**Pioneer Center North at North Cascades Gateway Center**
*Photo courtesy of Pioneer Center North*

# Transitioning Behavioral Health Services into the Community: Strengths, Needs, Community Recommendations and Models for Consideration

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North Sound Mental Health Administration
& Skagit County

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## Key Stakeholder Interviews

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*National Recovery Advocate and Researcher*

## Executive Summary

Skagit County and North Sound Mental Health Administration commissioned this report as part of a collaborative planning process to move behavioral health services currently offered at Pioneer Center North (PCN) and North Sound Evaluation and Treatment Center into new facilities and locations in the North Sound Region. The North Cascades Gateway Campus is being re-purposed and the current leases for the buildings are projected to expire in June 2018. The behavioral health services currently offered on this campus will transition into community-based settings over the next three years.

The focus of this report is to identify evidence-based, recovery-focused residential treatment models for providing the highest quality of care for individuals with high severity, chronic substance use disorders. In particular, the report examines services provided under the *Involuntary Treatment Act (ITA)* level of care and the needs related to initiating recovery and stability for the ITA population. The services provided by the North Sound *Evaluation and Treatment Cente*r will also be transferred into a new facility; however, the model that is currently being used for this treatment center will likely be replicated, fairly close, to what it looks like now; therefore, the focus in this report is on potential models for transitioning the services currently provided at Pioneer Center North.

## I. Qualitative Needs Assessment "The Wisdom of the Community"

A qualitative needs assessment was conducted in the summer and fall of 2015 to determine the strengths and limitations of the current residential *Substance Use Disorder (SUD)* adult treatment system (with a focus on individuals receiving Involuntary Treatment Act (ITA) services in the North Sound Region. The assessment included key community stakeholder interviews, consumer focus groups at Pioneer Center North (PCN), and Regional community forum meetings.

**System Strengths:** The location of PCN in the North Sound Region has increased access and availability to Involuntary Treatment Act (ITA) treatment services. Pioneer Center North serves the entire State of WA; however, about one-third of the population served are from the North Sound Region. The key strengths of the current system were identified as: 1) knowledge and experience of PCN staff; 2) sufficient lengths of stay in residential treatment (60-90 days); 3) semi-secure facility; and 4) strong community relationships and collaborations with PCN.

**System Limitations:** Barriers and limitations of the current system identified by stakeholders and consumer focus groups include six key areas:

1. Lack of support for transitioning from residential care back into the community.
2. Residential treatment capacity is insufficient to accommodate needs in a timely way.
3. Current system lacks services that are "fully integrated," and can simultaneously address *co-morbid* mental health, substance abuse, and physical conditions.
4. Limited *recovery support services*, especially supportive housing options, upon discharge.
5. Limited opportunities for family involvement and participation in treatment.
6. Funding and reimbursement costs are not sufficient to cover the costs of delivering care.

**Key Stakeholder Recommendations for Improving Care:** During the interviews, community meetings, and focus groups stakeholders were asked for suggestions and recommendations to improve care. Below is a summary of the key recommendations.

- Build a system that is based on a *stepped-care model* and offers intensive case management.
- Promote additional *evidence-based treatment* interventions and collateral supports to address issues around employment/vocation, family, trauma and mental health, and Medication Assisted Treatment.
- Provide fully *integrated care* for physical, mental health, and substance use disorders.
- Ensure the full continuum of care is available (recovery support services, post-treatment monitoring) and increase coordination across levels of care.
- Refine assessment process to better identify individuals who need the highest levels of care.
- Identify and implement models of care to increase collaboration across systems of care.

## II. Literature Review and National Expert Key Informant Interviews

A review of the current literature was conducted to identify the most effective residential treatment models for serving individuals with chronic, complex, high-severity substance use disorders. A "single" model of residential treatment with superior outcomes was not identified. Instead, this section of the report outlines key treatment factors and practices shown to enhance outcomes for individuals with high-severity SUDs. The table below outlines the treatment factors along with examples of evidence-based and promising practices to enhance each of the treatment factors identified.

| Treatment Factors/Practices | Specific Practices to Improve Outcomes (What Works?) |
|---|---|
| **Sufficient Dosage of Treatment** (Finney et al., 2009; Hubbard et al. 2003; Jason et al., 2013; Joe, 1999; McKay, 2009; Reif, et al. 2014; Simpson et al, 2002) | • Provide a full continuum of care to extend treatment and use a stepped-care approach to ensure clients receive on-going treatment post-discharge from residential services<br>• Expand the availability and use of recovery housing to ensure clients have safe and stable housing to support continuing care in the community (Reif et al, 2014) |
| **Matching clients to optimal treatment services and providing for collateral services** (Hesse et al., 2007; Finney, et al, 2009; McLellan et al, 1999) | • Provide flexible funding to allow treatment providers to provide individualized treatment in residential care<br>• Intensive Case Management Services (Morgenstern, 2009)<br>• Community Reinforcement Approach (Meyers & Smith, 1995) |
| **Use of Evidence-Based Treatment Interventions to include Medication Assisted Treatment** (CASA, 2012; NIDA, 1999; Thomas, et al, 2012; WA Institute for Public Policy, 2014) | • Utilize a variety of Evidence-Based Practices<br>• Ensure *Medication Assisted Treatment* is available to individual with alcohol and opioid use disorders as a standard part of care (Thomas et al, 2012; NIDA, 2015)<br>• Implementation practices to ensure fidelity to specific models of care (Fixen et al, 2005) |
| **Integrate physical, mental, and substance use disorder treatment to provide whole-person care** (Gerrity,2011; IOM, 2006; Kaiser, 2014; Sacks et al, 2010) | • Use of navigators and co-locating services (Kaiser, 2014)<br>• Use of organizational assessment tools (DDCAT) to measure level of integration and establish standards<br>• *Modified Therapeutic Communities* for individuals with Severe Mental Illness (Sacks, 2010) |
| **Organize services within a recovery management framework and provide extended continuing care** (McKay, 2009; White, 2008) | • Recovery Management Check-ups (Scott & Dennis, 2010)<br>• Physician Monitoring Program Models (IBH, 2014)<br>• Strengthen linkages with communities of recovery and mutual support groups (Kaskutas & Subbaraman, 2010) |

## III. Model Programs to Consider

Two "model" programs and one behavioral health system of care that are incorporating a number of the evidence-based practices described in this report were identified and interviews with key leaders of these programs were conducted to determine the feasibility of replicating components of these model programs and systems of care in the North Sound Region and other local communities throughout the State.

**Dawn Farm** is a Michigan addiction treatment center with an emphasis on community as the most important source of healing and recovery support for its clients. Treatment is built on solid recovery principles and includes significant involvement in the local recovery community. Dawn Farm provides the full continuum of treatment and recovery services with two long-term residential treatment centers. This treatment model is a good example of an organization that is based on a stepped-care model and provides long-term recovery management and post-treatment monitoring.

**Central City Concern** (CCC) is a large human services agency located in Portland, Oregon. Central City Concern provides comprehensive services for individuals experiencing homelessness, mental health, medical and chemical dependency issues. CCC has developed a comprehensive approach that addresses the needs of individuals by providing them with housing, health and recovery assistance in a fully integrated way. This treatment model is a good example of a service system that relies minimally on residential treatment services and focuses on providing supportive housing for clients and then wrapping "outpatient" and social services around the individual.

**The City of Philadelphia's Department of Behavioral Health and Intellectual Disabilities** (DBHIDS), is an example of a behavioral health system (versus a specific treatment model) that has transformed its services to a *Recovery Oriented System of Care.* Philadelphia's model is rooted in a recovery and resilience oriented approach which is person-centered, strength-based and focuses on helping individuals achieve health and wellness in the community.

## IV. Summary and Final Considerations

The findings in this report point to the fact that there are no simple answers or a magic formula for providing the highest quality of care and services possible for individuals with high severity, chronic, substance use disorders. Improving treatment outcomes is a complex process involving offering a multitude of recovery and treatment services and matching these services to the individual's stage of recovery. Residential treatment services represent only one point on the continuum of treatment services and cannot be improved without attention to the larger system. System-level and specific treatment-level considerations are discussed in the final section.

**System-level Considerations:** The results of the interviews with key stakeholders, consumers, and national experts all point to the need for systems level transformation efforts to better integrate services and provide a seamless continuity of care for individuals with high severity, chronic substance use disorders. The challenge involves moving from a treatment system that has historically focused on discrete short-term episodes of care to a system that supports long-term *chronic care disease management.* The American Society of Addiction Medicine (ASAM, 2011) defines addiction as a primary, chronic disease of brain reward, motivation, and related circuitry. Despite years of research identifying substance use disorders being "chronic conditions" for many people, the treatment system

has responded to these disorders as if they were acute disorders. Brief treatment episodes are unlikely to change lifelong patterns of addiction, especially for individuals with severe, complex, chronic SUDs. The current system is moving from an acute system of care to a recovery management system for these individuals. This is based on a recognition that substance use disorders are chronic health conditions that often require ongoing monitoring and provision of care and treatment. (Kelly & White, 2011; McLellan et al, 2000)

The *levels of care* in the substance use disorder continuum identified as being high priority areas, for both increasing capacity and quality, include recovery support services and effective/flexible continuing care services. In fact, many of the evidence-based and promising practices identified in this report are geared towards improving services at these levels of care. Another high priority in the Region is improving the transition from residential treatment services into lower levels of care, once again with a focus on recovery support and *continuing care* services. Providing a seamless continuity of care will require ensuring the services are available across the continuum and organizing the services into a true "system of care."

One model to consider as a blue print for improving the overall behavioral health system of care is a model referred to as recovery-oriented systems of care (ROSC). ROSC has been defined as, "a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems. (SAMSHA, 2010)" The current context of *health care integration* in the State of Washington along with the focus on moving the behavioral health services offered at North Cascades Gateway Center makes this an ideal time to consider an implementation of a full ROSC system transformation effort.

**Residential Treatment Service Design and Facility Location Considerations**

While final recommendations and strategic planning for developing community-based residential services throughout the North Sound Region will need to be developed in collaboration with key stakeholders in each County, several considerations are discussed in regards to the size and location of the facility, type of services offered, as well as alternative models of care to consider.

**Facility Size and Location:** One of the first key decisions moving forward has to do with the size of the treatment facility(s). Slalom Consulting will conduct a regional population needs assessment to determine the projected number of adult "residential" SUD treatment beds needed in the five county North Sound region. Slalom's report will also take into consideration the use of alternative models of care and how this might impact the overall projected number of residential beds. However, if we look at current numbers of individuals from the North Sound Region served at PCN (approximately 315 per year based on data from 2014 and 2015) along with the average length of stay (54-days) this would translate "roughly" into needing at least 52-54 beds to replace PCN beds currently serving the NS Region. This is a very rough estimate and does not take into account a number of considerations; it is only being used as a starting point for this discussion.

So why not build a 54-bed residential treatment facility to replace the services at PCN? There are two key reasons to avoid building a large SUD residential treatment facility. The first consideration has to do with what is referred to as the *Medicaid "IMD" rule* which prohibits the use of federal Medicaid financing for care provided to patients in MH and SUD residential treatment facilities larger than

16-beds. The second reason to avoid building another large facility is related to the needs identified in this report to provide residential treatment services that are community-based and have a strong focus on helping individuals' transition and reintegrate into the community. Remaining in one's community while attending residential treatment has several advantages:

- Family and friends are able to participate more fully in the individual's treatment process.
- Patients are able to develop strong linkages with the recovery community while still in residential treatment.
- *Recovery coaches* and *peer support specialist* from the community can be integrated into the treatment facilities programming which supports transition back into the community.
- A phase of residential treatment that is focused on helping individuals secure housing and employment and gradually reintegrating into the community is a viable option if the facility is located in the person's community.

Given these considerations, one option might be to build (2-3) smaller (16-32 bed) facilities strategically placed in cities across the region that have well-developed recovery communities and recovery support services. A possible strategy for rural communities in the region, that do not have the infrastructure or numbers to support a residential facility, might be to increase capacity for supportive housing and recovery support services and strengthen level of care transitional services through intensive case management.

**Residential Facility Clinical Programming and Special Population Focus:** The literature review did not point to any specific models of residential care that have been shown to produce "superior" outcomes. However, the literature review, along with the needs and recommendations identified by consumers, key stakeholders, and national experts point to several key components to be included in a recovery-focused, integrated residential treatment program.

- Provide individualized treatment and match clients to the appropriate level of care
- Offer a menu of evidence-based practices and match to client needs
- Provide access to medication-assisted treatment for individuals with alcohol and opioid disorders and align policy and resources to allow for continuation of the medication in continuing care
- Integrated treatment to address behavioral and physical health needs
- Strong linkages with recovery support services (supportive housing/employment, peer support)
- Emphasize the importance of on-going continuing care and post-treatment monitoring

Two additional considerations for clinical programming are: 1) to build a number of special population residential treatment facilities across the region (e.g. women and children, *co-occurring*, veterans, ITA, traumatic brain injury); and 2) to look closely at some of the emerging "alternative" models of care that focus on providing secure, stable housing and wrapping treatment and recovery services around the individual.

**Next steps** in this process will involve synthesizing this information along with the population-based needs assessment. These two documents will provide the foundation for working with regional and county community members and leaders to develop a detailed plan for the transition of services.

## Introduction

Skagit County and North Sound Mental Health Administration commissioned this report as part of a collaborative planning process to move behavioral health services currently offered at Pioneer Center North (a 141-bed residential substance use disorder treatment center) and North Sound Evaluation and Treatment Center (a 16-bed mental health Evaluation and Treatment Center) into new facilities and locations in the North Sound Region. The North Cascades Campus is being re-purposed and the current leases for the buildings are projected to expire in June 2018. The behavioral health services currently offered on this campus will transition into community-based settings over the next three years.

This transition process offers an opportunity to assess the strengths of the current residential treatment services offered at the North Cascade Gateway Center, as well as explore innovative, evidence-based treatment models to enhance the quality of care for the populations served.

**Purpose and elements of the report**

The focus of this report is to identify evidence-based, recovery-focused residential treatment models for providing the highest quality of care for individuals with high severity, chronic substance use disorders. In particular, the report examines services provided under the *Involuntary Treatment Act (ITA*) level of care and the needs related to initiating recovery and obtaining initial stability for the ITA population. The services provided by the North Sound *Evaluation and Treatment Cente*r will also be transferred into a new facility; however, the model that is currently being used for this treatment center will likely be replicated, fairly close, to what it looks like now; therefore, the focus in this report is on potential models for transitioning the services currently provided at Pioneer Center North.

This report will:

- Identify the strengths of the current residential treatment system for individuals with high severity, chronic substance use disorders.
- Assess and prioritize the treatment and recovery needs of individuals receiving residential care under the ITA designation.
- Identify treatment models that have sustainable funding (considering *IMD rule* for Medicaid).
- Present key stakeholder and consumer input regarding the transition of these services.
- Summarize the literature and best practices on providing integrated, residential substance use disorder (SUD) care.
- Identify potential model programs to consider for replication.

Information was gathered through several means: interviews with key community stakeholders and State of Washington leaders; focus groups with consumers from Pioneer Center North; key informant interviews with national leaders and experts in behavioral health; review of the literature, national reports, and consensus documents on SUD residential treatment services; and a large North Sound Region community forum planning session.

This report contains four sections: the current system's strengths and limitations, and recommendations for system improvement; a synthesis of the literature on key components of effective residential treatment for individuals needing high intensity care; three model programs to consider for potential replication or adaptation for the North Sound Region's future residential treatment services; and a summary of recommendations.


## Section 1: Qualitative Needs Assessment "The Wisdom of the Community"

A qualitative needs assessment was conducted in the summer and fall of 2015 to determine the strengths and limitations of the current residential SUD adult treatment system (with a focus on ITA services) in the North Sound Region. The assessment included:

1) **Key Stakeholder Interviews**: the interviews with community stakeholders included individuals from the substance use and mental health treatment provider system, state, regional and county behavioral health funders and policy makers, community recovery advocates and family members, behavioral health consumers, supportive housing providers, and law enforcement. Twenty-eight such interviews were conducted between July and October of 2015.
2) **Consumer Focus Groups**: Pioneer Center North graciously arranged and hosted two focus groups with Pioneer Center North clients from the North Sound Region. Two focus groups were held in October of 2015, with eighteen consumers of substance use disorder treatment participating.
3) **Community Forum Meetings**: Two Regional Community Forum meetings held in Skagit County on June 26 and October 31, 2015, elicited input and feedback from interested community members.

All three groups provided input on the strengths of the current system, limitations and barriers to recovery, and recommendations/suggestions regarding the transition of services and system improvement.

**Strengths of the Current System**

***1) Treatment access and availability of ITA Residential Treatment Services***

Treatment providers and community members participating in the interviews and community forums noted the availability of residential ITA services at Pioneer Center North as being a strength of the current system. Although there are often wait times to access detox and residential services, the general consensus is that having this service located within the region has significantly improved access to services for individuals living in the North Sound Region.

Family members and several community members view the ITA-designated treatment slots, and having a semi-secure locked residential and *detox* facility, as a significant strength of the current system. ITA-designated treatment is a service the community does not want to lose.

The fact that ITA designated treatment slots are funded through the State of Washington allows individuals access to services regardless of their ability to pay. The availability of publicly-funded treatment is very important, as the majority of clients receiving services at PCN have no ability to pay for services and are not always enrolled in Medicaid.

### 2) *Knowledge and experience of Pioneer Center North (PCN)*


Focus group participants described PCN staff as knowledgeable, caring, and compassionate. They expressed an appreciation for the number of PCN staff who are in recovery. Several focus group members talked about how working with counselors and staff in recovery provides them with a greater sense of hope and of being seen and understood. PCN staff were described as "good role models."

Another key strength noted by consumers was the "reward" based treatment philosophy of PCN. There was a common feeling that "we feel like we are being treated with dignity and respect." Interviewees felt this was a very important contributor to building consumers' self-efficacy and providing hope for a different future. Additional strengths of the current program at PCN include:

- opportunities to learn how to manage downtime;
- learning from peers in treatment and the social aspect of the environment;
- treatment that is focused on accountability and responsibility;
- opportunities to work (for minimum wage) as the patients' progress through treatment;
- AA/NA/CA meetings available on-site; and
- the beauty of the natural setting of the North Cascades Gateway Center.

Treatment providers noted the expertise of PCN in working with "chronic, high-risk clientele." Providers and community members expressed concern around losing experienced PCN staff during the transition process. PCN senior leadership noted that the diversity of experience and expertise available, due to the large number of staff, was an asset; further, they noted the strength of a larger facility in helping patients develop and experience a sense of community.

### 3) *Treatment duration (length of stay)*

One of the key features which sets ITA services apart from other residential care services is length of stay. Several focus group participants talked about the importance of having 60 or more days of residential treatment. Many of the consumers' previous residential treatment experiences were 28 days or less and the consensus in the groups was "this just isn't enough time to get our heads cleared and get stable in our recovery." The average length of stay for clients receiving services at PCN is 54 days for all clients admitted and 60 days for individuals completing treatment services (PCN summary data for 2015). Some focus group members talked about the need for even longer treatment stays of 60-90 days and being grateful for the option of longer stays if needed. Although it was also noted that this is not always possible due to funding issues.

Family and community members also identified the 60-90-day length of stay at PCN as being key to helping individuals initiate a solid base for recovery. Several providers also commented on the

importance of lengths of stay of 60 days or greater for individuals who are homeless and need long-term rehabilitation.

***4) Strong relationships and collaborations with Pioneer Center North***

Many community providers also view a history of successful collaboration with PCN as a strength of the current system. Providers and drug court staff identify "good working relationships" with PCN as being key to helping them secure services for their clients. Participants in the community forum discussions identified strong partnerships across diverse groups as a strength of the current system, and reinforced it is a feature they do not want to lose. Law enforcement in Skagit County is actively involved and interested in being a key player at the table to help influence and support a more integrated system of care.

**Limitations of the Current System and Barriers to Recovery**

Input in this area broadened to include the full continuum of care services. It was difficult to separate levels of care when discussing barriers to recovery and needs of individuals in residential treatment; however, to the degree possible, the primary focus is on the current limitations and barriers to treatment and recovery in the residential care service system.

***1. Transition across levels of care (fragmented system)***

A common theme emerging in the focus group discussions around barriers to recovery is the lack of support for transition between levels of service. Many focus group participants mentioned how helpful residential treatment services are for helping them "get sober" and "clear their heads;" however, a resounding message is "we need much more help transitioning back into the community." Additional assistance to secure housing, employment, establish a sober support system, address legal issues, and reintegrate into the community is needed. Focus group members talked about having a hard time focusing on treatment because they are worried about housing and employment after treatment.

Family members repeatedly expressed the need for better coordination and linkage between levels of care. They shared stories of family members discharged from treatment without a solid transition plan or sufficient support, which often resulted in the person relapsing even before they arrived home.

The transition between levels of care is further complicated by: a lack of common treatment language, a lack of interventions that work well between treatment programs, and a dearth of treatment models that build upon the progress made within each successive level of care. One treatment provider shared an illustrative example of how this issue affected transition and retention across levels of care in her facility. This provider noticed a drop in client engagement and retention as they transitioned from residential to outpatient care; when the clients were asked why they were not engaging in outpatient services a common response was that much of the programming was similar to what they had already received in residential care. In response to this finding, this provider redesigned outpatient services to better meet the needs and interests of the clients. For example, offering groups on trauma and building better relationships, dialectical behavioral therapy and a one-day intensive on relapse awareness. These change resulted in a significant improvement in retention of clients in outpatient care.

Providers, community members, and focus group participants all identified a need for enhanced *cross-system coordination* between providers, criminal justice, mental health, medical and other social service

providers. Intensive case/care management services were often identified as a key strategy for enhancing coordination between systems. Historically, these types of services have not been funded, making it difficult to compensate service providers who want to use case management to strengthen the transition between levels of care. Warm handoffs for individuals moving from one level of service to the next are not the "norm."

### *2. Treatment capacity and access issues*

Providers reported significant wait times for residential treatment services, ranging from a few weeks to 90 days or longer. One of the Skagit County Designated Chemical Dependency Professional identified a typical wait time of 30 to 60 days to access ITA residential treatment slots. The current system design appears to result in an insufficient number of residential beds.

Family members shared experiences of loved ones agreeing to enter *detoxification services* and then told they must wait several weeks to access residential treatment services. This often resulted in potential clients returning to their use of substances and not entering residential treatment services.

The behavioral health system is confusing and frustrating to families who are trying to secure help and assistance for family members with substance use disorders. Several family members talked about needing some type of "navigator" or "peer support" to help them navigate the treatment system. They also expressed a need for a centralized information resource for accessing various treatment and recovery services.

Providers and consumers also identified the need for greater access to Medication Assisted Treatment. Both providers and consumers stressed the need for community education to increase the awareness of the effectiveness of medication assisted treatment.

### *3. Lack of integrated care*

The current system lacks services that are "fully integrated," and can simultaneously address co-morbid mental health, substance abuse, and physical conditions. Providers noted the difficulties of accessing mental health services for clients with mental health issues who do not meet access to care standards. The majority of clients with SUD have mental health issues such as anxiety, depression, and trauma and stress related diagnoses. Publicly funded services to address these issues are seldom available or accessible. Focus group participants did acknowledge and express appreciation for PCN's efforts to address co-occurring disorders; however, they spoke of needing additional individualized services to address mental health issues. The majority of services offered at PCN are delivered via group therapy, and focus group participants identified this as a barrier to address mental health and trauma issues.

Treatment to help clients fully address trauma issues seems to be a major gap in services. Almost all of the focus group participants identified unresolved trauma as a major barrier to recovery and they reported minimal interventions, in all of their treatment episodes, to address this issue.

Family members shared stories of having been refused services for a loved one because the individual's diagnosis did not fit the service setting in which they found themselves. At the system-level there appears to be a need to establish a "No Wrong Door" approach.

**4. Limited Recovery Support Services**

In a majority of interviews, and in both focus groups, the lack of housing options was identified as a primary barrier to recovery. A large number of the focus group participants identified themselves as being homeless and expressed significant concern about the lack of housing options available to them upon discharge. PCN statistics indicate at least 40% of their clients identify as being homeless. Although *Oxford Housing* and Transitional Living Units are available throughout the region, the need far exceeds current capacity. Many focus group participants talked about having a list of the housing options and having minimal success at securing housing upon discharge, despite repeated attempts to reach out to these agencies. The group consensus was that, without housing upon discharge, they were likely to lose the gains they had made in treatment and return to substance use to cope with living on the streets.

Focus group members identified ways in which residential treatment could provide additional support to help them secure housing and employment upon discharge. At a minimum, they expressed a need to have greater access to computers and phones in residential treatment so they can conduct employment and housing searches while they are in residential treatment.

Providers and community members also identified the lack of transportation services and support for securing employment as major barriers to recovery for individuals leaving residential treatment services.

The value of recovery coaches and peer mentors was discussed by all three groups and was seen as a key recovery support service that might increase outcomes and help individuals navigate the system and transition across levels of care; however, at this time, peer recovery support services for individuals with SUD are not currently funded.

***Recovery Coach Training in Skagit County***
*Photo Courtesy of David Jefferson*

***5. Family involvement and participation in treatment***

Both consumers and family members identified a need for greater family involvement and participation in treatment. Focus group members reported that visiting times for families and children are limited in residential treatment. They also expressed a need for more options for spending quality time with family members when they are able to visit (e.g. shared recreational activities, more space to visit, passes to spend time with family members). Family programing in residential treatment was reported to be minimal in most residential treatment facilities consumers had attended.

***Funding and billing issues***

Providers talked about being open and willing to provide fully integrated treatment; however, current rates for SUD residential services do not provide adequate compensation to provide integrated care. The rates need to be much higher to be able to secure qualified staff to provide mental health, psychiatric, and medical services.

Community forum participants highlighted the importance of consumers helping to pay for some of their treatment costs, even if this involves providing some type of community service following the treatment episode.

There is a need for funding to support a full continuum of services from early engagement and residential treatment to long-term continuing care. Providers talked about not being able to provide "follow-up" services after the initial treatment episode due to funding and policy restrictions. Providers and community forum participants also noted the need for funding mechanisms to support long-term recovery check-ups and on-going support.

Another consideration for the new treatment facility mentioned during stakeholder interviews was the need to diversify funding sources -- to design the services in a way that they are not fully dependent on State or Medicaid funding. Involving business and accessing private insurance was seen as important to sustain this type of facility. Pioneer Human Services currently has an innovation business model called the *Pioneer Manufacturing Model* which includes a business enterprise to subsidizes funding for treatment services as well as proving on-the-job training and work experiences for their clients.

**Community Recommendations/Suggestions for Improving "Residential" Services**

1. ***Build a system that is based on stepped-care and offers intensive care management***

The key strategies and recommendations to address the issues of transition and fragmented care are to build a "stepped" care model; such a model would feature care managers to help clients and family members successfully access the services needed to support long-term recovery and enhance engagement and retention in treatment.

Some provider ideas for a stepped-care model include:

- residential treatment services on the same campus as transitional housing, where the transitional housing can serve as a step down in care for individuals who need this support upon discharge;
- secure medically-managed detox on the same campus as the residential services;
- a 16-bed secure detox unit and a 16-bed residential (ITA) treatment in the same facility;
- supportive housing that is closely connected to the residential treatment services;
- recovery campus that would include: secure detox, residential treatment services, and transitional/sober housing; and
- care that includes Medication Assisted Treatment + Intensive Outpatient Treatment + Intensive Follow-up with post treatment monitoring.

Several providers suggested designing a treatment facility that can provide residential services for those individuals needing the most intensive services, as well as providing "day" or "IOP" services for individuals who can reside in supportive housing while attending treatment services. Individuals living outside the residential setting would also need to have regular access to urine analysis monitoring (basically creating "treatment without walls"). Discussion with State of Washington facility staff indicated it is possible to have two 16-bed units in the same facility, as long as they are divided into two separate programs, and still bill Medicaid.

Two key services identified as being central to strengthening the transition between levels of care are: 1) intensive care/case management; and 2) additional transitional living opportunities (Oxford Houses, Sober Housing, Crisis Stabilization Housing, Housing "First" options). While these services are not the primary focus of this needs assessment, they do appear to be integral to improving outcomes for individuals with high severity, chronic substance use disorders in the North Sound Region.

### *2. Promote additional evidence-based treatment interventions and collateral supports*

When asked about residential treatment services as a whole, focus group participants identified the need for additional treatment interventions in the following areas:

- vocational/employment support;
- family/relationships;
- trauma and mental health;
- case management to secure housing and recovery support services; and
- cultural and spiritual.

Focus group participants identified the need to increase interventions that assist clients with day-to-day living skills and reintegration into the community. Other focus group recommendations included adding more case management and individual therapy and/or peer recovery support services in residential treatment. Even simple strategies such as offering more access to computers and phones was suggested to help clients transition back into the community and secure recovery-enhancing resources. The group also recommended including physical exercise facilities and options.

Community members discussed the need to mandate the use of evidence-based practices with more of a focus on outcomes and data collection. The idea of offering performance-based incentives to promote outcome-based programs was recommended.

All three groups advocated for an increase in the use of Medication Assisted Treatment (MAT) for individuals with alcohol use disorders and opioid use disorders. This is a highly effective, underutilized intervention for supporting recovery. Funding MAT in residential treatment and continued maintenance of MAT after treatment was a strong recommendation made by both providers and recovery advocates.

### *3. Improve use of integrated treatment*

Community members, key stakeholders, and focus group members all strongly advocated for residential services that fully integrate substance use, mental health and physical health. Many of those currently receiving services at PCN have co-morbid physical and mental health issues, in addition to substance use disorders. The majority of focus group participants verbalized a need for interventions to help them deal with trauma and mental health issues.

One model of integration used in Whatcom County by Lake Whatcom Community Mental Health is the integration of a primary care provider to provide on-site primary care services and participate in multi-disciplinary team care for all patients. This has been accomplished by including an exam room on-site and contracting with Molina Health to bill for primary care services. This type of model could be considered for the new residential SUD treatment facility.

Another idea is to include a Federally Qualified Health Center (FQHC) clinic as part of the recovery campus. The FQHC could provide both physical and behavioral health outpatient services, as well as Medication Assisted Treatment.

***4. Provide the full continuum of care and organize it for greater access***

Three clear needs emerged in the interviews with key stakeholders and community forum participants regarding the importance of providing and funding a full continuum of care in order to improve SUD treatment outcomes:

1. need high quality "integrated" assessments to accurately identify level of care and service components needed for all individuals entering the SUD system;
2. need for additional recovery support services and innovative models to help individuals transition back into the community; and
3. need to improve the coordination across disciplines to prevent individuals from "falling through the cracks" and create a system with a "no wrong door" approach.

***5. Provide centralized intake and assessment services***

Several providers and community forum members recommended refining assessments to more clearly identify individuals who need the highest level of residential SUD services; then, build a system (such as was previously described in Recommendation 1, above) with multiple options for providing care through a combination of transitional housing, intensive outpatient or day treatment services, Medication Assisted Treatment, and on-going monitoring and recovery support services. Community forum groups identified a need for integrated care assessments at the entryway of the system. They suggested considering a centralized program that is charged with assessment, placement, and on-going care management until long-term stability is achieved. This system might also include an intensive case management program to assist individuals in accessing services and following them after the initial treatment episode for on-going monitoring and recovery management. Community forum members expressed interest in exploring models of care, similar to the Physician Professional Programs which provide ongoing monitoring for 3-5 years.

***6. Enhance recovery support services***

Suggestions in this area include identifying new avenues of funding to support the development and on-going funding of recovery support services (supportive housing and transitional living, peer recovery support, transportation, family support, vocational and educational services). State leaders and funders recommended looking at the State of WA Medicaid (1115) waiver as a potential avenue for enhancing recovery support services in the North Sound Region. These recommendations lean towards looking at the larger system of care; however, they were identified as being key to improving the outcomes for individuals currently receiving residential treatment services by all three groups contributing to this report.

***6. Increase coordination across systems***

Community members and stakeholders recommended continuing to look at models of care to strengthen collaboration across systems. This is important to help increase engagement and retention of clients in services and to strengthen client reintegration following residential treatment. Building

better connections with the hospitals and emergency rooms to help transition individuals with SUDs into services needs to be strengthened, according to both providers and family members. The use of recovery coaches or case managers embedded in the hospitals was one strategy suggested to enhance coordination.

Continuing to partner with law enforcement was also identified as being key to creating and supporting a full continuum of care. Utilizing a strong care coordination model was another strategy suggested for strengthening the coordination across systems.

## Section II: Literature Review and National Expert Key Informant Interviews

A review of the current literature was conducted to identify the most effective residential treatment models for serving individuals with chronic, complex, high severity substance use disorder. The literature review was combined with several key informant interviews with national experts in the field of addiction, behavioral health services, and recovery. The overall goal was to identify evidence-based models for providing community-based integrated health services to initiate recovery and help individuals with severe substance use disorders achieve initial stability and move towards long-term recovery in the community.

A "single" model of residential treatment with superior outcomes was not identified. Instead, this section of the report will offer key factors and components of treatment services found to enhance long-term outcomes for individuals with severe substance use disorders, as well as promising and evidence-based models for consideration.

### 1. Residential Treatment Services (models and lengths of stay)

The first question explored in this literature review was, "Is there a specific type of residential treatment model that demonstrates superior outcomes for SUDs?" This is difficult to answer for a number of reasons: residential treatment usually refers to a level of care versus a specific type of intervention; residential treatments vary greatly and are seldom defined by any one specific treatment model; and, the majority of the effectiveness studies compare residential treatment to other levels of care rather than comparing various types of residential treatment models.

Historically, substance use disorder residential care has utilized three "somewhat distinct" models of care:

1) Minnesota Model – a treatment model based on the 22-28-day clinical programs developed by Hazelden Foundation. These residential programs are based on a unique blend of behavioral science and AA principles. They typically use a multi-modal therapeutic approach and use a multi-discipline team of professionals to support the client. Abstinence is a prerequisite and a large portion of the programing occurs in groups and is based on AA principles and step-work. (NIDA, 2000)
2) California Social Model- this model relies almost entirely on recovering staff. The Social Model is similar to the Minnesota Model in regards to a heavy focus on twelve-step programming and step-work. (Borkman, et al, 1998)
3) Therapeutic Communities - a treatment model used in long-term residential treatment facilities derived from Synanon (the first ex-addict-directed therapeutic community). Historically, lengths of stay range from 6-18 months; currently due to rising costs in health care and tightening of state budgets, the typical length of stay now ranges from 3-6 months. Treatment focuses on social and psychological causes and consequences of addiction. Therapeutic communities are based on "community as method" and are designed to promote pro-social behavior and help individuals learn personal and social accountability. (NIDA, 2015a)

In practice, many residential treatment programs are comprised of a combination of these three models. Several treatment outcome studies have found similar outcome effects across various types of residential treatment (Hubbard et al, 2003, Reif, et al, 2014a). Therapeutic community models have

received the most attention in the literature reviews as they have been included in several of the National Institute on Drug Abuse (NIDA) sponsored large research studies (DATOS and TOPS). There appears to be some evidence that individuals who are homeless, have co-occurring disorders, or have been or are in prison may have slightly better outcomes when receiving services in Therapeutic Communities (NIDA, 2015a). However, due to methodological issues and the lack of comparison groups with-in the same level of care in several of the TC studies the overall evidence for one type of residential treatment model over other models is limited (Smith, Gates, Foxcroft, 2006).

The Substance Abuse and Mental Health Administration (SAMHSA) commissioned an extensive review of the literature to assess the evidence-base for residential treatment for substance use disorders. In this review, Reif and colleagues (2014b) evaluated research reviews and individual studies on residential SUD treatment from 1995-2012. The overall conclusion of this review was moderate evidence for effectiveness of residential treatment services. No one type of residential service consistently produced better outcomes in this extensive review of residential SUD treatment.

The one consistent predictor of improved outcomes found in the literature is retention in treatment and lengths of stay. The research indicates that most individuals need a minimum of 90 days of treatment to significantly reduce or stop their alcohol and/or drug use and that the best outcomes occur with longer durations of treatment (NIDA, 1999). In the DATOS study (the last large U.S. study on treatment effectiveness) individuals with high severity use and significant social and psychological problems did better in residential care if they stayed a minimum of three months (Simpson, 1999). However, many of the studies conducted to determine the effectiveness of various treatment models have been based on an acute model of care, so treatment length (and the corresponding outcomes) were assessed at only one level of care versus across a full continuum of care. The minimum dose of 90 days of service for non-methadone residential and outpatient programs refers to the duration across all levels of care. For individuals with opioid addiction the minimum length of methadone maintenance outpatient treatment is one year to achieve optimal outcomes (NIDA, 1999).

What research has demonstrated consistently is that acute (short-term) care does not work for persons with high problem severity/complexity and low recovery capital. (White, 2008). The challenge is, with shrinking resources and increasing Medicaid managed care, extended stays (3 months or longer) in residential services are not likely to be approved and/or funded. The key then becomes finding effective ways to extend care beyond the initial residential treatment phase of care to ensure a minimum threshold of three months of care.

***Practices and strategies to ensure sufficient treatment dosage and retention***

**A. Stepped-care approach/providing a full continuum of care**

A stepped-care approach is a feature of a system of care that is able to adjust the intensity and level of service to best meet individual needs. In a true stepped-care model, a person receives services at the lowest level of intensity possible (given the person's needs and resources) and then the level of care is adjusted based on progress and or emerging needs (McKay, 2009). So for example, an individual who requires stable housing but has demonstrated some success in outpatient SUD services may have a treatment plan developed that includes admission to a recovery residence along with intensive outpatient treatment. Care may also be stepped down and so individuals receiving high intensity residential care with limited "recovery capital" may be stepped down into outpatient care and sober

living or recovery housing. Using a stepped-care approach that successfully transitions individuals across levels of care is one strategy for increasing the duration of treatment.

A stepped-care approach requires sufficient services and resources to provide a full continuum of care. This type of model is also dependent on having a "true system of care" that is integrated and organized in a way that facilitates an individual's smooth transition across levels of care. This requires a common language across treatment programs and an increase focus in residential care on linking individuals with the resources needed in the community to support on-going treatment and recovery.

**B. Expand the use of recovery housing**

SUD residential treatment has historically been defined as a stable 24-hour clinically managed residential setting and classified by ASAM as Level III treatment (Reif, et al, 2014, Mee-Lee, et al, 2013). However, there are a growing number of recovery residences available for individuals who may need a supportive living environment, but may not require the high intensity of services offered by either short-term or long-term residential treatment.

The National Association of Recovery Residences (2012) defines a recovery residence as a "sober, safe, and healthy living environment that promotes recovery from alcohol and drugs." Recovery residences are divided into levels of support depending on the intensity and duration of support they offer. Recovery residences (such as sober living houses, recovery homes and Oxford Houses) are examples of Level 1 and 2 recovery residences that can provide a vital bridge between inpatient/residential treatment (Levels 3 and 4) and building a life in the community. Some individuals are able to successfully complete outpatient, intensive-outpatient, or day treatment while living in a stable recovery-oriented housing environment. These residences also provide on-going support for individuals and are a cost-effective way to increase the duration of treatment and recovery support. Studies on Oxford Housing have identified a tipping point of six months or longer stays increasing abstinence rates. Oxford House residents who stayed more than six months had relapse rates of 16.6% at 24-month follow-up versus relapse rates of 45.7% for residents staying less than six months (Jason et al, 2007). Recovery housing is an essential part of preparing or transitioning to an independent life in the community (Reif, et al, 2014). Although, the overall research on recovery housing is in the early stages and somewhat limited, documented positive results include: 1) decrease in drug and alcohol use; 2) increase in employment; and 3) decrease in criminal activity (Reif, et al, 2014).

## 2. Individual treatment and treatment matching

The most consistent finding in the literature around treatment matching and residential care is individuals with high severity addiction, co-occurring disorders, who are experiencing homelessness or have unsupportive living environments, and have criminal justice issues typically do better in high intensity residential treatment services (Finney et al, 2009, DeLeon et al, 2008). The other factor to consider when determining placement is assessing an individual's level of recovery capital. Recovery capital is defined as the "volume of internal and external assets that can be brought to bear to initiate and sustain recovery from alcohol and other drug problems" (Grandfield & Cloud, 1999). Individuals with high addiction severity and low recovery capital (Finney et al, 2009, White, 2008) will likely require a higher intensity of treatment. These findings support providing long-term residential care for individuals with high severity, chronic addiction, who also have low recovery capital.

The other treatment matching finding with consistent evidence is the value of providing treatment services for identified problems beyond the presenting addiction issue. Individuals with substance use disorder often present to treatment with a multitude of needs (psychiatric, housing, family, employment). There is strong evidence for improved outcomes when individuals' other needs are addressed in addition to their substance use disorder (Hesse, Vanderplasschen, Rapp, Broekaert, & Fridell, 2007; McLellan et al, 1999; Morgenstern et al., 2009). Several treatment studies suggest addressing the specific individual needs of clients (e.g., medical, psychiatric, family and employment services) may improve outcomes by 20-40% (White, 2008).

These research findings point to the need to adapt and tailor services to meet the individual characteristics and needs. A key part of residential treatment is identifying the specific risk factors for each individual and helping them identify the resources and behavioral changes necessary to support recovery in the community upon discharge.

***Practices and strategies to enhance matching clients to optimal treatment services***

**A. Unbundling treatment service rates**

Fayette Company, a large treatment organization in Illinois, committed to broad scale changes to implement recovery management principles and practices into its treatment organization. One major effort of this process involved restructuring residential treatment services to be aligned with Recovery Management principles. Michael Boyle, the CEO of Fayette Company, describes the challenge as "creating a residential treatment intervention that could effectively treat an individual's severe addiction to alcohol and drugs while simultaneously helping the person rebuild or develop a recovery support system in the community" (Boyle, Loveland, and George, 2010). Fayette Company made some concrete changes to residential services, including:

- creating computer labs where residents could do job searches, write resumes, take an on-line course and email friends and families;
- allowing residents to secure employment while in treatment and work on evening and weekends;
- creating a transition phase of treatment where residents could increase employment and secure stable housing while decreasing actual involvement in clinical programming; and
- increasing the amount of individual and family counseling services.

One of the barriers Boyle reported regarding these changes had to do with the State licensing requirements -- that individuals in residential treatment receive a minimum of 25 hours of weekly treatment. Boyle was able to work with the State of Illinois to unbundle service rates, which allowed them to better modify treatment services to the individual needs of clients (i.e., individual and family therapy, employment support services, recovery coaching) (Boyle, Loveland, and George, 2010).

The City of Philadelphia, which has also engaged in significant transformation efforts aimed at creating a recovery oriented system of care, also report instituting policy and fiscal changes to develop alternative payment arrangements so that more flexible menus of service could be developed, versus having to adhere to strict programming requirements (White, 2008).

### B. Intensive case management

Case management is focused on linking individuals with services and resources that will support their recovery and address ancillary issues (housing, medical, employment, legal assistance, parenting). As mentioned above, studies on case management have demonstrated improved outcomes in lowering substance use as well as improvement in the areas specifically addressed through case management linkages and access of needed services (McLellan, 1999, McKay, 2009).

Case management services (both alone and in addition to standard treatment) have been shown to engage and retain clients in services, lower drug and alcohol use rates, increase the use of ancillary services and help individuals improve employment, housing, and criminal justice system issues (McLellan, et al, 1999, Siegel et al, 1996). There are a variety of case management models that have been shown to improve engagement and retention in treatment and recovery services. One specific model reported in the literature with significant outcomes is an intensive case management (ICM) program developed by Morgenstern and colleagues. Morgenstern (2006) and colleagues studied an intensive case management program for women with SUD who were receiving TANF. Intensive case management services were provided for 15 months. The ICM services were offered prior to entry to treatment, throughout the duration of treatment, and after treatment. When compared to the usual outpatient follow-up care, the ICM increased treatment initiation, engagement and retention. Rates of abstinence at follow-up (15-months) were 43% in the ICM condition versus 26% in the usual outpatient care.

### C. Community Reinforcement Approach

The Community Reinforcement Approach (CRA) is a highly researched treatment approach that has been supported in multiple clinical trials (Miller & Wilbourne, 2002). The basic principle of the Community Reinforcement Approach is sobriety must be as, if not more, reinforcing and rewarding than drug and/or alcohol use. CRA has been found to be effective in both outpatient and inpatient treatment for substance use disorders. It has also been found to be effective with individuals who are homeless, addicted to opioids, and individuals with low motivation for treatment. This treatment approach, although highly effective, has not been widely adopted in the SUD treatment settings (Miller, Forchehimes, & Zweben, 2011). CRA draws on a menu of treatment options that also includes a focus on adjunctive services such as social and recreational needs, family and marital counseling, job skills training. It is an approach that can be highly individualized (McKay, 2009).

## 3. Utilize a combination of evidence-based practices

White (2008) in his monograph on recovery management identifies two primary in-treatment factors associated with improved outcomes:

1) differential skills of individual counselors; and
2) effectiveness of particular program service ingredients.

Program service ingredients are most often defined by the evidence-based practices being utilized by a treatment program. This section will briefly review the evidence-based practices that have been shown to be particularly effective for substance use disorders in terms of patient outcomes and cost-effectiveness. This is not an extensive review of the evidence-based practices available for the treatment of substance use disorders. For a full review see SAMHSA's National Registry of Evidence-

Based Practices at http://www.samhsa.gov/data/evidence-based-programs-nrepp. For a full review of evidence-based practices with extensive information on cost-effectiveness see Washington State Institute for Public Policy at www.wsipp.wa.gov. Several reviews and meta-analyses have identified the following practices as having significant evidence for successfully treating adults with substance use disorders (Miller & Wilbourne, 2006; Witkiewitz, K. & Marlot, A, 2011).

- **Coping and social skills training** approaches address various life problem areas in addition to the substance use disorder. It is based on social learning theory and skills training to enhance individual coping skills. The Community Reinforcement Approach, described in the previous section, is one example of a social skills treatment approach. Basically, these approaches seek to help the individual learn additional life coping skills as an alternative to using substances as a primary coping mechanism. These approaches are sometimes referred to as "broad spectrum social skills" training (Monti, et al, 2002; Hester & Miller, 1995, Miller & Wilbourne, 2006).
- **Contingency management approaches** are based on the principles of operant conditioning – the use of reinforcement and punishment to maintain positive behavioral changes. Contingency management typically involves monitoring the individual's use of substances through UAs or blood tests; providing positive rewards for abstinence and withholding rewards when substance use is identified (Higgens, Silverman, & Heil 2008).
- **Marital and family approaches** seek to promote sobriety by improving the quality of the patient's relationships. Relationship factors that may influence a person's substance use are identified and addressed jointly with family members. Treatment components include: enhancing communication skills, building positive reinforcement for abstinence; and identifying mutually enhancing positive activities to engage in together. Behavioral Couples Therapy has the strongest evidence for improving treatment outcomes with adult with Substance Use Disorders who have a significant other (Miller, Forcehimes, & Zweben, 2011).
- **Cognitive-behavioral therapy (CBT)** begins with an analysis to identify beliefs, attitudes, and situations that contribute to the patient's substance use. Based on this analysis, coping responses that the patient can use are developed and practiced in high-risk situations to avoid relapse. Marlot's relapse prevention therapy is one of the most commonly used therapies in standard drug treatment programs. (Witkiewitz & Marlot, 2011, NIDA, 1999)
- **Twelve-step facilitation (TSF)** is designed to help patients engage more successfully in 12-step programs. It focuses particularly on the first five steps of the 12 steps, but also includes other components, such as assessing the patient's family history of AOD use and the situations that typically lead to AOD use, and providing support for sober living. (NIDA, 2000)
- **Motivational enhancement therapy** is based on the idea that the reasons for change and the ability to change exist within with client. This therapy seeks to elicit internal motivation and help the client identify strategies and solutions for change. This is a patient-centered approach that is highly individualized and is often used as a means to help an individual prepare for change, rather than as a stand-alone treatment intervention (Miller & Rollnick, 2013).
- **Medication assisted treatment** has strong evidence for its value to assist individuals who are being treated for opioid dependence. In SAMHSA's Assessing the Evidence Base (Thomas, Fullerton, & Kim, 2013) for MAT with buprenorphine, sixteen high-level randomized controlled trials of buprenorphine medication treatment indicated a high level of evidence for its impact on treatment retention and reduction of illicit opioid use. Similar results were also found for the

use of methadone treatment for opioid dependence (Fullerton et al, 2013). Medications that have shown to be effective in reducing alcohol use include disulfiram, oral naltrexone, extended release naltrexone, and acamprosate.

- **Eye Movement Desensitization and Reprocessing (EMDR) and Trauma Focused CBT** are the two trauma-focused intervention with the strongest evidence-base for resolving trauma issues and promoting recovery from PTSD and trauma related symptoms (Schurr, P. 2008). Seeking Safety, a treatment intervention designed to address both trauma and substance abuse, has been identified as a research-based practice for improving the effects of PTSD and as a promising practice for improving substance abuse issues (Washington State Policy, 2014).

***Strategies to increase the use of evidence-based practices***

Over the last decade there has been a significant focus on increasing the use of evidence-based practices in SUD and MH services (Fixen, et al., 2006, IOM, 2006). Fixen (2006) and colleagues conducted a synthesis of the literature on implementing evidence-based practices and identified a number of key factors associated with successful implementation:

- carefully select the evidence-based practice based on the needs and outcomes identified for the population being served;
- provide comprehensive, ongoing training to clinicians along with coaching and performance assessments;
- provide the infrastructure needed for training, clinical supervision and regular process and outcome evaluations;
- involve communities and consumers in the selection of evidence -based programs and practices; and
- policy makers and funders provide funding and align policies to support the evidence-based practices selected.

## 4. Integrate physical, mental health, and substance use disorder treatment

The lack of integrated care for substance use disorders is linked to poor outcomes and cost ineffectiveness (White, 2008). Providing integrated care is particularly important for individuals with chronic, complex substance use disorders (Kelly & Daley, 2013, IOM, 2006, Sterling, Chi, & Hinman 2008). The Association of Behavioral Health Institute defines integrated services as “whole person-care that focuses on overall health; creates partnerships across all aspects of health; and is facilitated by a variety of clinical, structural, and financial arrangements and community supports” (ABHI, 2015).

Research indicates 25 to 50 percent of participants in substance abuse treatment have more than one SUD and at least one other psychiatric condition (Sterling, Chi, & Hinman, 2008). The literature also indicates individuals with SUDs also have a higher prevalence of medical conditions, such as HIV, Hepatitis B and C, hypertension, asthma, arthritis, COPD, and many pain conditions (Sterling, Chi, & Hinman, 2008; IOM, 2006). Integrated services have been shown to improve outcomes for individuals with substance use disorders and other mental health and physical health conditions. Individuals receiving integrated services appear to stay in treatment longer and have better substance use outcomes (Willenbring & Olson, 1999, Weisner et al, 2006). One study (Willenbring & Olson, 1999) looking at the effectiveness of providing integrated care found that at the 2-year follow-up, 74% of

individuals receiving integrated care were abstinent, versus 47% of individuals in standard treatment. This study integrated behavioral health services and medical care.

Reif and colleagues (2014) in their review of residential treatment services reported integrated residential treatment services for individuals with co-occurring disorders resulted in reduced illicit drug use and alcohol use, improved psychiatric functioning, higher reported quality of life and improved social and community functioning than those in treatment as usual. These studies point to the need to provide integrated care for individuals with high severity SUDs in residential treatment services to improve outcomes.

***Practices and strategies to support integration of physical and behavioral health services***

**A. Navigators and co-located services**

A Kaiser Commission on Medicaid and the Uninsured (2014) identified five promising practices for physical and behavioral health care integration. These practices include:

- Universal screening
- Navigators
- Co-located services
- Health homes
- System-level integration

Navigators and co-located services are two practices important to consider for the new model being developed in the North Sound Region. These two practices are directly relevant to SUD treatment services and have been shown to improve coordination and integration of care.

Navigators help individuals understand and utilize the health care system and coordinate services. Navigators may be nurses, social workers, or certified peer specialists. Specific duties of navigators may include helping individuals seek appropriate care and locate services, assist individuals in getting to their medical and behavioral health appointments, and serving as an advocate and interacting with the individual's health care providers. Several states have employed a "Certified Peer Specialist" to serve as health care navigators and they have found the use of navigators improve the patient's ability to self-manage their conditions. (Kaiser, 2014)

Co-locating services is another promising practice for increasing integration of services. One example of this is Federally Qualified Health Centers, which have been enhancing their capacity to provide integrated services by incorporating behavioral health services directly in their clinics. (Kaiser, 2014, IOM, 2006)

Genesee Health System and Hope Network in Michigan has developed a hybrid model of using navigators and co-locating services to enhance integration. A small study of this model found that psychiatric inpatient admissions per person fell from an average of 1.95 in the year prior to receipt of navigator services, to .48 after receiving navigator services for one (Kaiser, 2014).

**B. Dual Diagnosis Capability in Addiction Treatment (DDCAT)**

Assessing organizational capacity to address co-occurring disorders is another key strategy to ensure individuals are receiving a higher level of integrated services. The Dual Diagnosis Capability in Addiction Treatment (McGovern et al, 2010) is a fidelity tool designed to measure the level of integration of mental health and substance use disorder treatment services in addiction treatment settings. The DDCAT's five dimensions assess levels of integration in regards to 1) program milieu; 2) clinical process: assessment; 3) clinical process: treatment; 4) continuity of care; 5) staffing; and 6) training. The DDCAT provides objective ratings of integration ranging from "Addiction Only" to "Dual Diagnosis Capable" to "Dual Diagnosis Enhanced" using a 5-point scale. In a personal communication with Dr. McGovern (2015), he suggested ensuring residential treatment services range from 3-5 on the DDCAT scale to ensure a mental health issues are being addressed simultaneously with addiction issues.

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**C. Modified Therapeutic Community Programs**

Sacks and colleagues (2010) have studied adapting therapeutic communities to better service individuals with severe mental illness and substance use disorder(s). Therapeutic Community programs adapted for individuals with co-occurring disorders include teaching individuals about their mental illness, how it influences substance use patterns, the process of recovering from both (or in some cases) several disorders, and how to access mental health and social services in the community. Studies have shown modified TCs result in better outcomes for individuals with co-occurring disorders in substance use, mental health, crime, HIV risk, employment, and housing outcomes (NIDA, 2015). This model might be considered for treatment facilities being designed to treatment individuals with SUD and severe mental illness.

## 5. Use a recovery management framework and extended continuing care

Residential treatment is an essential service component of the treatment continuum for many individuals to help them initiate recovery and stabilize; however, long-term recovery and obtaining quality of life happens within the person's natural community. Regardless of how effective a residential treatment episode may be, post-treatment monitoring and support are essential to sustain the gains made in residential treatment services (Scott & Dennis, 2010, White, 2008). These findings point to the importance of improving the larger system of care to sustain the gains made in residential treatment.

Two consistent findings from long-term follow-up studies of SUD treatment are 1) treatment effects diminish over time; and 2) relapse rates are high (Kelly & White, 2011). SUD outcome research consistently demonstrates individuals are at a high risk for relapse during the first year after treatment (50-70%). Most of these relapses will occur within the first 30-60 days (Scott, Foss, & Dennis, 2005; Simpson, Joe, & Broome, 2002, White, 2011). These outcome rates are fairly similar across treatment modalities. This data indicates the need for significant support for individuals who are leaving residential care or other treatment services and yet, studies show that less than 50% of individuals leaving residential treatment services receive follow-up care within two weeks of discharge (Garnick, 2009).

The American Society of Addiction Medicine (ASAM, 2011) defines addiction as a primary, chronic disease of brain reward, motivation, and related circuitry. Despite years of research identifying

substance use disorders being “chronic conditions” for many people, the treatment system has responded to these disorders as if they were acute disorders. Brief treatment episodes are unlikely to change lifelong patterns of addiction, especially for individuals with severe, complex, chronic SUDs. The current system is moving from an acute system of care to a recovery management system for these individuals. This is based on a recognition that substance use disorders are chronic health conditions that often require ongoing monitoring and provision of care and treatment. (Kelly & White, 2011; McLellan et al, 2000)

Three key assumptions underlie this chronic disease framework: 1) a single brief treatment episode without post-treatment monitoring and support is unlikely to result in lasting behavior change; 2) multiple treatment episodes, if integrated with a long-term recovery management plan, have been shown to help people move through the developmental stages of recovery; and 3) it is often the synergy of treatment combinations that help people move into recovery (Kelly & White, 2011).

A recovery management model has been proposed as an adaptation of the chronic disease management model currently employed in the medical field for a number of chronic conditions (e.g., asthma, diabetes, hypertension, Hepatitis C). A recovery management model refers to a philosophical framework for organizing addiction treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance and quality-of-life enhancement for individuals and families affected by severe substance use disorders (White, 2008, pg. 13). A central component of a recovery management system is providing the full continuum of care over an extended period. The shift to a recovery management model requires an increased focus on providing ongoing care and monitoring following brief intensive treatment episodes. McKay (2009) identifies the goals of continuing care as:

- facilitating transition across levels of care and easing re-entry into the community;
- providing on-going support through group or individual counseling;
- linking the patient to collateral sources of support in the community;
- addressing relapse issues as they surface; and
- consolidating gains made in residential treatment and supporting transfer of learning

Implementing practices to support continuing care and post-treatment monitoring is essential to helping individuals achieve long-term recovery and obtain a higher quality of life.

***Practices/Strategies to support continuing care and promote a recovery management model of care***

**Recovery management check-ups**

Models of ongoing monitoring and early re-intervention are being studied as a way to shift the SUD field from an acute system of care to a recovery management system of care. Scott and Dennis (2010) have developed a Recovery Management Check-up (RMC) protocol that offers on-going support and monitoring to individuals following an intensive episode of substance abuse treatment. Individuals receive quarterly “recovery” check-ups in which they are tracked and provided an assessment to determine current needs and facilitate rapid readmission to treatment, if they are in relapse. The acronym TALER is used to summarize the protocol. TALER stands for: 1) Track – to determine the whereabouts of participants; 2) Assess – using valid instruments to assess which individuals need early reintervention; 3) Link- to help link individuals with treatment and/or recovery services; 4) Engage –

assertive follow-up to facilitate participant engagement in services; and 5) Retain – to ensure on-going involvement in treatment services. The goals of this protocol are to re-intervene early and increase treatment participation to enhance long-term recovery outcomes. RMCs were found to reduce both the time to readmission as well as the time spent in the community using and to increase levels of treatment participation and rates of abstinence. (Scott & Dennis, 2010)

**Professional monitoring programs**

Programs designed for impaired professionals (physicians, nurses, pharmacist, pilots) have demonstrated recovery rates ranging from 70-96 percent (IBH, 2014). These are some of the highest rates identified in the literature of SUD recovery rates. And significant, when you compare them to the overall lifetime recovery/remission rates for substance use disorders which are around 50% (White, 2012). These programs are designed to provide ongoing monitoring and support for three to five years. The timeframe is based on research showing that substance use disorder relapse rates drop to around 15% after 4-5 years of recovery (Kelly & White, 2010). Over the last decade similar types of long-term care management have been developed and piloted with criminal justice clients with similar rates of long-term abstinence and improved quality of life.

Key components of this model include:

- An initial intensive (independent) assessment followed, when indicated, by a formal episode of treatment (30-90 days) – this may be residential or intensive outpatient treatment.
- Signing of a 3-5-year monitoring contract that includes long-term monitoring of the individual to include random drug and alcohol testing over the duration of the contract.
- The monitoring agreement identifies specific and certain consequences related to drug and alcohol use. The expectation is abstinence-based recovery.
- Care management and monitoring is provided for a full five years to both support on-going recovery efforts as well as to provide re-intervention when indicated.
- Involvement in mutual support groups is highly recommended and in some cases required as a part of the monitoring agreement.

Recently, the Institute for Behavioral Health held a symposium for experts in the field of behavioral health and developed a proposal for creating a new standard of care and outcomes based on what they are calling the “New Paradigm” model (IBH, 2014). The “New Paradigm” provides a model of care that is based on a chronic disease management and incorporates several key components from” Impaired Professional” long-term monitoring programs. What is unique about the “New Paradigm” model is that it contains a strong accountability and contingency management component designed to override the “addicted” thinking that is common in individuals in early recovery.

**Linkages to communities of recovery**

One consistent finding in the literature is the significance of involvement in mutual support groups (such as AA and NA) to improve long-term recovery outcomes. In NIDA’s DATOS studies (Etheridge et al, 1999) participation in intensive mutual support groups following residential treatment significantly lowered relapse rates. Studies looking at 12-Step Facilitation consistently demonstrate abstinence rates of 10% or higher than usual care conditions at 1-year follow-up (Kaskutas & Subbaraman, 2010).

These findings support the importance of residential treatment assertively linking individuals with mutual support groups and the recovery community. Promising and evidence-based approaches that support this goal include: 1) recovery mentors/coaches; 2) twelve-step facilitation therapy; 3) Making AA Easier (MAAEZ), a protocol for use in residential and outpatient setting to help clients interact with people they meet in AA/NA; and 4) in-reach to residential treatment facilities by alumni and community-based recovery organizations to provide on-site meetings and facilitate residents attending community-based meetings as well.

## Section III: National Treatment Models to Consider

Several "model" treatment programs incorporating a number of the evidence-based practices described previously were identified as part of this research/needs assessment project. Interviews with key leaders of these programs were conducted to determine the feasibility of replicating components of these model programs in the North Sound Region. The next planning phase of this transition project will include site visits to learn more about these programs. The purpose of the site visits will be to gather practical, on-the-ground information on the implementation and sustainability of the identified models.

### Dawn Farm

Dawn Farm is a Michigan addiction treatment center with an emphasis on community as the most important source of healing and recovery support for its clients. Treatment is built on solid recovery principles and includes significant involvement in the local recovery community. Dawn Farm provides the full continuum of treatment and recovery services. Residential services include a 36-bed long-term facility call *The Farm* (a 64-acre working farm) and a 13-bed facility located in downtown Ann Arbor called *Downtown.* Dawn Farm's *Spera Recovery Center* provides detoxification services along with a number of beds for individuals who have completed detox but are in need of some type of residential housing and need interim services while awaiting placement. Dawn Farm also operates 12 transitional housing units throughout the community that provide 170 sober housing beds.

Residential treatment services are based on a Therapeutic Community Model and lengths of stay were historically, 9-12 months; however, with the addition of sufficient recovery housing, average lengths of stay are now 60-90 days. Residential facilities offer daily group therapy, individual therapy and case management. Services also include medical care, art and work therapy, vocational referrals and job training, high school and GED and specialized family services. Treatment plans combine evidence-based approaches including: Twelve-step Facilitation, CBT, DBT, personal medicine for co-occurring disorders, EMDR for trauma, and individual-based psychiatric services provided by a psychiatric nurse practitioner. All residential clients have the opportunity to enroll in supportive transitional housing. The primary goal of the residential treatment programs is to assist residents in finding a place within the recovery community. Continuing care services are provided for a minimum of six months. A key philosophy of this treatment organization is to keep individuals engaged long-term and maintain an on-going relationship with all clients.

Jason Schwartz, Dawn Farm's Clinical Director, (personal communication) identifies the following aspects of Dawn Farm as being key to the success and sustainability of Dawn Farm:

- Diversifying funding streams (public, private, first-party funding)
- Development and availability of transitional housing
- Recovery community involvement and linkages
- Shifts in funding (capitated rates); allows for flexibility
- Intensive case management and recovery coach supports
- Addressing trauma and the use of evidence-based practices
- Using a Modified Therapeutic Community Approach

The Dawn Farm model contains a significant number of the key components identified in the literature to promote successful outcomes for individuals with high severity SUDs.

This treatment organization is located in Ann Arbor, Michigan, which is a similar in population to several of the communities in the North Sound Region and is surrounded by several farming communities. The population of Ann Arbor is 113,000. Dawn Farm residential treatment services cost approximately $130 per bed day, which covers room and board, intensive therapy, recreational activities and a comprehensive therapeutic milieu. All residential clients are offered supportive housing upon discharge and they can remain in supportive housing for up to 2 years. Program fees in housing range from $460 to $510 a month, depending on location. While in housing, people are working and paying their own program fees.

Source: www.dawnfarm.org and Personal communication with Jason Schwartz.

**Central City Concern**

Central City Concern (CCC) is a large human services agency located in Portland, Oregon. Central City Concern provides comprehensive services for individuals experiencing homelessness, mental health, medical and chemical dependency issues. CCC has been recognized nationally for its innovative, recovery-oriented approach to providing services. CCC has developed a comprehensive approach that addresses the needs of individuals by providing them with housing, health and recovery assistance in a fully integrated way. The agency was founded in 1979 and, over the years, they have developed a continuum of affordable housing options integrated with direct social services including healthcare, recovery and employment.

Central City Concern Health and Recovery direct social services include:

- CCC Recovery Center (Outpatient and Intensive Outpatient SUD services)
- Eastside Concern (Outpatient and Intensive Outpatient SUD services)
- Hooper Detoxification Stabilization Center
- Housing Rapid Response (an emergency services response program)
- Letty Owings Center (Residential SUD services for women with children)
- Old Town Clinic (Federally Qualified Health Center/ Patient-centered Medical Home)
- Bud Clark Clinic
- Old Town Recovery Center (outpatient mental health and SUD treatment program for individuals with severe mental illness)
- Puentes (culturally specific services – Hispanic)
- Imani Center (African American-centered mental health and addiction program)
- Recovery Mentor Program (a peer mentor recovery program)
- Recuperative Care (provides post-hospitalization and case management for individuals experiencing homelessness)
- Sobering Station (Emergency Response Center)

Central City Concern's approach to substance use disorder treatment involves providing individuals with a variety of options for initiating stabilization and recovery. Lynn Smith-Stott (personal interview) described CCCs three key models for delivering substance use disorder services:

1) Recovery Mentor and ADFC Housing model - provides integrated treatment through primary care services and intensive outpatient care. Individuals receiving services in this model are

supported through transitional living, recovery mentors, and strong involvement in twelve-step programing.

2) Hooper Detoxification – Outpatient induction model for opioid medication-assisted treatment and involvement in intensive outpatient services. Outpatient services include suicide prevention, opioid overdose prevention, and chronic pain management group.
3) Harm Reduction Model is based on "housing first." This model is geared towards individuals who may not be ready to abstain from drugs and alcohol. The goal of this program is to keep individuals safe and out of the criminal justice system. This model is designed to engage individuals and develop long-term service relationships.

CCC's Recovery Mentor and Alcohol and Drug Free Communities (ADFC) program has demonstrated significant reductions in drug use and criminal activity. The Regional Research Institute for Human Services at Portland State University conducted a study on the Recovery Mentor and ADFC Housing program in 2008. Herinckx and colleagues (2008) interviewed 87 CCC Recovery Mentor and ADFC Housing participants to look at drug use and criminal activity one year prior to entering treatment and program services at CCC and their drug use and criminal activity post-entering CCC programs. Study participant were predominately male (70%); mean age as 42-years old; 47% lived on the street or shelter in the year prior to entering CCC programs; 97% were poly-substance users; 55% reported a co-occurring mental health diagnosis. Study participants had all participated in CCCs Recovery Mentor Program and were living in CCC's ADFC mentor housing units as well as attending outpatient treatment at CCC's Recovery Center. The results of the study found a 95% reduction in drug use and 93% reduction in criminal activity. (Herinckx, 2008). CCC's model is a good example of one that is less dependent on residential services and uses a combination of recovery support services, transitional living, and intensive outpatient treatment.

Source: http://www.centralcityconcern.org/ and key informant interview with Lynn Stott-Smith.

**City of Philadelphia Department of Behavioral Health and Intellectual disAbilities**

A model for consideration to address the larger system of care issues identified in this report is the City of Philadelphia's Department of Behavioral Health and Intellectual Disabilities (DBHIDS), Recovery Oriented System of Care. In 2004, under the leadership of Commissioner Arthur Evans, the DBHIDS launched a system change initiative to transform the Philadelphia's behavioral health system. Philadelphia's model is rooted in a recovery and resilience oriented approach which is person-centered, strength-based and focuses on helping individuals achieve health and wellness in the community.

The overarching goal of these transformation efforts has been to shift the system of care from an "acute care" approach to a "recovery-management" approach that provides individuals with long-term supports and opportunities to sustain long-term recovery and achieve meaningful lives in their communities. The focus is on developing a system of care to provide integrated, recovery-focused services for individuals with both mental health and substance use disorders.

The leadership of the DBHIDS choose a "transformational approach" to system improvement. As the word suggests this type of approach requires a fundamental shift in paradigm and is predicated on the assumption that the system will look completely different once it is transformed. The transformative approach involves system-level efforts to develop and promote recovery-oriented, integrated services

across the entire treatment system. This has involved major redesign of the behavioral health treatment system in Philadelphia.

The first step in the process involved bringing together people in the recovery community, along with treatment professionals and city officials to develop a comprehensive strategy for transforming the system. The DBHIDS in collaboration with community providers and service consumers developed Practice Guidelines for Resilience and Recovery Oriented Treatment which outlines 10 core values, four service domains, and seven system goals.

The overall change strategy has been described as aligning concepts, practice, and context. Dr. Arthur Evans (White, 2006) describes the process as focusing on:

- How do we want thinking (concepts and ideas) to change?
- How do we want behavior (work processes, practices, relationships) to change?
- How do we want the overall context (fiscal, policy, administration) to change?

These three questions have provided the framework for change and have guided the phases of transformation:

**Phase 1) Focus on conceptual alignment:** The first two years of this process involved establishing high preforming collaborative partnerships with people in recovery and their families, providers, system stakeholders, and city officials. The focus was on creating a common vision of recovery and a recovery oriented system along with the defining the values to guide the process. This phase also involved the establishment of a Recovery Advisory Committee and assessment of recovery orientation at the system, organization, and practitioner level to assess current strengths and needs.

**Phase 2) Focus on practice alignment**: Several priority areas were identified and the practice guidelines (Figure 1) were developed and practices to align with these guidelines were implemented. Several demonstration projects were launched and evaluated. Improving service outcomes with attention to health disparities, trauma, and implementation of EPBs. An initiative to transform Day Services for the SMI population was implemented. Training and technical assistance was provided in EBPs and leadership development.

**Phase 3) Focus on contextual alignment:** Regulatory and financing issues were addressed to align with the changing system and recovery-focused services. The environment was shaped to support the changes in practice. Contextual alignment also involved working with the community to decrease stigma and to continue to build partnerships (i.e., faith-based, business community, other social service organizations). (Achara-Abrahams, Evans, & King, 2010)

Dr. Evans almost ten years into the ROSC transformation, describes the key components of the Philadelphia Model as:

- Recovery is the overarching framework
- Individualizing Treatment by addressing
    - Trauma
    - Co-occurring conditions
    - Matching to treatment interventions to developmental stages

- Using data, science, and technology to inform policy and practice
- Addressing known health disparities
- Implementing evidence-based practices
- Using a community approach
    - Faith-based
    - Prevention and outreach

Philadelphia Department of Behavioral Health and Intellectual disAbilities http://dbhids.org/

## Section IV: Summary and Final Considerations

The key themes identified in this report for improving residential treatment services, as well as the larger system of care for individuals with high severity, chronic substance use disorders include:

- **Develop a "coordinated" recovery-oriented system of care** that truly integrates behavioral health (mental and substance use disorders) and physical health services. Integrate psychiatric and medical services into residential treatment and create funding mechanisms to support integrated services.
- **Strengthen transitions** between levels of services, using "warm hand-offs" and focusing a greater portion of residential treatment activities on preparing and linking clients to services in the community.
- **Provide a full continuum of care** and a system for delivering stepped-care that is responsive to the changing needs of clients at various stages of recovery.
- **Enhance services and supports for family members** and increase opportunities for family involvement in residential treatment services.
- **Provide active linkages** and support to family members and clients to help them successfully navigate the behavioral health system of care.
- **Increase the use of evidence-based practices** in residential services that focus on trauma, co-occurring disorders, employment and housing support, and medication-assisted treatment.
- **Provide individualized treatment** that continually assesses and treats specific needs and concerns of patients in ITA services; move away from "program" based services. Funding and policy mechanisms must be developed to fund this type of approach.
- **Develop services based on a recovery management framework** and extend continuing care services for several months to years to support on-going post-treatment monitoring and early re-intervention when needed. Use approaches that are adaptive and meet specific client needs.
- **Develop and support additional transitional and sober housing** for individuals leaving residential treatment who do not have housing or adequate support in their recovery environment.

As evidenced by this list of needs and recommendations, there are no simple answers or a magic formula for providing the highest quality of care and services possible for individuals with high severity, chronic, substance use disorders. Improving treatment outcomes is a complex process involving offering a multitude of recovery and treatment services and matching these services to the individual's stage of recovery. Residential treatment services represent only one point on the continuum of treatment services and cannot be improved without attention to the larger system. Therefore, key considerations for moving forward in this report are divided into two distinct categories. One section addresses the need to build a more coordinated system of care that is recovery oriented and based on a recovery management model; and a separate section discussing specific considerations for residential treatment service design.

**System-level Considerations**

The results of the interviews with key stakeholders, consumers, and national experts all point to the need for systems level transformation efforts to better integrate services and provide a seamless continuity of care for individuals with high severity, chronic substance use disorders. The challenge

involves moving from a treatment system that has historically focused on discrete short-term episodes of care to a system that supports long-term chronic care disease management (or what has been referred to as "recovery management" in the SUD field). Shifting to a recovery management model requires that the full continuum of substance use disorder care be available. The full continuum of care in substance use disorder treatment services includes: 1) Early Intervention and outreach; 2) Withdrawal Management/Detoxification; 3) Residential Treatment Services; 4) Partial Hospitalization; 5) Intensive Outpatient Services; 6) Outpatient Services/Continuing Care; and 7) Recovery Support Services (housing, transportation, supportive employment, peer support, childcare, recovery coaching) and Post Treatment Monitoring. (Mee Lee, et al, 2013)

The qualitative needs assessment findings in this report indicate a need for an increase in capacity of the higher levels of care (i.e., detoxification and residential treatment). The closing of Pioneer Center North will further increase the need for residential treatment beds. Exact numbers regarding adult residential treatment beds needed in the North Sound Region is being assessed through a population needs assessment currently being conducted by Slalom Consulting.

The levels of the SUD care in the continuum identified as being high need priority areas, for both increasing capacity and quality, include recovery support services and effective/flexible continuing care services. In fact, many of the evidence-based and promising practices identified in this report are geared towards improving services at these levels of care. Another high priority in the Region is improving the transition from residential treatment services into lower levels of care, once again with a focus on recovery support and continuing care services. Providing a seamless continuity of care will require ensuring the services are available across the continuum and organizing the services into a true "system of care."

The question then becomes how do we create a true "system of care" in the North Sound Region that is closely tied to the community and draws on both the professional knowledge and services offered by treatment and recovery providers as well as building and drawing upon the natural supports and recovery resources in the community?

**Recovery Oriented Systems of Care**

Over the last decade a number of cities, counties, and states across the nation have launched behavioral health system transformation efforts to build what has been referred to as Recovery Oriented Systems of Care (ROSC) guided by a Recovery Management Model of Care. A ROSC has been defined as, "a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems." (SAMSHA, 2010) These initiatives have been in response to many of the same issues identified earlier in this report, such as the need to better integrate services, to expand the treatment/recovery continuum, to individualize services, to actively involve the recovery community in treatment and recovery services, and to create a system that provides on-going meaningful recovery support services and post-treatment monitoring.

The central focus of a ROSC is to create an infrastructure or "system of care" with the resources to effectively address the full range of behavioral health problems within communities (SAMHSA, 2010). These ROSC transformation efforts have resulted in significant improvements to the respective city and

state's behavioral health service systems (Kirk, 2010; Evans, 2013). The State of Connecticut launched its ROSC system transformation efforts in 2000 with a shift in focus from acute care to quality improvement and continuity of care. After implementing a number of changes and initiatives to move towards a ROSC the State of Connecticut databases demonstrated a 62% decrease in acute care and 78% increase in ambulatory care, with 14% lower cost even after adding extensive recovery-support services such as housing and transportation, 40% increase in first time admissions, and a 24% decrease in average annual cost per client, especially for high service utilizers (Kirk, 2011) The City of Philadelphia's Department of Behavioral Health and Intellectual disAbilities' ROSC initiative has resulted in improved patient outcomes, fewer inpatient admissions and visits to crisis centers (DBHIDS, 2015).

While a full discussion of the process for implementing a ROSC is beyond the scope of this document, a syntheses of implementation steps/phases and corresponding activities is described in the table below. This information is based on recovery-oriented systems transformation efforts in several States (e.g., Connecticut, Georgia, Massachusetts, Maine, California), cities and counties (Philadelphia, Hancock, Ohio). (SAMHSA, 2010; White, 2006; White, 2007; Achara-Abrahams, Evans, & King, 2010; Kirk, 2010; SAMHSA, 2012).

| **Implementing Recovery-Oriented Services and Systems of Care** |
|---|
| **Assessing Current Interest and Establishing an Urgency:** The first step in the process involves assessing the level of interest and commitment to this process at multiple levels (BH funders, county and state behavioral health departments, treatment providers, people in recovery and their families). Assess readiness and value of using a ROSC framework to improve services.<br>**Activities/Strategies**<br>Meet with key partners in the system to secure a broad range of support<br>Create a coalition of stakeholders to examine the level of commitment and feasibility for the effort<br>Determine who will be the primary "sponsors" of this initiative (State, County, Regional BHO)<br>Examine resource availability for this effort |
| **Creating a vision and defining core values and principles:** This step in the process involves bringing together providers, recovering people and family members, and other community partners to establish a common vision, core values, and system elements. Build strong partnerships.<br>**Activities/Strategies**<br>Community forums with funders, patients, family members, providers, and other community partners<br>Defining recovery and a ROSC will look like in each community<br>Create a Recovery Advisory Board<br>Establish Cross-State/County Agency Collaborations |
| **Establishing a conceptual framework based on the vision and values:** This step involves assessing the current system's strengths and needs from a recovery-focused perspective and developing a long-term strategic plan to guide the process of system transformation.<br>**Activities/Strategies**<br>Create a framework for operationalizing the principles and values throughout the system.<br>Assess community strengths and needs and formulate ROSC plan that will be compatible with the larger state, regional, and national health care reform and integration (Needs Assessment)<br>Developing a strategic plan that includes both short and long-term objectives and goals |
| **Changing Program and Services to align with recovery-orientation:** This phase of the process focuses on improving care based on the conceptual framework identified in the previous phase of the process. Some key clinical areas focused on in several of the ROSC implementation initiatives include: |

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|---|
| engagement and retention of clients; peer-delivered services: global, strength-based assessments; evidence-based practices; patient-centered care; post-treatment monitoring and supports.<br>**Activities/Strategies**<br>Development of Intensive Case Management Services for high need populations<br>Trauma and Evidence-based practices Workgroups<br>Peer Specialist Programs and Development of Recovery Center<br>Securing federal funding for demonstration programs<br>Workforce development activities (training, technical assistance, coaching/supervision) |
| **Aligning fiscal and administrative supports:** This phase of the process in practice has been described as happening simultaneously with practice change. Policy and funding must be aligned with the new practices and designed to fully support a recovery-focused system.<br>**Activities/Strategies**<br>Reinvestment of funds saved by diverting clients from high cost service<br>Diversifying funding (identifying new partners, securing new federal and state funding)<br>Inventory existing policies and regulations and development of policies to support a ROSC<br>Developing alternative payment arrangements so that more flexible menus of service can be offered<br>Rate negotiations to include recovery support services |

A key component of ROSC system change that provides the foundation for the processes describe in the table above is using data to guide service improvements and inform the decision making process (Kirk, 2011; Evans, 2013) As you can see from this outline, ROSC system transformation is a long-term, complex process requiring significant commitment and effort over several years. Profound change is required at the system-level to guide this process and align funding and policy with recovery-oriented services. Given this, a question to consider is: "Is this the right time to take on such a large endeavor? "

**Context for System Change**

The current health care environment is one of rapid change and innovation, which on one hand makes it difficult to plan and design new services and engage in long-term strategic planning and on the other hand offers an unprecedented opportunity to transform behavioral health services into more effective, organized systems of care. The current context of health care reform and system improvement efforts in Washington offers a unique opportunity to transform systems, realign resources, and improve the quality of services to better meet the needs of the people being served. Currently there are a number of initiative underway in the State of Washington moving the system in the direction of strengthening the service delivery system to one that is person-centered, integrated, and draws upon the principles of chronic disease management and population health. Two closely related initiatives are:

**Healthcare Integration and Transformation:** The State of Washington is in the early stages of implementing a five-year Health Care Innovation Plan. The Innovation Plan recommends three core strategies 1) improve payment system to be based on outcomes; 2) ensure health care focuses on the whole person; and 3) build healthier communities through a collaborative regional approach. This plan includes the creation of Behavioral Health Organizations (BHOs) to purchase and administer public mental health and substance use disorder services under managed care. (Washington Health Care Authority, 2014) The North Sound Mental Health Administration is the North Sound Region's new Behavioral Health Organization. North Sound Behavioral Health Organization (NSBHO) will assume responsibility for managing public mental health and substance use disorder services in April 2016. This

will bring mental health and substance use disorders under the same funding and management umbrella for the first time and offers the opportunity to improve integration of MH and SUD. The State will fully integrate the financing and delivery of physical health, mental health, and substance use disorder services in the Medicaid program though managed care by 2020 (Washington Health Care Authority, 2014)

**Washington State Medicaid Transformation Demonstration Initiative (Section 1115 Waiver Demonstration)** The Washington 1115 Medicaid Demonstration Waiver is seeking additional federal funding to support system transformation in Washington. One of the primary goals of this initiative is to reduce the use of intensive services such as acute care hospitals, psychiatric hospitals and other acute care services. If the funds are awarded, the regional Accountable Communities of Health (ACHs) will be given funding to support a number of activities in its regions to address the needs of the most vulnerable populations. One of the key features of the Transformation Demonstration proposal is to enhance the provision of Targeted Foundational Community Supports (supportive housing and employment). One of the three transformation project domains outlined in the application is "Care Delivery Redesign" which includes: bi-directional integrated delivery of physical and behavioral health; transitional care focused on specific populations; alignment of care coordination and case management to serve the whole person; and outreach engagement and recovery support services. Many needs identified in the application and proposed strategies align closely with needs and potential strategies outlined in this report. If awarded, this will be an important potential source for funding recovery support services. (Washington Health Care Authority & Department of Social and Health Services, 2014)

So while some of the terminology is different (e.g. chronic care models versus recovery management), the concepts and goals of general health care transformation and ROSC system transformation are basically the same. The Recovery Oriented System of Care Transformation efforts and models outlined in this document provide one possible blueprint for change to prepare the behavioral health system for full integration in 2020.

The Washington State Division of Behavioral Health and Recovery, several counties, and many recovery and treatment providers have been engaged in a number of activities over the past several years to increase the availability and use of recovery support services as well as increasing the focus on services that are recovery-oriented. So while the concept of recovery and recovery-focused services is not new, the transitioning of behavioral health services from the North Cascades Gateway Center could be an impetus for launching a "full ROSC system transformation" in the North Sound Region.

**Residential Treatment Service Design and Facility Location Considerations**

We return now to the issue of how to use the data collected in this report to guide the design and development of "new" community-based SUD residential treatment services. While final recommendations and strategic planning for developing community-based residential services throughout the North Sound Region will need to be developed in collaboration with key stakeholders in each County, several considerations are outlined below in regards to the size and location of the facility, type of services offered, as well as alternative models of care to consider.

**Facility Size and Location**

One of the first key decisions moving forward has to do with the size of the treatment facility(s). Slalom Consulting will conduct a regional population needs assessment to determine the projected number of adult "residential" SUD treatment beds needed in the five county North Sound region. Slalom's report will also take into consideration the use of alternative models of care and how this might impact the overall projected number of residential beds. However, if we look at current numbers of individuals from the North Sound Region served at PCN (approximately 315 per year based on data from 2014 and 2015) along with the average length of stay (54-days) this would translate "roughly" into needing at least 52-54 beds to replace PCN beds currently serving the NS Region. This is a very rough estimate and does not take into account a number of considerations: it is being used just as a starting point for this discussion.

So why not build a 54-bed residential treatment facility to replace the services at PCN? There are two key reasons to avoid building a large SUD residential treatment facility.

One reason is related to the IMD rule. The Institution for Mental Disease (IMD) rule requires Medicaid funds to be used to promote small, community-based living arrangements as alternatives to large institutions. The IMD rule prohibits the use of federal Medicaid financing for care provided to patients in MH and SUD residential treatment facilities larger than 16-beds. MH and SUD residential/inpatient facilities larger than 16 beds have historically been funded through State dollars. With Medicaid expansion it is critical to access Medicaid funding for inpatient SUD care. The State of Washington has requested and may receive a temporary IMD Medicaid waiver, which if granted, would allow for Medicaid funds to be used for SUD residential treatment facilities with more than 16-beds. However, this would be a temporary waiver and so it is still important to keep the IMD rule in mind in designing new facilities. The safest route to ensure the facility can use Medicaid funds is to build/design a 16-bed unit. However, discussions with providers currently running 16-bed units indicate this size treatment facility is very difficult to sustain fiscally. Three of the 16-bed programs reviewed during this process were women-and-children residential programs. These programs are able to access additional funding for housing and support of the children, which helps to sustain a 16-bed unit. Dawn Farms in Ann Arbor Michigan has a 13-bed adult residential treatment facility; however, they receive capitated and diversified funding which has allowed them to sustain a smaller facility. The bottom line (based on the programs reviewed during this needs assessment) is that financially sustaining a single 16-bed facility is "very difficult." Providers also note that smaller facilities with a small number of residents make it more difficult to fully utilize a "social or therapeutic community model" program. Further, a smaller number of staff often results in less diversification of counseling skills and experience and, therefore, fewer options for use of specialized treatment approaches (e. g. PTSD, criminal justice treatment interventions, co-occurring disorders).

There appear to be two or three possible options to address this issue:

- The first option is to create a 32-bed unit that has two separate programs. In discussion with the State of WA facility staff, this option still allows for adherence to Medicaid regulations. For example, one community in the region might design a 32-bed facility that includes a 16-bed co-occurring residential treatment program and a 16-bed ITA treatment program. This increases the size of the facility and allows for some cost sharing.

- A second option, identified as a possibility by the State of Oregon, is for a 16-bed residential treatment facility to also offer day treatment programming to individuals not actually residing in the unit. This option would likely allow for additional staffing and increase the number of individuals being served. This option might also help to strengthen a "stepped-care" approach for individuals in transitional living situations who also need intensive SUD treatment services.
- Or the third option is to just move forward with building a residential treatment unit that is based on identified need and assume the Washington IMD rule waiver will be granted and Medicaid funding will be available to SUD residential treatment centers larger than 16-beds.

The second reason to avoid building another large facility is related to the needs identified in this report to increase residential treatment services that are community-based and more focused on helping individual's transition and reintegrate into the community. Remaining in one's community while attending residential treatment has several advantages:

- Family and friends are able to participate more fully in the individual's treatment process.
- Patients are able to attend local mutual support groups while in treatment and begin to establish strong linkages with the recovery community while still in residential treatment.
- Recovery coaches and peer support specialist from the community can be integrated into the treatment facilities programming which supports transition back into the community.
- A phase of residential treatment that is focused on helping individuals secure housing and employment and gradually reintegrating into the community is a viable option if the facility is located in the person's community.

Given these considerations, one option might be to build (2-3) smaller (16-32 bed) facilities strategically placed in cities across the region that have well-developed recovery communities and recovery support services. A possible strategy for rural communities in the region, that do not have the infrastructure or numbers to support a residential facility, might be to increase capacity for supportive housing and recovery support services and strengthen level of care transitional services through intensive case management.

A few additional considerations to keep in mind in planning for the size and location of the facility based on findings in this report include:

- Ensure there is space in the facility to place a medical office for physical health integration, as well as to support the use of Medication Assisted Treatment. Or the facility could be located close to a FQHC (community health clinic) and partnerships developed to integrate physical health services.
- If possible, locate the facility in a community that will support ongoing recovery and quality of life and promote active involvement of the recovery community.
- Ensure there is space in the facility for family visiting and physical/recreational activities.
- Locate the facility either close to already existing supportive housing or secure enough land to also build supportive housing in the same location to be able to offer a stepped-care model.
- Ensure there is sufficient space in the facility for offering continuing care services and/or day treatment services. This is another strategy for building a stepped-care model.
- Look at some of the innovative residential architectural designs that provide a semi-secure facility without the look or feel of an "institution."

- Include space and secure funding to include a computer lab for linking to community resources and engaging in housing and employment searches.

**Residential Facility Clinical Programming and Special Population Focus**

The literature review did not point to any specific models of residential care that have been shown to produce "superior" outcomes. However, the literature does point to several key components that have been shown to improve outcomes. This information along with the needs and recommendations identified by consumers, key stakeholders, and national experts point to several key components to be included in a recovery-focused, integrated residential treatment program.

| Key Component | Evidence-based Practices & Strategies to Consider |
|---|---|
| Individualized Treatment & Treatment Matching | • Ensure a comprehensive, global assessment is provided and match treatment services accordingly; continue to assess needs over time and adjust treatment plan accordingly<br>• Use of ASAM criteria to determine level of placement<br>• Flexible funding to support individualized services |
| Evidence-Based Psychosocial Therapies | • Offer a menu of evidence-based practices (e.g. Motivational Interviewing, Contingency Management, CBT)<br>• Consider the use of Community Reinforcement Approach to strengthen linkages with the community<br>• Increase emphasis on programming to address family issues, co-occurring disorders, & trauma |
| Medication-Assisted Treatment (MAT) | • Provide access to MAT for individuals with alcohol and opioid disorders during residential treatment and align policy and resources to allow for continuation of the medication in continuing care |
| Integrated treatment to address mental and physical health needs | • Use of a "Dual Diagnosis Capability" instrument to ensure all new residential programs are at least dual diagnosis capable and for programs designated as co-occurring meet standards for full integration<br>• Consider health care integration models to ensure physical health needs are addressed during residential care<br>• Trauma-informed services with trauma EBPs offered either in the program or through collaboration with MH agencies |
| Recovery Support Services | • Consider adding a case management/recovery coaching component to the program that will serve to initially engage clients, remain in contact with them during residential treatment, and work with them in the continuing care phase of the treatment continuum to enhance linkage with recovery supports<br>• Build strong collaborations with the recovery community and design "reach-in" services to enhance linkage with mutual support groups |

| | |
|---|---|
| | • Build in a phase of treatment that is focused on linking patients with recovery support services (housing, employment, peer support, transportation) |
| Continuing Care and Post Treatment Monitoring | • Consider new models of continuing care (recovery check-ups, telephone-based continuing care)<br>• Offer intensive case management<br>• Look at models of on-going monitoring and care that are based in primary care clinics<br>• When possible, locate responsibility for continuing care services with the residential treatment center for continuity of care |

**Special Population Residential Services**

The other consideration around programming is responding to the need for special population residential services. Consumers and key stakeholders interviewed for this report identified several special populations for which they would like to see specific residential treatment services designed:

- Woman and children
- Individuals with traumatic brain injury
- Veterans
- ITA population (semi-secure unit)
- Two co-occurring disorder treatment
    - One for individuals with high severity mental illness
    - One for individuals with lower severity mental illness

So one possible avenue is to design several "special population" treatment facilities across the region. However, this type of approach has the potential to interfere with the number of individuals receiving treatment services in his or her own community, as these would need to be placed across the region.

**Alternative Models of Care**

One final and important consideration to keep in mind in planning new services and facilities, is the trend in the SUD field towards using models of care that use high intensity levels of services (detoxification and/or residential treatment) for very brief episodes of care (1-2 weeks, or less) to establish initial sobriety and stability. The lengths of stay are often just long enough to manage withdrawal symptoms and help patients secure some type of supportive or recovery housing (if needed). Once the person has safe and stable housing they are enrolled in Intensive Outpatient Treatment or Outpatient services (to include services for co-occurring disorders on-site or in collaboration with other service providers) often along with intensive case management services/recovery coaching This model has the advantage of helping individuals learn how to cope with day to day stressors within their natural environment and address long-term needs around establishing and building a healthy and meaningful life in the community. This is a model that is embedded in various degrees in all of the Model Programs described in Section IV of this document.

The advantage of this model is a decrease in the use of high intensity services, however, this model is only possible if there is sufficient supportive housing and recovery supports available. So one

consideration going forward is to also look at potential opportunities to collaborate with the housing authorities and identify initiatives to increase the availability of supportive housing options. If supportive housing becomes more readily available in the Region, this type of model may be one strategy to decrease the demand for residential treatment beds and could impact the total number of beds needed.

**Next Steps**

Given all of this information, what are the next steps in the process of transitioning behavioral health services from the North Cascades Gateway Center? There seems to be three key next steps/activities to consider at this point:

1) Synthesizing this information with the population needs assessment Slalom Consulting is conducting to identify the exact number of adult residential beds needed in the North Sound Region. Slalom is scheduled to complete the Population Needs Assessment by May.
2) Collaborating with county and tribal leaders and community stakeholders to determine individual county/tribal needs, resources, and interest in collaborating on placement of one of the residential treatment facilities in their respective communities. The five counties in the region are currently doing an inventory of resources and assessing residential treatment needs and are planning to have this information available in later April or early May.
3) Meeting with State, Regional, and local leaders and key stakeholders to determine the level of interest in using this opportunity as the impetus for initiating a full ROSC transformation effort.

Once these three activities have been completed it seems like the next major step in the process is to bring together key stakeholders across the Region and share several potential options for moving forward. A regional community forum or some other type of participatory process is important to provide key stakeholders across the region (this includes consumers and their families) with additional opportunities to inform the details of a final plan such as:

- Location of the facilities
- Initiatives to strengthen the system of care
- Population and clinical focus of the new facilities
- Consideration of new models of care that include recovery housing along with strong community supports.

Another goal of this meeting would be to identify a process for on-going collaboration and coordination across the Region to inform the development of a formalized “transition plan”. The plan will include a request to the legislature for funds to support the transitioning of behavioral services into new community-based facilities.

# Glossary of Key Terms

**Behavioral Health (BH)** – refers to mental/emotional well-being and/or actions that affect wellness. Behavioral health problems include substance use disorders; alcohol and drug addiction; and serious psychological distress, suicide, and mental disorders. Problems that range from unhealthy stress or subclinical conditions to diagnosable and treatable diseases such as serious mental illnesses and substance use disorders are included. These illnesses and disorders are often chronic in nature but people can and do recover from them with the help of a variety of interventions, including medical and psychosocial treatments, self-help, and mutual aid. The phrase "behavioral health" is also used to describe service systems that encompass prevention and promotion of emotional health; prevention of mental and substance use disorders, substance use, and related problems; treatments and services for mental and substance use disorders; and recovery support (SAMHSA, 2013).

**Continuing Care** – refers to the on-going care and treatment interventions provided to individuals after an initial "intensive" treatment episode, such as residential treatment (McKay, 2009).

**Continuum of Care** – refers to a treatment system in which clients enter treatment at a level appropriate to their needs and then step up to more intense treatment or down to less intense treatment as needed (SAMHSA, 2006).

**Co-occurring Disorder** – The coexistence of both a mental health and a substance use disorder is referred to as co-occurring disorders (SAMHSA, 2015).

**Detoxification Services** – Detoxification refers to the process of removing toxins from the body, readjusting normal functions to the absence of the drug. Detoxification services are designed to assist individuals with the detoxification process and manage withdrawals symptoms; these services may be offered at several different levels of care (outpatient, residential treatment, medical detox facility) (CSAT, 2006).

**Dual Diagnosis Capability in Addiction Treatment** (DDCAT) - The Dual Diagnosis Capability in Addiction Treatment is a fidelity tool designed to measure the level of integration of mental health and substance use disorder treatment services in addiction treatment settings (McGovern et al, 2010).

**Evaluation and Treatment Centers (ENT)** – This is an inpatient (usually 16-beds) facility to provide treatment for mentally ill adults under 72-hour involuntary detention and/or 14-day commitment in accordance with Washington State Involuntary Treatment Act RCW 71.05.

**Evidence-based Practices (EPPs)** - Interventions that show consistent scientific evidence of improving client outcomes.

**Federally Qualified Health Centers (FQHC)** – refers to outpatient health clinics that qualify for specific reimbursement systems under Medicare and Medicaid. Serve underserved areas or population.

**Health Care Integration** -The systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs (SAMHSA/HRSA, 2016).

**Integrated care/treatment –** is when healthcare professionals (both primary care and behavioral health) work together to consider all of the patient's healthcare conditions at the same time and provide comprehensive, whole-person care (ABHW, 2015).

**Intensive Case Management (ICM)** – is designed for people with multiple needs who often have chronic long-term mental, physical, and/or substance use disorders. ICM typically includes the coordination of services and linking people with resources (McKay, 2009, McLellan, 1999)

**Institute on Mental Diseases (IMD) Exclusion** - The federal government currently denies Medicaid reimbursement for persons otherwise Medicaid eligible who are over 21 and under 65 years of age if such persons reside in facilities designated as "Institutions for Mental Diseases" (IMDs). State hospitals, nursing homes, and residential facilities of 16 or more beds may be classified as IMDs if they provide specialized "mental illness" services, have over 50 percent of their patients diagnosed as "mentally ill," or meet certain other criteria (Rosenbaum et al, 2002).

**Involuntary Treatment (ITA)** – Involuntary treatment provides a secure, long-term residential treatment program for chronic chemically dependent (SUD) individuals who present a likelihood of serious harm to themselves or others or are gravely disabled by alcohol or drug addiction. After investigation and evaluation of specific facts, a designated chemical dependency specialist may file a petition for commitment of the individual with the superior/district/or other court (DBHR, 2015)

**Levels of Care for Substance Use Disorder Treatment –** Treatment for substance use disorders is delivered at varying levels of care in many different settings. The American Society of Addiction Medicine (ASAM) has developed guidelines for determining the appropriate intensity and length of treatment for individuals with substance use disorders, based on assessment involving six areas: 1) level of intoxication and potential for withdrawal; 2) presence of other medical conditions; 3) presence of other emotional, behavioral, or cognitive conditions; 4) readiness or motivation to change; 5) risk of relapse or continued drug use; 6) recovery environment. The most common settings/levels of care are Outpatient/Intensive Outpatient, Partial Hospitalization, and Residential/Inpatient (MeLee, 2013)

**Medication Assisted Treatment (MAT)** - Medication-assisted treatment (MAT), including opioid treatment programs (OTPs), combines behavioral therapy and medications to treat substance use disorders. There are several medications approved for the treatment of alcohol use and opioid use disorders (SAMHSA, 2016).

**Oxford House** - Oxford House describes a democratically run, self-supporting and drug free, recovery home. The number of residents in a house may range from six to fifteen. Oxford Houses (like other recovery housing) provide a safe and stable living environment and promote recovery from alcohol and other drugs (NARR, 2012)

**Peer Provider** - A peer provider (e.g., certified peer specialist, peer support specialist, recovery coach) is a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency (SAMHSA/HRSA, 2016)

**Recovery** - 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, 2012)

**Recovery Capital** - Recovery capital refers to the resources (both external and internal) that a person has to support his/her recovery. (Grandfield & Cloud, 1999).

**Recovery Management** - A philosophical framework for organizing addiction treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance and quality-of-life enhancement for individuals and families affected by severe substance use disorders (White, 2008).

**Recovery Oriented Systems of Care** - A coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems (SAMSHA, 2010).

**Recovery Support Services** - Recovery support services are non-clinical services that are used with treatment to support individuals in their recovery goals. These services are often provided by peers, or others who are already in recovery. Recovery support can include: Transportation to and from treatment and recovery-oriented activities; employment or educational supports, recovery housing, peer-to-peer services, mentoring, coaching, spiritual and faith-based support, parenting education, self-help and support groups, outreach and engagement, staffing drop in centers, clubhouses, respite/crisis services, or warm lines (peer-run listening lines staffed by people in recovery themselves), education about strategies to promote wellness and recovery (SAMHSA, 2016).

**Stepped-care** - a person receives services at the lowest level of intensity possible (given the person's needs and resources) and then the level of care is adjusted based on progress and or emerging needs (McKay, 2009).

**Substance Use Disorders (SUD)** – A substance use disorder refers to a pattern of using alcohol or other drugs in a way that interferes with daily life or causes significant impairment and distress. The DSM-V identifies 11 criteria related to having a substance use disorder and severity levels range from mild, moderate, to severe depending on the number of symptoms an individual is experiencing. (APA, 2013).

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