with the principles outlined at the National Summit on Recovery. Participants in the summit stated that these fundamental components are expected to infuse services and systems that are recovery-oriented. These fundamental components are:

1. Self directed
2. Individualized and person-centered
3. Empowerment
4. Holistic
5. Non-linear

6. Strength-based
7. Peer support
8. Respect
9. Responsibility
10. Hope

REVIEW OF THE ISSUES

The mental health and substance use disorder systems currently share many recovery values and principles. There are differences and contrasts, however, that can create barriers to assuring recovery-oriented service availability and the development of recovery-oriented systems of care. Determining which ingredients have broad consensus, and where consensus is lacking across the mental health and substance use disorder systems, can facilitate the development of steps to implement integrated State and local recovery-oriented systems. Table 1 summarizes common elements of the mental health and substance use disorder systems under a recovery vision.

Table 1 – Common Characteristics Under a Recovery Vision

	Mental Health	Substance Use Disorder
<i>Goal</i>	To assist people affected by mental illnesses by reducing disability, and improving quality of life	To assist people affected by <i>substance use</i> disorders by reducing disability and improving quality of life
<i>Role of the Person with the Condition</i>	Person is agent of recovery Active involvement is necessary for recovery	Person is agent of recovery Active involvement is necessary for recovery
<i>Principles</i>	Broad heterogeneity of population and outcomes Focus on person and environment Long-term perspective Recovery is a process and a continuum Non-linear process of recovery Family involvement is helpful Peer support is crucial Spirituality may be critical component of recovery Multiple pathways to recovery Recovery is holistic and encompasses an individual's whole life.	Broad heterogeneity of population and outcomes Focus on person and environment. Long-term perspective Recovery is a process and a continuum Non-linear process of recovery Family involvement is helpful Peer support is crucial Spirituality may be critical component of recovery Multiple pathways to recovery Recovery is holistic and encompasses an individual's whole life.

Mental Health

Substance Use Disorder

Values

Person-centered
Partnership (person involvement)
Growth
Choice
Strengths perspective
Focus on wellness and health

Person-centered
Partnership (person involvement)
Growth
Choice
Strengths perspective
Focus on wellness and health

Strategies to Facilitate Recovery

Treatment i.e.: Crisis intervention, medication, therapy, illness management education
Community support (connection to peer-support and recovery organizations)
Skills for valued roles
Ongoing, flexible recovery-enhancing services
Advocacy

Treatment i.e.: pre-treatment priming, detoxification, residential treatment, outpatient treatment, post-treatment monitoring, early re-intervention, medication, and therapy
Community support (pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality of life enhancers)
Skills for valued roles
Ongoing, flexible recovery-enhancing services
Advocacy

Essential Ingredients of Recovery-Oriented System

Treatment
Rehabilitation
Peer support
Community support
Legal aid
Enrichment
Basic support (food, shelter, clothes etc.)
Family education and support

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Rehabilitation
Peer support
Community support
Legal aid
Enrichment
Basic support (food, shelter, clothes, etc.)
Family education and support

Societal Attitudes

Historically, prognosis was considered hopeless
Debates about cause(s) and nature of illness
Criminalization of illness
Prejudice and discrimination

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Adapted from Gagne, White, & Anthony, 2007, with permission.

While many common elements exist throughout the mental health and substance use disorder systems, there are significant differences in ideologies, practices, and procedures that may present barriers to supporting the SAMHSA-identified values of recovery (CSAT, 2005). Panelists recognized there is a perception of difference even among the ‘experts.’ It was also recognized that neither the mental health nor the substance use disorder system has instilled all recovery values in its service delivery. For example, the principle that ‘recovery is self-directed and empowering may conflict with many substance use disorder system’s service and support models that utilize standard programming and corrective approaches. Similarly, the principle that ‘there are many pathways to recovery’ is often in conflict with mental health service models that require medications as an essential part of treatment.

A major barrier to implementing recovery-oriented systems that integrate mental health and substance use disorder systems is different understandings of the meanings of language used to describe recovery, recovery-oriented systems of care, and recovery support systems including the terms *support, care, power, systems, inclusion, and continuum of care*. Between mental health and substance use disorder systems, these terms are commonly used; however, the words have different meanings within each of these systems. It is important to determine whether the differences reside in the words or with the values underlying the use of language. Either way, common ground must be sought and nurtured in order to successfully integrate services and systems and develop viable recovery-oriented systems.

Many have contributed to the definition of the concept of recovery. These definitions of recovery vary among the different groups, though they share many common elements. The research community has attempted to create definitions of recovery as an outcome such as the reduction of symptoms, functional improvement, or abstinence from drug use (Belleau, et al., 2007; Bellack, 2006; Dodge, Krantz, & Kenny, 2010). Other definitions have focused on the lived experience of recovery such as finding purpose, meaning, and hope. SAMHSA’s working definition of recovery is:

“A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2011).

Philosophical and Historical Differences across the Mental Health and Substance Use Disorder Systems

There are philosophical and historical differences between mental health and substance use disorder treatment systems that can impede the development of recovery-oriented systems. Differences that have long existed in the mental health and addictions fields could provide opportunities for synergistic growth in both fields; each field has much to learn from the other. Table 2 summarizes these differences.

Table 2: Philosophical and Historical Differences across the Mental Health and Substance Use Disorder Systems

Philosophical/ Historical Difference	Mental Health	Substance Use Disorder
<i>Recovery Vision</i>	Long promoted a goal of partial recovery; however, has lacked a viable concept for full recovery (Gagne, 2007)	Well-developed concept of full recovery; however lacks a legitimized concept of partial recovery (Gagne, 2007)
<i>Duration of Treatment</i>	Traditionally available at various degrees throughout the life-cycle whenever needed	Generally shorter episodes of acute care with length of stay limits
<i>Role of People in Recovery</i>	Various roles in advocacy, self-help and peer support offered outside of the traditional system or as peer specialists hired by traditional mental health providers (Davidson, Chinman, Sells, & Rowe, 2006)	12-step, mutual aid communities are most widely recognized, while recovery coaching and other peer based addiction recovery supports are growing in popularity and availability across the United States (White, 2009)
<i>Access to Disability Related Policies and Supports</i>	Supported by Americans with Disabilities Act, Ticket-to-Work and Work Incentives Improvement Act, as well as Supreme Court decisions such as the Olmstead Decision in 1999 which upheld the integration mandate of the ADA	People with substance use disorders are not adequately supported or included in major disability related policies or supports
<i>Family and other ally involvement</i>	Recovery is generally seen as an individual process and families are not always chosen by the individual to be a part of his/her recovery community The mental health advocacy community actively participates in the broader cross-disability movement to address policy issues such as employment	Families are often an integral part of the recovery process and considered members of the recovery community The substance use disorder advocacy community has limited engagement with the cross-disability community as an ally towards recovery supports such as employment

Barriers to Operationalizing Recovery-Oriented Systems

As previously discussed, there are differences in the values and principles of recovery-oriented systems both within and across the mental health and substance use disorder systems that can advance or impede the development and implementation. Additionally, there are other system and organizational issues which could act as impediments to transformation. These include administrative concerns and issues of program evaluation and outcomes, workforce development, cross-system collaboration, and community inclusion.

ADMINISTRATIVE

Strong leadership is an essential ingredient for transformation to a recovery-oriented system. To sustain change within an organization or system, leaders must engage stakeholders, create culture change, and foster organizational learning (Crews, 2010; Kotter, 1995). Leaders must also guide the development of policies and procedures to assist in the implementation of recovery-oriented systems. In Connecticut, the DMHAS Commissioner issued a policy statement entitled *Commissioner's Policy Statement No. 83: Promoting a Recovery-Oriented Service System*, which committed the State to systems transformation (SAMHSA, 2009). Furthermore, leaders must facilitate the development of recovery-oriented mission, vision, and values to guide the implementation and sustainability of recovery-oriented systems.

As one of the many drivers behind organizational and systems change, leadership is also essential in engaging the various stakeholders or the people, groups, and organizations that can affect or be affected by an organization or system (Kotter, 1995). A recovery orientation means that stakeholders involved in the change process will include service and support providers, members of the community, community organizations, and people in recovery. Finding an effective way to engage and involve all stakeholders is essential to operationalizing recovery within the system.

Several system transformation initiatives have successfully engaged stakeholders. Philadelphia, for example, set up a Recovery Advisory Committee (RAC), comprised of providers, people in recovery, and families and community members to establish a definition of recovery and recovery values as well as create vision for systems transformation (Lamb, Evans & White, 2009). Similarly, the Texas Recovery Initiative (TRI) established the TRI taskforce, which is comprised of representatives from the Texas Department of State Health Services (DSHS), funded and non-funded treatment providers, prevention programs, criminal justice, and community and faith-based service organizations (DHS, 2012). The TRI Task Force engaged the community by hosting town hall meetings, established guiding principles and created workgroups to address priority areas (DHS, 2012). Additionally, when Massachusetts integrated its mental health and substance use disorders systems, stakeholders across both systems and in the community were engaged to foster buy-in for change to support system transformation (Sheedy, 2009). Massachusetts used the Quality Improvement Collaborative (QIC) Model to build consensus as it considered community values and strengths, mobilized the community, and evaluated both process and outcomes (Barreira, Espey, Fishbein, Moran, & Flannery, 2000).

PROGRAM EVALUATION AND TARGETED OUTCOMES

Both the mental health and substance use disorder systems hold values that can impede the implementation of integrated recovery-oriented systems. In both systems, addiction and mental illnesses are seen as primarily stemming from biological issues. This focus has led to the development of services and systems that treat addictions and mental health issues primarily as medical illnesses, with some attention to psychosocial needs (Corrigan & Watson, 2004; White, 2000). Such a framework, while discouraging a moral judgment against those with substance use and psychiatric disorders, maintains a predominate illness-orientation that seeks limited treatment outcomes such as abstinence and reduction of symptoms, rather than the achievement of quality of life goals that a recovery-oriented system intends to address. This paradigm also supports the episodic provision of treatment services rather than on-going recovery supports. In a recovery-oriented system, more ambitious and holistic goals and outcomes are sought, such as improved health and wellness and enhanced quality of life.

WORKFORCE

One of the essential ingredients of a recovery-oriented system is the inclusion of people in recovery in all areas of the system including the workforce. People in recovery are valuable to the delivery of services and supports; however, the systems' organi

zational culture, policies, and procedures can present many challenges to peer providers. Building the capacity of the workforce through training, goal setting, and follow-up can positively affect the inclusion of peers and promote the implementation of practices associated with inclusive workplaces (Gates, Mandiberg, & Akabas, 2010).

In organizational and system transformation, workforce capacity building is essential to implementing change (Kotter, 1995). In the Connecticut initiative, workforce competencies and skills were developed through education, training and consultation as an important step in the implementation of their recovery-oriented system (Sheedy, 2009). During Michigan's system transformation, training was used not only to educate providers and stakeholders of new practices and philosophies, but also to secure widespread support in the transformation process (Halvorson & Whitter, 2009). As part of their training plan, the State brought in experts from the Great Lakes Addiction Technology Transfer Center to assist in skill training for both consumers and providers (Halvorson & Whitter, 2009).

CROSS-SYSTEM COLLABORATION

The mental health and substance use disorder systems face several challenges in integration and collaboration needed for the implementation of recovery-oriented systems, including differences in philosophies, use of language, practices, and procedures. Furthermore, integration and collaboration require culture and system change, which can be difficult to implement and sustain (Kotter, 1995). Fostering stakeholder involvement in the planning and implementation process can foster buy-in and support of change. The panelists identified many of the barriers to cross-system collaboration and discussed creative ways to overcome them. Strategies identified included:

- ◆ Amending policies on the federal, State, and local levels that inhibited collaboration
- ◆ Financing and incentivizing services and systems that reached outside of current silos to integrate services
- ◆ Incentivizing collaboration through policy and finance restructuring
- ◆ Involving the recovery community in developing cross-system services and supports

COMMUNITY INCLUSION

For a recovery-oriented system to be successful, it must be an integral part of the community, engaging stakeholders within not only the mental health and substance use disorder systems, but also the general community. Recovery-oriented systems must assess existing resources, map community recovery capital, and assist in how to utilize natural community supports as part of their recovery. Currently some of the programs and practices of both the substance use disorder and mental health systems serve as barriers to community inclusion. Longer lengths of stay in segregated treatment programs, discouragement of employment while in these programs, and a lack of formal linkages to the natural community supports are barriers to forming economic, educational, and social connections that are crucial to recovery. Breaking down the unnatural barriers between the mental health and substance use disorder communities, and the natural communities around them, will reduce stigma and discrimination and increase opportunities for meaningful inclusion in the community.

Models for Implementation

Several models have been developed to operationalize recovery-oriented systems and to meet the specific needs of the programs and systems it transformed. SAMHSA has created a ROSC Resource Guide that outlines planning and implementation steps (SAMHSA, 2010). The first step in this model is to determine the readiness and ability to implement recovery-oriented systems. This assessment identifies the strengths, as well as the weaknesses, in services and support within the current system. Following the readiness assessment, SAMHSA (2010) proposes the following cyclical steps of operationalizing recovery-oriented systems:

- ◆ Create a conceptual framework;
- ◆ Conduct a needs assessment;
- ◆ Build capacity;
- ◆ Develop a strategic plan;
- ◆ Implement the strategic plan by aligning financing, policies and procedure; and
- ◆ Evaluate the process and outcomes (which affects the conceptual framework).

In Connecticut, the transformation to a recovery-oriented system was conducted using a three-phase approach (Kirk, Evans, & Daily, 2005). In the first phase, the direction and development of the ROSC model was established by defining the principles and core values, developing consensus, and creating awareness. The next phase initiated change by assessing organizational capacity, workforce development needs, and service system re-design including funding realignment. The third phase focused on increasing the depth and complexity of ROSC through advanced training, establishing performance measures, and implementing policy and resource changes.

Philadelphia's ROSC initiative began with a change in leadership and by assessing the city's behavioral health system (White, 2007). Additionally, the city established a Recovery Advisory Committee to act as a steering committee and involved family members, providers, advocates, and city staff. Philadelphia conducted a community recovery assessment in order to determine the city's assets and limitations. Concurrently, the city held community forums to raise awareness about the ROSC initiative. Next, the city implemented a system-wide ROSC plan that was informed by stakeholders and the community assessment. The city also invested financially in the ROSC development by offering mini-grants to foster implementation.

Philadelphia, under the direction of Arthur Evans, M.D, established seven building blocks to creating a ROSC:

1. aligning treatment;
2. providing individualized and high quality services;
3. integrating recovery support services (RSS);
4. culture of peer leadership;
5. intentional strategies of supporting communities;
6. facilitating processes and partnerships; and
7. aligning administrative structures.

In 2007 and 2009, the Texas Department of State Health Services began hosting town hall meetings for stakeholders to introduce the initiative and gather input of community need (DSHS, 2012). Subsequently, the Texas Recovery Initiative (TRI) Task Force was established to continue to engage the community, establish guiding principles, and create workgroups to address priority areas identified by Task Force members. Next, the DSHS brought in an expert on ROSC transformation to increase awareness of the TRI and create a sense of urgency for transformation. As a result, approximately 25 communities have established ROSC initiatives across the State.

SUMMARY

Although there are differences among and between the mental health and substance use disorder systems on numerous issues, there is also consensus on the scope of the problem and the need to develop mechanisms to overcome these barriers for successful implementation of recovery oriented systems. The greatest need is for the leaders within these two systems to listen to each other and to the voices of those who use services within these systems. There are perceptions on both sides that, although not necessarily true, remain as perceptions of truth and create barriers to shared understanding and implementation of an integrated service system. Once these perceptions are acknowledged and deconstructed, then the obstacles outlined within this report can be addressed so that integrated recovery-oriented systems can be developed.

Summary of Proceedings

SAMHSA's Expert Panel on Operationalizing Recovery-Oriented Systems of Care (ROSC) met at the SAMHSA offices in Rockville, MD on May 22-23, 2012.

SAMHSA's Expert Panel on Operationalizing Recovery-Oriented Systems of Care (ROSC) was organized with careful attention given to recording a wide range of perspectives, while keeping the panel size manageable (see Appendix A for Participant List). BRSS TACS and colleagues recruited experts who represented different geographic regions of the United States, urban and rural, and representing different roles and responsibilities (i.e., research, State systems, workforce development, providers and peers) and worked in different systems (i.e., substance use disorder systems, mental health systems, or both). Several panelists filled multiple roles. Sixteen experts were recruited for the panel, with 14 available to serve.

The overarching goal of the panel was to understand the needs of behavioral health systems and authorities as they operationalize recovery-oriented systems and to develop strategies to address implementation needs.

Specific questions the expert panel considered included:

- ◆ Which key recovery-oriented systems ingredients currently have broad consensus across mental health and substance use disorders systems?
- ◆ Which key ingredients lack consensus? What are the drivers behind this?
- ◆ How do mental health and substance use disorders systems tend to support or impede consensus on key ingredients?
- ◆ How do existing State and local experiences with implementation of recovery-oriented systems confirm or challenge the view of key ingredients?
- ◆ What new key ingredients do existing State and local implementation experiences suggest?
- ◆ How is State and local implementation impacted by lack of consensus around key ingredients?
- ◆ Given key ingredients, and the opportunities and challenges of implementation, what are the necessary steps to put recovery-oriented services and supports into operation across mental health and substance use disorders systems in relation to policy, workforce development, research and outcomes, peer leadership, and community inclusion?

The agenda for the expert panel meeting was structured to facilitate small and large group discussions as well as verbal reports on a wide range of issues and focused topics (see Appendix B for meeting agenda). The development of the agenda was an iterative process over several weeks, led by SAMHSA, the BRSS TACS team, and other experts, some of whom participated in the panel.

A background paper was distributed to the panelists before the meeting to each panelist to broaden their perspectives and to increase their understanding of a whole range of issues. The meeting began with a presentation on SAMHSA's eight strategic initiatives and the work of BRSS TACS.

The work of the panel can be organized into three themes

1. The state of the field and mapping recovery-oriented systems
2. Perspectives from recovery communities on creating recovery-oriented systems
3. State and local recovery-oriented systems State and local examples of putting recovery-oriented systems into operation

THEME ONE:

MAPPING RECOVERY-ORIENTED SYSTEMS: DETERMINING THE ESSENTIAL OPERATIONAL ELEMENTS OF RECOVERY-ORIENTED SYSTEMS

Presentations focused on the work that has been done to describe recovery-oriented systems. Over the past decade, there have been several efforts to describe the essential elements of recovery-oriented systems through research, practice, and consensus-building meetings. In 2005, SAMHSA sponsored a National Summit on Recovery, which through a consensus process established 17 essential elements and 12 principles of Recovery-Oriented Systems. In addition, in 2005, O'Connell and col-

leagues conducted a comprehensive review of the literature on mental illness and addictions recovery that identified the elements of a recovery-oriented environment. According to these authors, a recovery-oriented environment is one that:

- ◆ Encourages individuality
- ◆ Promotes accurate and positive portrayals of psychiatric disability, while fighting discrimination
- ◆ Focuses on strengths
- ◆ Uses a language of hope and possibility
- ◆ Offers a variety of options for treatment, rehabilitation, and support
- ◆ Supports risk-taking, even when failure is a possibility
- ◆ Actively involves service users, family members, and other natural supports in the development and implementation of programs and services
- ◆ Encourages user participation in advocacy activities
- ◆ Helps develop connections with communities
- ◆ Helps people develop valued social roles, interests, and hobbies

The presentation also provided an overview of the various elements of ROSC identified in the BRSS TACS State Policy Academy proposals, which are described in the background section earlier in in this report.

This presentation stimulated a large group discussion about what recovery-oriented systems need in order to be operationalized in State and local systems. Panelists discussed the need to establish common vocabulary around recovery, recovery-oriented systems of care, and recovery support services across the substance use disorder and mental health systems. The panel identified differences in perspectives between the mental health and substance use disorder systems, including:

- ◆ The language used to describe recovery, recovery-oriented systems of care, and recovery support systems including the terms: support, care, power, systems, inclusion, monitoring, and continuum of care
- ◆ Different perspectives between the mental health and substance use disorder systems on what are the facilitators and inhibitors to recovery
- ◆ The role of the family in the recovery community
- ◆ The process of recovery
- ◆ The role of data collection, evaluation and outcomes
- ◆ The involvement of the broader disability community in ROSC
- ◆ The role of best practices and evidence-based practices in recovery-oriented systems of care
- ◆ Use of the term ‘monitoring’ when referring to ‘ongoing monitoring and outreach’ as an essential ingredient to a ROSC; panelists suggested using the term engagement
- ◆ Use of the phrase ‘adequately and flexibly financed’ as an essential ingredient of recovery-oriented systems. Panelists noted that recovery-oriented systems should be able to develop and thrive without or despite having adequate or flexible financing

Also identified were some tendencies within the mental health and substance use disorder systems that impede consensus on key ROSC ingredients. For example, the concept of self-determination, so central to the recovery process in mental health is controversial in the substance use disorder field because there is a strong belief that people in recovery from addiction must accept their condition and follow the advice of their treatment teams in order to recover.

There continues to be some biases between the mental health and substance use disorder systems with people in each system holding on to prejudicial beliefs about people who use services in the other system. These prejudices create barriers to implementation of integrated recovery-oriented systems.

The trend towards specialization of services and supports in the health care system, including the behavioral health systems, may also be a barrier to integration of mental health and substance use disorder systems.

Panelists offered several solutions to address the areas where consensus was lacking. Discussion focused on strategies to expand the promotion and implementation of recovery-oriented services through: expanding peer services, increasing the involvement

of the criminal justice system, evaluating the financing of recovery support services, and investing in the infrastructure of recovery communities.

Panelists suggested and discussed several key elements of recovery-oriented systems including:

- ◆ A model of care focused on quality of life and social determinates of health.
- ◆ Data collection and evaluation methods that focus on quality of life and social determinates of health and can be used for performance improvement
- ◆ Services and supports that allow for multiple pathways of recovery
- ◆ Strong leadership
- ◆ Safe environments of care
- ◆ Peer involvement
- ◆ Involvement of the broader community
- ◆ Engagement of the recovery community
- ◆ Person-centered and consumer-driven
- ◆ Initiatives which support culture change
- ◆ Workforce development
- ◆ Identification of best practices and evidence based practices

Panelists proposed four building blocks essential to the development of recovery-oriented systems:

1. Recovery-oriented services and supports;
2. Leadership of people in recovery at all levels of the system;
3. Promotion of community health to ensure the community is a resource for healing; and
4. Recovery-oriented administrative alignment that includes cross-system partnerships, workforce development, evaluation, financing, policies and procedures, and community integration.

It was noted by the Panel that it is important to distinguish between the ‘what’ and ‘how’ when discussing operationalizing recovery-oriented systems. ‘What’ refers to the principles and values of a recovery-oriented system and ‘how’ refers to the way that values become part of the processes. While there seems to be strong consensus around the ‘what’ of recovery-oriented systems and that these principles and values are non-negotiable foundation of the system, there continues to be a lack of clarity around how to achieve it.

It was also noted that the principles and values of recovery-oriented systems need to inform all that is done within the system including services, training, and evaluation.

Panelists identified essential elements for operationalizing recovery-oriented systems, with recovery-oriented mission, vision and values as the over-arching influence. These elements include:

- ◆ Administrative alignment (including policy, training and evaluation)
- ◆ Recovery-oriented services and supports (including treatment and community resources)
- ◆ Peer leadership at all levels
- ◆ Community health (including relationships with other systems, inclusion, quality of life, and prevention)

THEME TWO:

PERSPECTIVES FROM THE RECOVERY COMMUNITY ON CREATING RECOVERY-ORIENTED SYSTEMS

Presentations focused on the experiences of recovery communities in implementing recovery-oriented systems. Presenters noted barriers that members of their communities experienced and some of the philosophical differences between recovery communities comprised of people with substance use disorders and people with mental illnesses.

There was strong consensus that policy barriers that limit access to services and supports need to be identified and removed and that access to employment, education, housing, and training needs to be increased. Many of these policy barriers relate to in-

involvement with the criminal justice system. Much work needs to be done to remove these barriers. Although much of the work will be done at the State level, these changes are needed nationwide.

These presentations stimulated discussion on perceived ideological differences between the mental health and substance use disorder systems. Panelists discussed how self-determination might be viewed as willfulness in the substance use disorder system and is, therefore, often not encouraged. Additionally, it was noted that there are cultural differences on the perception of self-determination. Panelists agreed that an individual's right to self-determination might be affected by the diagnosis he/she receives because society will often question an individual's decisions and decision-making ability after he or she receives a label. Panelists also discussed the ideological differences in the mental health and substance use disorder systems on the value of power.

Also discussed, were the ideological differences in the mental health and substance use disorder systems on the value of duration of treatment. Panelists noted that in the substance use disorder system, most people receive treatment for a short period, which is different than those in the mental health system. In order to bridge these differences and implement recovery-oriented systems, the focus must shift from duration of treatment to access to services and supports. Additionally, the focus should be on offering needed continuing care/treatment/support rather than episodic care/treatment/support.

THEME THREE:

STATE AND LOCAL RECOVERY-ORIENTED SYSTEMS OF CARE INITIATIVES

Presentations focused on the implementation of recovery-oriented systems in Philadelphia, Delaware, Oklahoma, and Connecticut, and expanding the network of recovery-oriented services to other systems, like the criminal justice system.

The change process in Philadelphia began with establishing common language across the mental health and substance use disorder systems around recovery, recovery programs, and recovery-oriented systems. The process of change was implemented through collaboration with multiple community stakeholders. Additionally, there was an emphasis on taking a "big tent" approach by involving the broader community and recognizing its need to make changes to support recovery.

The transformation process in the city of Philadelphia included the establishment of seven building blocks needed to create a recovery-oriented system:

1. Aligning treatment;
2. Providing individualized and high quality services;
3. Integrating recovery support services;
4. Fostering a culture of peer leadership;
5. Developing intentional strategies of supporting communities;
6. Facilitating processes and partnerships; and
7. Aligning administrative structures to support a recovery-oriented system

Additionally, strong leadership, financial investment, assessment of community needs, and peer workforce development are essential in operationalizing a recovery-oriented system.

It was noted that introducing peers into an organization could be challenging. To be successful integrating peers, it is important to follow some guidelines. The following steps were recommended:

1. The process should be done slowly and methodically while working with staff to introduce the change
2. It is important that agencies hire more than one peer in a program
3. The peers should make living wages
4. Peers should report directly to a high-level administrative staff member, allowing problems to be addressed quickly so that the peer, and incorporation of peers, can be successful

Another presentation focused on the implementation of recovery-oriented services within the criminal justice system. Recovery-oriented systems are a network of services, not all coming from behavioral health services. In Oklahoma, peer-to-peer services were developed and offered by those with a history of incarceration for those who are currently incarcerated. Oklahoma has been successful in implementing peer-to-peer support services in a criminal justice system. Peers in Oklahoma are certified as

recovery support specialists, which prompted legislators to ask for a standard definition of person in recovery, outside of self-identification. The presentation stimulated discussion about the following issues:

- ◆ The importance of recruiting, training, and employing a significant number of peers who can offer peer support services and not engaging in tokenism;
- ◆ The importance of clarity around the definition and meaning of recovery for different stakeholders in the system;
- ◆ The importance of offering culturally competent recovery support services

These presentations stimulated a large group discussion on implementing State and local recovery-oriented systems initiatives. There was strong consensus about the importance of stakeholder and community involvement and buy-in for building and maintaining momentum for the transformation process. It was suggested that it is important to bring as many stakeholders as possible together to build consensus and buy-in until the system reaches a tipping point.

Across the small group discussions, several issues were raised around the panelists' experiences with implementing recovery-oriented systems across the behavioral health system. Panelists noted key transformation characteristics across successfully implemented recovery-oriented systems include:

- ◆ Designing recovery-oriented systems to meet the needs of each specific community
- ◆ Beginning the transformation process with changes that are small and short-term (“low-hanging fruit”) can serve by building momentum for the transformation
- ◆ An easy to achieve step towards implementing ROSC is to incorporate person-first language into system policies, laws, and practices.
- ◆ Creating financing mechanisms to support each State or local initiative
- ◆ Summarizing and publicizing the current dissatisfaction with the status quo and external pressures on the system
- ◆ Developing strong leadership, and leadership capacity within many stakeholder groups
- ◆ Building buy-in among all stakeholder groups (e.g., community, providers, administrators, etc.)
- ◆ Creating a ‘culture of change’ by facilitating open dialogues with all stakeholder groups
- ◆ Establishing a conceptual framework around the principles, goals and objective of a recovery-oriented system rather than designing a menu of services and supports, including establishing the system’s mission, vision, and values
- ◆ Determining the role of data collection and evaluation in the implementation process
- ◆ Data collection and evaluation is a key process in implementation of a recovery-oriented system; however, the type of data and process for data collection needs to be specific to a recovery-oriented system

Also identified were possible factors related to the current behavioral health system that could impede the successful implementation of recovery-oriented systems:

- ◆ The use of a medical model to guide integration of mental health and substance use disorder systems
- ◆ The lack of clear understanding of the goals, processes, and lack of a common vocabulary around recovery between the mental health and substance use disorder systems
- ◆ The lack of clarity around the role of the primary care system
- ◆ The use of involuntary commitment and forced treatment across the behavioral health systems

To summarize the experiences of presenters and panelists in implementing recovery-oriented systems, the following steps were identified as common across several occurrences of implementing recovery-oriented systems.

To lay the foundation:

- ◆ Engage community members using peers and providers to provide information and education;
- ◆ Involve stakeholders by maintaining an open dialogue throughout the transformation process;
- ◆ Establish the mission, vision and values of the system;
- ◆ Establish and infuse recovery-oriented values by developing outcomes;

- ◆ Raise awareness about recovery-oriented systems by publishing information, including a White Paper on the ROSC in Behavioral Health;
- ◆ Change policies and administrative structures; raising awareness through publishing a white paper on the ROSC model;
- ◆ Define recovery, treatment, and recovery-oriented evidence-based practices;
- ◆ Determine which recovery-oriented evidence-based practice will work for the system;

To develop leadership and other roles:

- ◆ Develop the workforce by raising awareness about the transformation process and bringing in experts to provide education and training;
- ◆ Develop leadership through capacity-building through the use of a leadership institute;
- ◆ Develop strategic plans with areas of responsibility assigned to increase accountability for actions and outcomes;
- ◆ Develop a performance improvement framework with providers and peers in improve their competencies in delivering recovery-oriented services;
- ◆ Incorporate peers as equal workforce participants.

To develop policies that support a recovery-orientation:

- ◆ Require meaningful participation of peers in the implementation and evaluation of policy;
- ◆ Adapt policies to have recovery-oriented language;
- ◆ Conduct cross-agency collaboration and planning;
- ◆ Create policies which support individuals in the community to shift from acute care focus (e.g., redefine medical necessity);
- ◆ Develop policies that promote self-determination.

To develop networks of recovery-oriented services:

- ◆ Conduct community recovery asset mapping;
- ◆ Modify existing service delivery models and resources to fit the established ROSC model
- ◆ Identify barriers and benefits of transforming into ROSC for each system identified;
- ◆ Establish funding around mutual goals for multiple systems to increase buy-in for transformation;
- ◆ Modify policies and laws to remove the barriers to cross-system collaboration;
- ◆ Build an infrastructure that incentivizes collaboration between systems;
- ◆ Enact a punitive system to address non-collaboration between systems to help remove silos;
- ◆ Involve the recovery community as an equal partner in multiple systems;
- ◆ Establish mechanisms to establish and enhance communication between systems;
- ◆ Create an advisory panel to direct system collaboration; and
- ◆ Monitor and evaluate the collaboration process.

To fund recovery-oriented systems:

- ◆ Change reimbursement methods to provide incentives for recovery-oriented services and supports (e.g., State-level changes with Medicaid);
- ◆ Fund recovery-oriented services and supports by changing the reimbursement model;
- ◆ Foster funding streams to support peer-run programs, supportive housing, and recovery communities as a part of ROSC;
- ◆ Create funding streams that support social capital building;
- ◆ Expand the recovery-orientation of Block Grants and increase the accountability of grantees; and
- ◆ Fund public awareness initiatives around behavioral health and recovery to reduce stigma and increase recovery-oriented awareness for young people.

To monitor, evaluate and research recovery-oriented systems:

- ◆ Create a mechanism for people in recovery to define outcomes and train people to understand them;
- ◆ Use mixed methods to promote quality in assessment and evaluation;
- ◆ Use data to support the transformation;
- ◆ Increase the accessibility of data by using creative ways to share the information (e.g., podcasts);
- ◆ Build research capacity;
- ◆ Establish new data systems which are integrative to create concurrent monitoring and data collection;
- ◆ Increase federal funding for recovery-oriented research

The Expert Panel on Operationalizing Recovery-Oriented Systems stimulated much discussion that led to the formulation of recommendations and possible next steps. The next section of this report focuses on future directions for behavioral health to move toward recovery-oriented systems.

Future Directions: Operationalizing the Essential Ingredients of Recovery-Oriented Systems

Below are the concrete suggestions that emerged from the Panel for State or local systems to begin to assure that recovery-oriented care is implemented across the mental health and substance use disorder systems.

POLICY

Policies and procedures to support recovery-oriented system implementation and incentivize adherence to principles across systems are an essential building block to assuring a successful recovery-oriented system. Although certainly not the only essential element, policies and procedures that support integrated recovery oriented service provision can guide and support the development and sustainability of a system. There are a number of essential steps in recovery-oriented policy development that include:

- ◆ Require meaningful participation of peers in the evaluation and implementation of policy;
- ◆ Adopt recovery-oriented mission, vision, and values within key government agencies and organizations involved in the system;
- ◆ Adapt existing policies and practices to have recovery-oriented language;
- ◆ Conduct community recovery asset mapping;
- ◆ Create policies and practices which require cross-agency collaboration and planning;
- ◆ Create policies that shift services and supports from an acute care delivery model to a model that fosters quality of life and wellness;
- ◆ Develop policies and practices that promote recovery principles and modify policies and practices that inhibit recovery; Modify policies to foster the inclusion of peers in the workforce;
- ◆ Review and modify policies that pose barriers to employment, education, and housing for people who have criminal justice histories;
- ◆ Establish campaigns to raise awareness about recovery and to reduce the stigma of substance use and mental health issues.
- ◆ Change reimbursement methods to provide incentives for recovery-oriented services and supports (e.g., State level changes with Medicaid);
- ◆ Foster funding streams to support peer-run programs, supportive housing, and recovery communities as a part of the recovery-oriented system;
- ◆ Create funding streams that support social capital building; and
- ◆ Expand the recovery-orientation of Block Grants and increase the accountability of grantees.

WORKFORCE DEVELOPMENT

Establishing a recovery-oriented workforce is essential to assuring implementation of recovery oriented services and supports. Both the philosophy and practice of recovery-oriented service provision are needed by all who deliver services within the system. Training and supports are needed to nurture and maintain a workforce that has adopted the values and principles of recovery and is capable of providing services in ways that encourage self-determination and empowerment. Necessary steps to developing a competent and effective workforce are:

- ◆ Foster team building; clearly define staff roles and responsibility;
- ◆ Incorporate peers at all levels of the organization;
- ◆ Define recovery and recovery-orientation and assess and modify current workforce policies, practices, and curriculums to ensure recovery concepts are incorporated into all levels of the system;
- ◆ Create a strategic plan to implement change and establish focus groups to build buy-in and involvement;
- ◆ Create and nurture learning environments; and
- ◆ Build resiliency and promote health and wellness of staff to prevent burnout.

RESEARCH AND OUTCOMES

To promote the implementation of integrated recovery-oriented systems nationwide, data and outcomes capturing the benefits of the system need to be collected. Outcome measures should describe the full array of life domains and mirror the values and principles. When creating recovery-oriented systems, the following should be done in relation to research and outcomes:

- ◆ Create a mechanism for people in recovery to be involved in the processes of defining outcomes for recovery;
- ◆ Utilize mixed methods to promote quality in assessment and evaluation;
- ◆ Use data in support the transformation process;
- ◆ Increase the accessibility of data by using creative ways to share the information;
- ◆ Build research capacity;
- ◆ Establish new data systems which are integrative to create concurrent monitoring and data collection across all of the systems involved in a ROSC;
- ◆ Increase federal funding for recovery-oriented research; and
- ◆ Increase training and education around ROSC in the research community.

CROSS-SYSTEM COLLABORATION

Historically, the mental health and substance use systems have grown separately from each other and become silos with their own policies and procedures. These differences between systems have created barriers for those individuals who need access to services in multiple systems and have contributed to the fragmentation of service delivery. It is essential in recovery-oriented systems to break down these barriers and focus on common ground. Ways to begin the process of collaboration include:

- ◆ Identify stakeholders and the barriers and benefits of transformation for each stakeholder;
- ◆ Establish funding around mutual goals for each system to increase buy-in for transformation;
- ◆ Modify policies and laws to remove the barriers to cross-system collaboration;
- ◆ Build infrastructure that incentivizes collaboration between systems;
- ◆ Involve the recovery community as an equal partner in the cross-system collaboration;
- ◆ Establish mechanisms to enhance communication between systems;
- ◆ Create an advisory panel to direct system collaboration; and
- ◆ Monitor and evaluate the collaboration process.

PEER LEADERSHIP

Involvement of the peer community on every level is essential to the development of recovery-oriented systems. Nurturing peer leaders will assure that the peer voice remains strong throughout the transformation and within every aspect of service delivery and evaluation. Ways to cultivate peer leadership include:

- ◆ Provide training and education to peers to foster leadership skills;
- ◆ Fund and develop peer-run programs to educate and train peer providers;
- ◆ Establish opportunities for peers to take meaningful leadership roles;
- ◆ Retrain and educate the workforce to understand and respect the role of peer providers;
- ◆ Establish pay scales which acknowledge the value of lived experience in the workforce; and
- ◆ Create media campaigns to educate and reverse stigma.

COMMUNITY INCLUSION

To be truly community integrated, the mental health and substance use disorder systems must expand their understanding of community, which will vary by state, city, and locality. Community includes everyone and everything that provides natural supports and this does not stop at the mental health and substance use disorder service systems. It encompasses all those who play a part in helping individuals to regain their sense of self and attain their hopes and dreams. Ways to begin to engage the community as an active participant in recovery-oriented systems include:

- ◆ Identify and engage community stakeholders and leaders;
- ◆ Create opportunities to build social capital within the community;
- ◆ Map community recovery capital to identify the resources of the community;
- ◆ Develop linkages with community partners and champions;
- ◆ Consider poverty and social determinants of health; and
- ◆ Build welcoming in the community.

Conclusion

Participants in this expert panel examined the differences in visions and guiding principles between mental health and substance use fields while working together to blend them under an overarching umbrella of recovery for behavioral health systems. Important steps to operationalizing recovery-oriented systems were identified and concrete suggestions for engaging in successful change were offered. Most importantly, consensus was reached on the need for barriers to be broken down, services to be integrated, and those who access services to be primary in, not only service and system implementation, but also in their design.

Although this expert panel made much progress, future directions must also include an open and honest discussion of the differences and commonalities of mental health and substance use disorder systems. Leaders in both fields must learn to listen not only to the language, but also to the perceptions of those who deliver services, as well as those who access services in both fields.

With the recent vast changes in our health care system, the mental health and substance use disorder systems are currently faced with an opportunity to create an integrated system that can be much more responsive to the needs of those who are using it. The overarching concepts directing these changes will always be the mission, vision, and values designed to create a mental health and substance use system that is person-centered, recovery-oriented, culturally competent, and driven by those who use it.

“Leaders, through their words and actions, fill in the details of the vision. The metaphors, the anecdotes, the traditions, past successes and failures, these all serve to elaborate on the vision” (Anthony, Cohen, Farkas, & Gagne, 2002, p. 301).

This panel brought together the experts, the leaders who could fill in the details of the vision of recovery to create a clearer roadmap for operationalizing recovery-oriented systems. During these two days, this group struggled through the difficult issues to find a way to reach consensus and remove the barriers to achieving that vision.

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Appendix 2: Expert Panel Agenda

BRINGING RECOVERY SUPPORTS TO SCALE TECHNICAL ASSISTANCE CENTER STRATEGY (BRSS TACS) EXPERT PANEL

Operationalizing Recovery-Oriented Systems of Care
May 22 - 23, 2012
Rockville, Maryland

Agenda

PANEL OBJECTIVES:

1. Identify key ingredients of a Recovery-Oriented System of Care (ROSC)
2. Understand how mental health (MH) and substance use disorders (SUD) systems tend to support or impede implementation of ROSCs
3. Develop strategies to put key ROSC ingredients into operation across State/local systems of care

MAY 22, 2012—DAY ONE

- 9:00–9:15 Welcome and Opening Remarks**
Marsha Baker, LCSW, *Public Health Advisor*, Center for Substance Abuse Treatment
Catherine D. Nugent, LCPC, *Senior Public Health Analyst*, Center for Mental Health Services
- 9:15–9:30 Introductions**
Jeff Olivet, MA, Center for Social Innovation
Tom Hill, MSW, Faces and Voices of Recovery
- 9:30–9:45 Goals and Expectations**
Jeff Olivet and Tom Hill
- 9:45–10:30 Plenary Presentation: Mapping Recovery-Oriented Systems of Care (ROSC),
Consensus to Date**
Jeff Olivet and Tom Hill
- 10:30–11:30 Breakout Groups: Sharing Perspectives on ROSC Consensus**
Questions for Breakout Group Discussion:
- ◆ Which key ROSC ingredients currently have broad consensus across MH and SUD systems?
 - ◆ What areas of consensus were missed in the morning presentation?
 - ◆ What key ROSC ingredients lack consensus? What are the drivers behind this?
 - ◆ How do MH and SUD systems tend to support or impede consensus on key ROSC ingredients?
- 11:30 – 12:30 Lunch Discussion: Creating Recovery-Oriented Systems—Perspectives
from the Recovery Community**
Guided by Pat Taylor, Faces and Voices of Recovery
Daniel Fisher, MD, PhD, National Empowerment Center
Participants are encouraged to bring their own lunch or take advantage of the SAMHSA café.

- 12:30 -12:45 **Overview of Afternoon**
Jeff Olivet and Tom Hill
- 12:45-1:45 **Plenary Discussion: Distilling Key ROSC Ingredients**
Moderated by Jeff Olivet and Tom Hill
- 1:45-2:45 **Plenary Discussion: State/Local ROSC Initiatives**
Arthur Evans, Ph.D., Philadelphia's Department of Behavioral Health and Intellectual DisAbility Services
Phillip Valentine, Connecticut Community for Addiction Recovery
Ijeoma Achara, PsyD, Achara Consulting, Inc.
Amber Guerrero, MA, Oklahoma Department of Mental Health and Substance Abuse Services
- 2:45–3:45 **Breakout Groups: Using State/Local Experiences to Inform ROSC Ingredients**
Questions for Breakout Group Discussion:
- ◆ How do existing State/local experiences with ROSC implementation confirm or challenge the view of key ROSC ingredients?
 - ◆ What new key ingredients do existing State and local implementation experiences suggest?
 - ◆ How is State/local ROSC implementation impacted by lack of consensus around key ingredients?
- 3:45–4:45 **Plenary Discussion: Learning from State/Local ROSC Implementation**
Moderated by Jeff Olivet and Tom Hill
- 4:45 **Adjournment**

MAY 23, 2012 – DAY TWO

- 9:00–9:30 **Day 2 Welcome, Review and Charge**
Jeff Olivet and Tom Hill
- 9:30–10:15 **Plenary Presentation: Putting ROSC Ingredients into Operation**
Lionetta Albright, BS, Ed., Great Lakes Addiction Technology Transfer Center Network
Kevin A. Huckshorn, RN, MSN, CADC, Division of Substance Abuse and Mental Health, Delaware Department of Health and Social Services
Marci Scalera, MSW, Livingston-Washtenaw Substance Abuse Coordinating Agency, Washtenaw Community Health Organization
- 10:15–11:15 **Breakout Groups: Identifying Operational Steps**
Question for Breakout Group Discussion:
- ◆ Given key ROSC ingredients, and the opportunities and challenges of implementation, what are the necessary high-level steps to put recovery-oriented care into operation across MH and SUD systems?
- 11:15–11:45 **Plenary Discussion: Developing A ROSC Operational Framework**
Moderated by Jeff Olivet and Tom Hill
- 11:45–12:40 **Closing Session: Leveraging the Panel's Work**
Jeff Olivet and Tom Hill

12:40-12:45 Acknowledgements and Adjournment

Jeff Olivet and Tom Hill

Deepa Avula, MPH, *Chief, Quality Improvement and Workforce Development Branch*, Center for Substance Abuse Treatment

Appendix 3: Additional Resources

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