Houston Recovery Initiative

A Project of the Texas Department of State Health Services

September 15, 2010

Gulf Coast Addiction Technology Transfer Center

This project was supported by the Texas Department of State Health Services (DSHS) with funding from the Social Services Block Grant of the US Department of Health and Human Services (DHHS). The contents of this report are solely the responsibility of the authors and do not necessarily represent the views of DSHS or the DHHS.

Gulf Coast Addiction Technology Transfer Center
University of Texas at Austin
1717 W. 6th Street, Suite 335
Austin, Texas, September 15, 2010

Table of Contents

PURPOSE AND GOALS: 4

PROCESS: 4

HOUSTON RECOVERY INITIATIVE 6

PARTICIPANTS: 6

Conveners: 6

Workgroup Members: 7

Advisors and Facilitators: 8

PROJECT SUMMARY 10

Overall Needs and Gaps 10

SERVICE GAPS 10

OTHER PROBLEMS 10

Overall Recommendations 11

Treatment 11

Treatment policies and procedures 11

Recovery Support Services 11

Peer Recovery Support 12

Training and Education 12

SIX PRIORITIES 13

1. CUSTOMERS ON ADVISORY BOARDS AND CONSUMER COUNCILS 13

2. PEER SUPPORT CONTACT WHILE WAITING FOR TREATMENT 13

3. HOUSING 14

4. RECOVERY COMMUNITY CENTERS 14

5. 12-STEP COMMUNITY INVOLVEMENT 14

6. EDUCATION ON THE “CHRONIC CARE MODEL” 15

NEXT STEPS 16

APPENDICES 17

PURPOSE AND GOALS:

The purpose of the Houston Recovery Initiative (HRI) project was to begin development of a Recovery Oriented System of Care (ROSC) model for Houston and surrounding areas.

Initial goals were to:

1) Establish linkages with community members to enlist them in a planning process for implementation of a ROSC in Houston.

2) Develop an implementation plan to include Recovery Support Services and Peer recovery coaching.

3) Submit a report to DSHS outlining an implementation plan which will include recovery support services and peer recovery coaching to enhance the continuum of substance abuse recovery care.

PROCESS:

The primary strategy underlying the process of this project was to engage key stakeholders in the Houston area to become workgroup members and leaders for development of the initiative. This strategy was intended to give stakeholders ownership and thereby to facilitate their commitment to the continued development and implementation of the initiative beyond the initial phase.

Phases

There are three phases envisioned for the Houston Recovery Initiative (see Phases in the appendix)

The initial phase which is covered by this report consists primarily of Consensus Building activities. The recruitment of key stakeholders to be workgroup members and leaders addressed the first three strategies of:

1) Stakeholder Involvement,
2) Developing Consensus on Recovery Roadblocks and Service Gaps, and
3) Developing Consensus on New Directions Needed.

Substantial accomplishments have been achieved in each of these three areas through workgroup formation, development of initial reports of problems and gaps, and development of recommendations for new directions. As evidenced in the major stakeholder conference conducted on July 30, 2010, the project has reached a major milestone of achieving initial community consensus for launching a broad-based effort for implementation of HRI. This has prepared initiative members to begin the work of the next phase (Phase II) of implementation which will involve specific planning and organizing for change. Phase III will address long term challenges for addressing other community barriers to recovery such as stigma, mobilizing training and technical assistance resources for recovery, and evaluating and adding supports for implementation.

Meetings

After a series of planning conversations among the Texas Department of State Health Services (DSHS), the Gulf Coast Addiction Technology Transfer Center (GCATTC) at the University of Texas, and the

Council on Alcohol and Drugs Houston (CADH), interagency agreements were completed, an overall strategy was developed, and the following meetings were convened to initiate the HRI process.
May 10, 2010. Following a meeting between CADH and GCATTC, community leaders in five areas of activity were identified and invited to attend a kickoff planning session to be convened at the offices of CADH where all HRI meetings were subsequently held. One hundred percent of the 23 leaders and speakers invited to the initial meeting attended and agreed to participate in the initiative. Resource people were in attendance including Ben Bass of El Paso and Doug Denton of Dallas. State officials from DSHS were present as well as GCATTC personnel. At this meeting, the participants were asked to select one or more workgroups to meet with in break-out sessions. Each of the breakout groups selected a chair person and a recorder. They were asked to engage in an initial discussion of challenges and new directions needed in each area. They agreed to conduct their own work sessions and selected their first separate meeting dates to be conducted before the next general meeting. The five workgroups were Treatment, Recovery Support Services, Peer Recovery Coaches, Customer Voice, and Public Policy.

May 21, 2010. During the second planning meeting, each of the workgroups reported on its progress in identifying challenges and recommended new directions. There was extensive discussion across groups and additional clarification was developed about the nature and purpose of their groups as well as the similarities and overlap among the topics covered in each workgroup.

June 4, 2010. In the third meeting, a special guest, Dr. Thomas Kirk, made a presentation and led the group in an extensive discussion about how to work toward a Recovery Oriented System of Care (ROSC). Dr. Kirk is the former state director of mental health and substance abuse services in Connecticut and one of the national leaders in developing and implementing ROSC programs and policies at a state level. Workgroup chairs then reported on their progress and solicited reactions and advice from Dr. Kirk. Initial planning steps were discussed in preparation for a large stakeholder meeting scheduled at the end of July.

June 18, 2010. The fourth planning meeting continued in the pattern of the first three, with workgroup chairs reporting on their discussions and exchanging views among the participants on each topic reported. Plans for the stakeholder meeting were discussed, including selection of invitees, program presenters and development of a program flyer.

July 9, 2010. The fifth planning meeting continued the work of reporting and discussion of the identified challenges and recommended new directions. Thirty seven participants attended this meeting. A guest speaker, Michaelanne Hurst, Executive Director of “Communities for Recovery”, made a presentation on her program, a peer recovery coach support program headquartered in Austin. Extensive discussion followed about the feasibility of replicating this model in the Houston area. The group moved to the auditorium where the stakeholder conference was to be held for a lengthy discussion of the planned conference agenda and the delivery of final workgroup reports at that meeting.

July 30, 2010. The HRI stakeholder conference was convened as planned and over 100 people actively participated. Speakers from Philadelphia, Detroit, Chicago, and Louisiana provided a national perspective on how ROSC programs have been implemented elsewhere in the country. Communities for Recovery made a lunch presentation of its program. The workgroup chairs presented on their assessments of the recovery system problems and needs in Houston as well as recommendations for change. The speakers and audience members provided feedback and asked clarifying questions of the workgroup members, and there was an active exchange among the attendees. There were active discussions before and after the meeting as well as during the working lunch among the stakeholders in

attendance, and it was reported that enthusiasm was high for supporting the initiative. Evaluations reported a high level of participation satisfaction with the meeting and a many participants signed up for future continued work to support the initiative.

August 20, 2010. A follow-up meeting was convened to debrief participants from the stakeholder conference and to provide feedback from the delegation of 8 participants who were sent to a national team development program for Recovery Oriented Systems of Care (ROSC) in Tampa, Florida. Prior to this meeting, a preliminary report of the HRI initiative including 33 recommendations for action was distributed to the members. The recommendations documents was were enlarged as posters and hung around the room for the participants to "vote" on the most important issues, and those actions which were the most urgent. See the section in this report which describes the six most important and urgent recommendations.

HOUSTON RECOVERY INITIATIVE
PARTICIPANTS:

Conveners:

The following persons convened and facilitated the meetings or represented DSHS at meetings:

Leonard Kincaid – Chair, HRI
Chief Government Relations Officer
The Council on Alcohol and Drugs Houston

Richard Spence, PhD, ACSW
Research Professor and Director
Addiction Research Institute and Gulf Coast Addiction Technology Transfer Center (GCATTC)
University of Texas at Austin

Laurel Mangrum, PhD
Research Scientist
Addiction Research Institute
University of Texas at Austin

Philander Moore, Sr., MAHS, LCDC
Unit Manager, SA Services Unit
Mental Health and Substance Abuse Division
Texas Department of State Health Services

Workgroup Members:

The following persons participated as workgroup members during the initial three months of the project:

TREATMENT AND RECOVERY SUPPORT RESOURCES WORKGROUP
Kay Austin*, Santa Maria Hostel
Regina Hasan, Unlimited Visions Aftercare
Marilyn Jones, Unlimited Visions Aftercare
Michael Robinson, Riverside General Hospital
Jeff Berry, Career and Recovery Resources
Mary Bushner, Volunteers of America
Nadine Scamp, Volunteers of America
Rupa Shukla, The Council on Alcohol and Drugs Houston

Peer Support Workgroup
Dillon West*, Winner Circle Recovery Coach Academy
Laura Czepiel, DSHS
Ben Bass, El Paso Alliance
Maxine Young, AIDS Foundation Houston

Customer Workgroup
Mary Covington*, STAR Drug Court & Veterans' Court Programs
Sandy Olson, Coalition of Behavioral Health Services
Regina Hasan, Unlimited Visions Aftercare
Laura Czepiel, DSHS
Kerby Stewart, MD, DSHS
Ben Bass, El Paso Alliance
Debbie Drake, Santa Maria Hostel

Public Policy Workgroup
Janis Bane*, Sam Houston State University
Sandy Olson*, Coalition of Behavioral Health Services
Debbie Drake, Santa Maria Hostel
Ray Andrews, Houston Crackdown

*Workgroup Chair or Co-Chair

Advisors and Facilitators:

The following resource people provided assistance as resource people or presenters:

Lonnetta Albright, BS Ed
Executive Director
Great Lakes Addiction Technology Transfer Center (GLATTC)
University of Illinois at Chicago-Jane Addams College of Social Work

John. R. Rocco
Certified Peer Specialist
NorthEast Treatment Centers

Luke Bergmann, PhD
Director of Recovery Systems
Department of Health and Mental Hygiene
New York City

C. Joseph Schultz, M Ed
Director of Pennsylvania Behavioral Health Services
NorthEast Treatment Centers

Thomas Kirk, PhD
Former State Agency Commissioner
Connecticut State Department of Mental Health and Addiction Disorders

Michael Duffy, RN, BSN, CD
Consultant
Former State Agency Director
Louisiana Office for Addictive Disorders

Ben Bass
Director, Recovery Alliance
El Paso, Texas

Douglas Denton, MA, LCDC, LCCA, ADS
Director, Homeward Bound
Dallas, Texas

Michaelanne Hurst
Executive Director
Communities for Recovery

Laurel Mangrum, PhD
Research Scientist
Addiction Research Institute
University of Texas at Austin

Richard Spence, PhD, ACSW,
Research Professor and Director
Addiction Research Institute and Gulf Coast Addiction Technology Transfer Center (GCATTC)
University of Texas at Austin

Kerby Stewart, MD
Clinical Coordinator, SA Services Unit
Mental Health and Substance Abuse Division
Texas Department of State Health Services

Laura Czepiel, **LCDC, CPS, CCJP**
Program Specialist, SA Program Unit
Substance Abuse Services Unit
Texas Department of State Health Services

PROJECT SUMMARY

Overall Needs and Gaps

Based on workgroup meetings and input during the stakeholder conference, as well as from other suggestions, comments, and recommendations received, the following needs and recommendations were identified:

SERVICE GAPS

1. Aftercare needed
2. Supportive Housing needed
3. Other Recovery Support activities and services are needed
    a. In-house 12-Step Recovery Meetings
    b. Outside 12-Step Recovery Meetings
    c. Alumni Groups and follow-up recovery checkups after treatment
    d. Fellowship areas in treatment programs for clients to meet with sponsors
    e. Community organizations with donated space for recovery groups and other recovery functions
    f. Transportation
    g. Intensive efforts to keep women engaged

OTHER PROBLEMS

1. Paperwork burden creates a barrier to client engagement
2. Barriers for persons in achieving and maintaining recovery include:
    a. Safe / Sober Housing
    b. Stable employment
    c. Transportation
    d. Childcare
    e. Limited mental health services
    f. Complicated and/or misleading eligibility requirements
    g. Waiting lists
    h. Outdated resource guides
    i. Lack of sober activities
    j. Lack of knowledge about addiction and recovery within the medical community
    k. Complicated and/or misleading eligibility requirements
3. Cumbersome intake processes and confusing eligibility rules
4. Workforce Deficits
    a. Insufficient number of available clinicians
    b. Need for a larger number of competent clinicians and clinicians who are sensitive to addiction and recovery
5. Regulatory Obstacles
    a. Limited volunteer involvement after treatment
    b. Restricted eligibility for workers who have criminal histories
6. Need for a Recovery Support Manual to guide use of peer specialists and recovery support services

Overall Recommendations

Please note the following indicators of high priority as designated during the August 20 meeting following the stakeholder conference.

** The most IMPORTANT recommendations*

*** The most URGENT recommendations. These should be addressed first.*

Treatment -- The following service gaps should be addressed:

1. Lack of aftercare services *
2. Lack of direct services to family members
3. Lack of sufficient alternatives to jail for offenders with substance use disorders

Treatment policies and procedures --The following procedures should be implemented:

4. Search for solutions for paperwork burden which creates barriers to engagement and recovery.
5. Encourage clinicians and all others we work with to use Recovery-Friendly Language including: *Recovery planning, recovery capital, patient-directed services,* and *empowerment.**
6. Treatment programs should seek customer input on their policies for re-admissions and use of peer recovery volunteers.
7. Treatment programs should conduct periodic "walk-throughs" to help see services through a client's perspective.
8. Treatment programs should include customers on advisory boards and in evaluation activities to ensure the voice of recovery is considered in program decisions. **
9. A Customer Council should be formed of persons receiving treatment in Houston.
10. Programs should implement recovery-oriented procedure changes before and after treatment including:
    - Supportive peer contacts while on waiting lists **
    - In-House 12-Step Recovery Meetings
    - Facilitate attendance in Outside 12-Step Recovery Meetings
    - Bridge groups and Alumni groups to help transition out of treatment
    - Assistance at discharge in connecting with alumni groups, and 12-Step groups
    - Recovery checkups following discharge
11. Treatment programs should seek out new linkages and maintain existing ones in order to enhance access to recovery support resources.

Recovery Support Services -- The following actions should be undertaken:

12. An online recovery support service directory should be developed to facilitate quick, accurate, information and referrals for persons in recovery. This is in progress by CADH.
13. Housing should receive priority attention with emphasis on the following populations: **
    - Transitional Housing Programs
    - Aftercare Programs for Veterans
    - Re-entry Programs for Offenders
    - Transitional Housing Programs Women and Children
    - Housing Programs for Persons Living with HIV/AIDS
    - DARS Programs for Substance-Abusing Clients
    - Persons with co-occurring psychiatric disorders
14. Provide employment assistance and vocational training

15. Provide transportation and childcare assistance to enable persons to complete treatment and transition to independent living. *
16. Develop an active sober recreational and social community similar to Phoenix Multisport. Expand support for the "Houston Sober Recreation Committee."
17. Establish recovery community centers. **
18. Increase usage of online resources for recovery support.
19. Provide support for volunteer and paid peer coaches. Volunteerism can be an important part of an individual's recovery plan and can be a key to the public support of the program. *

Peer Recovery Support -- The following actions should be undertaken to support peer workers:

20. A community education and professional training effort should be developed to inform the community that peer coaches are different from sponsors and counselors, and that they may be either volunteers or paid workers without violating AA traditions. *
21. Peer recovery workers should receive organizational assistance for better linkage with 12-Step and faith-based groups, as well as for treatment linkages, training, and peer guidance.
22. The large 12-Step community in Houston needs to be enlisted to support and partner with this movement so that they are a positive resource instead of a source of conflict. **
23. Review and revise regulations to facilitate and encourage volunteer involvement after discharge.*
24. Review and revise regulations to ease counselor and volunteer restrictions for criminal history and allow case-by-case consideration of eligibility.
25. Treatment clients and providers should be recruited to provide input for treatment and workforce standards and regulations.
26. Develop certification procedures for Recovery Coaches.
27. Develop accreditation procedures for organizations which support and utilize recovery coaches.
28. Develop standards for peer-recovery organizations and their volunteers.
29. Develop procedures to allow peer workers to provide the following services: a) telephone-based recovery checkups, sober living houses, waiting list supportive contacts.

Training and Education -- The following initiatives need to be undertaken:

30. Educate referral agencies and criminal justice agencies and the medical community about the "Chronic Care Model" of addiction and about the use of recovery language. **
31. Conduct a community educational campaign for stigma reduction for persons in recovery. *
32. Expand training and support activities for peer recovery coaches.
33. Implement an ongoing program of training for professional development of treatment personnel in the principles and practices of recovery oriented systems of care. *

** The most IMPORTANT recommendations*

*** The most URGENT recommendations. These should be addressed first.*

SIX PRIORITIES

Out of the 33 recommendations developed by the HRI initiative during phase 1 of the ROSC development process as itemized above, consensus of the group was reached during the August 20, 2010 meeting that these six strategies should be given top priority for immediate action. These six are not the only recommendations requiring implementation; in fact, there was very broad support for almost every recommendation. However, in the group process, members were only given a limited number of votes to arrive at the top priorities. Please see the attachment for a full tally of importance and urgency ratings.

1. CUSTOMERS ON ADVISORY BOARDS AND CONSUMER COUNCILS

Treatment programs will include customers on advisory boards and in evaluation activities to ensure the voice of recovery is considered in program decisions. **

This recommended action received strong support as one of the most important and also most urgent of all the topics discussed and reported by the group. Although several treatment programs and other organizations represented in the initiative already have persons in recovery on their boards, it is not a widespread practice. Another mechanism of consumer input is a separate consumer council comprised of persons currently in treatment. A consumer council for every major treatment program was strongly recommended by the panel of experts in the stakeholder conference conducted on July 30, 2010. The Consumer Council in Philadelphia was presented as an example and a handout of its policies and procedures was distributed. Obstacles anticipated include administrative resistance and apprehension about loss of control over policies and program direction. No additional funding would be needed in order to implement this recommendation.

Initial steps: Establish communication among current treatment programs about readiness for these changes and seek practical advice about initial steps from colleagues who have already implemented this practice.

2. PEER SUPPORT CONTACT WHILE WAITING FOR TREATMENT

Supportive peer contacts will be provided to those seeking care while on waiting lists. **

This practice was also picked as one of the most important actions that could be undertaken immediately. The need involved in this recommendation is that persons on wait lists are often in a crisis mode and need practical advice and support to deal with their immediate situation. Peer recovery workers may be able to support and assist them to maintain their readiness and ability to enter treatment. Often by the time a vacancy appears, they are no longer able or available to take advantage of the opportunity. This may be able to be implemented without extensive new funding if peer volunteers are used. However, funding would be needed to provide training, support, and supervision of the peer workers.

Initial steps:
Procedures may be developed for asking persons on waiting lists if they would like to be in contact with a peer coach, making arrangements for the contact, monitoring the contacts, and the training and supervision of the peer contacts.

3. HOUSING

Housing will receive priority attention with emphasis on underserved populations. **

A strong consensus was also reached for the importance of a focus on housing issues. Housing issues are a recurrent theme within other areas of identified need for a Recovery Oriented System of Care. There are several populations whose recovery is challenged by a lack of short-term housing assistance. Their ability to attain and maintain recovery is hampered by several challenges which are escalated by lack of a recovery-supportive living environment. These groups include:
Transitional housing and sober living houses
Aftercare programs for veterans
Transitional housing for women and children
Persons living with HIV/AIDS
DARS clients with substance use disorders
Persons with co-occurring psychiatric disorders

Initial steps:
Compile an improved, user friendly housing resource guide to facilitate better knowledge and access to existing housing resources. Convene a special meeting of agencies which may be able to contribute to problem-solving and planning ahead for future funding plans and proposals to appropriate federal agencies for help.

Outcomes and possibilities: The Department of State Health Services has initiated renewed support for initiation of "Oxford Houses" in various locations in the state. These facilities are self-governed and self-supported sober housing programs for persons who are in recovery.

4. RECOVERY COMMUNITY CENTERS

Establish Recovery Community Centers. **

This recommendation involves the establishment of community facilities which would assist in developing and supporting an improved recovery environment. Such facilities could provide locations for 12-step meetings, venues to meet with recovery coaches or sponsors, opportunities for sober recreational activities, vocational and educational classes, and so forth. These centers could provide alternatives for persons whose normal social environment is not recovery-friendly.

Initial steps:
Meet with directors of City of Houston Multi-Service Centers to discuss possibility of scheduling utilization for recovery meetings and classes.

5. 12-STEP COMMUNITY INVOLVEMENT

The large 12-Step community in Houston will be welcomed to enlist its support and partnership with this movement so that it is a positive and active resource. **

There is a consensus among HRI members that it is important to integrate the HRI initiative with the broader recovery community in Houston. Although the HRI has significant representation from Alcoholics Anonymous chapters and other 12-Step groups in Houston and surrounding communities,

there is no formal representation or communication. It is strongly desired that the HRI is seen as a mutually supportive effort with them that builds on the good will and the recovery environment nurtured by AA in Houston.

Initial steps: Convene a meeting of 12-Step representatives to brief them on the purpose and goals of the HRI and the initiatives we hope to accomplish in Houston, and to enlist them to form partnerships to help advance our recommendations in various venues including public education, agency changes, and public policy initiatives.

6. EDUCATION ON THE "CHRONIC CARE MODEL"

Referral agencies and criminal justice agencies and the medical community will be educated about the "Chronic Care Model" of addiction, and about the use of recovery language. **

Educational recommendations received broad support by the HRI members. The largest and most immediate challenge is to infuse the chronic care model of care into the way social service agencies and medical personnel think about addiction and the way they talk about addiction and recovery. Adoption of chronic care language is a critical first step in changing the way services are planned and delivered, and in improving the recovery environment of the entire community. Also, using the "people first" language to identify "people with a substance use disorder" instead using the term "addicts" can help reinforce the chronic care concept.

Initial steps:
It is appreciated that the substance use disorder treatment community needs to take the first step in modeling the use of these terms consistently when we talk among ourselves about who patients are, what treatment is, and how treatment is related to recovery. We also need to use chronic care concepts when talking with referral agencies, criminal justice agencies, and medical personnel. This will introduce the concept in the way we communicate and will force them to learn and consider what we are talking about.

NEXT STEPS

1. DSHS Committees should be formed in order to:

a. Review possible mechanisms of future funding to meet current service gaps

b. Review funding obstacles for services to family members

c. Review procedures for initiating the process for consideration of regulatory changes regarding limitation of volunteer involvement following treatment in the same facility, and ineligibility of paid or volunteer workers due to criminal history

2. Houston Groups should be formed:

a. Houston Recovery Initiative -- Implementation Group
This expanded group is formed to organize and support implementation of ROSC. Meetings will initially focus on the six priority areas.

b. Consumer Council
This is an organization of persons who are current or recent patients in SUD treatment

c. Peer Recovery Organization
The purpose of this group is to support persons in recovery who are coaching others in recovery.

SPECIAL NOTE: Youth populations need to be the focus of the next phase of development of a ROSC system in Houston. The initial phase of HRI was limited to adult populations; the initiative now needs to expand to youth.

APPENDICES

A. Phases of Change

B. HRI in a Nutshell

C. Workgroup Reports

D. Conference Flyer

E. Conference Agenda

F. Conference VIPs

G. Workgroup PowerPoint Presentations

H. Recommendation Priority Tabulation

I. Accomplishments To Date

J. Group Photograph – July 9, 2010 Meeting

Phases of the Houston Recovery Initiative

Phase I (NOW) Consensus Building	Phase II (NEXT) Planning and Organizing for Change	Phase III (LONG TERM) Implementing and Sustaining Systemic Change
1. Stakeholder Involvement	4. Develop Guidelines for needed changes. Develop stakeholder network to promote and support transformation	7. Address Stigma and other recovery barriers in the community
2. Consensus on Recovery Roadblocks and Service Gaps	5. Assess Agency Capacity and Readiness for Changes	8. Training and Technical Assistance for Technology Transfer
3. Consensus on New Directions needed	6. Preparation, including policy, funding, and regulatory planning.	9.Monitoring Outcomes and Supporting Implementation

(HRI In a Nutshell)

The Houston Recovery Initiative (HRI)

is an effort to work toward a Recovery Oriented System of Care for those in our community who are affected by alcoholism and addiction.

This initiative is based on the recognition that addiction is a chronic health disorder, similar in many ways to other chronic health conditions such as diabetes or hypertension which are usually disorders of life-long duration.

Chronic disorders sometimes may require treatment for acute symptoms to resolve the immediate crisis. However, this treatment does not cure the disorder. Following the crisis, and before discharge, patients are educated about how to maintain their recovery. This requires life-long attention to health and wellness practices in order to achieve and remain symptom-free. Failure to maintain diet and health regimens will ensure recurrence of life-threatening symptoms.

Achieving and maintaining recovery from alcoholism and addiction also may require occasional treatment for acute problems, but more importantly, it requires lifelong work to maintain health and wellness in all areas of life, including 12-step peer support and family support for recovery.

Support for long-term recovery is the emphasis of this initiative. It is a paradigm shift which moves beyond thinking of treatment as the cure for addiction; treatment may help people start the process of recovery, but the work of recovery is a broader and longer term commitment. This shift requires changes in the way we think about the role of treatment, the importance of linkages with other community service agencies, and the contributions that can be made by peers-in-recovery as recovery coaches.

Treatment providers, heath agencies, customers, peer coaches and other key stakeholders in the Houston community are meeting together to develop plans to transform our existing programs and services to make them more recovery-friendly. Our hope is that our systems and actions will support long term recovery instead of merely being focused on short-term treatment as a “cure”.

WORKGROUP REPORTS:

1. *TREATMENT and RECOVERY SUPPORT Workgroup*

The members of the Treatment and Recovery Support Workgroup summarized their appraisal that: SYSTEM TRANSFORMATION is needed to move from an Acute Stabilization model -- To a Sustained Recovery model. . (See the "HRI In a Nutshell" document in the Appendix for related information)

Funding:

While being mindful that funding was not the only issue that could be considered, the issue of financing the initiative was briefly addressed. The group examined possible funding sources, which included ATR, Community Partnerships, Medicaid and private donors. The group agreed that support will be needed to assist the agencies with Recovery Coaches and Peer Support.

Policy:

Volunteers - It was also agreed that policy must agree with our mission, and clear, written guidelines should be presented by DSHS that govern the programs' relationships with discharged clients. Presently, rule §448.217(g) that addresses specific acts prohibited by the provider states, "Providers shall not enter into a personal or business relationship of any type with an individual receiving services until at least two years after the last date an individual receives services from the provider." The team acknowledged that this standard, left to individual interpretation, could be problematic.

Counselor Licensure - The group discussed counselor licensure and volunteer policies that prevent providers from utilizing the most productive members of our service community. Criminal background checks of individuals that reveal histories of nonviolent, drug-related offenses often prevent some agencies from hiring or using these applicants as volunteers. But these same individuals are able to receive employment or are able to volunteer at other social service agencies.

The discussion concluded with the question - Should consideration for qualified persons convicted of non-violent crimes be evaluated on an individual basis as opposed to being painted with a broad brush stroke and excluded based on generalized criteria?

Housing:

The group concluded its discussion by identifying ongoing recovery systems that would benefit the client after discharge from residential programs or other institutions. Programs identified that would support recovery include:

- Transitional Housing Programs
- Aftercare Programs for Veterans
- Re-entry Programs for Offenders
- Transitional Housing Programs Women and Children
- Housing Programs for Persons Living with HIV/AIDS
- DARS Programs for Substance-Abusing Clients

Other Recovery Support Services:

- There are many resources in addition to traditional treatment that may be needed for persons to sustain their recovery plan. These include medical and psychiatric, vocational, housing, and other needs.
- Funding support like "Access to Recovery (ATR)" have worked in the past. Renewal of ATR is recommended.
- Improved linkages with existing community resources can also help meet these needs.

The Treatment Provider Workgroup would like to collaborate with both the Policy and the Customer Workgroups in developing guidelines.

2. ***PEER SUPPORT Workgroup***

This is a brief draft and overview of the needs to build an effective peer recovery-based program in Houston. This draft can be modified and extended to meet the needs of the core group. Having a basic solid foundation will enable peer recovery groups to meet the needs of the recovering community as a whole.

Capacity building:

It is important for Peer Recovery Organizations to receive assistance from other established organizations in the recovery oriented systems to help develop their organizations.

Competencies and Standards:

Develop standards for peer recovery organizations and their volunteers

- Certification of Recovery Coaches
- Accreditations for organizations involved in training recovery support advocates

Treatment and Peer Recovery Partnerships:

- Ensure professionals remain involved and motivated to display genuine care and concern for the person in recovery
- Recovery Support Centers and Recovery Coaches should be separate from treatment, however they should work hand in hand
- Treatment and Peer Recovery Organizations should have clear and defined memoranda of agreements and work as a team

Including Peer Recovery Support:

- Houston has a diverse recovering community from the Twelve Step Groups to Faith-Based Organizations in which many of these have resources and volunteers that could be an asset to the Recovery Oriented System Of Care
- Meet with organizations and explain to them the concept of Recovery Oriented Systems of Care for their communities
- Invite them to become part of the process

New Service Modalities

- Telephone-based recovery support
- Sober-living houses

3. CUSTOMER Workgroup

Introduction:
The Customer Workgroup was designed to be the face of the recovery community. Initially the workgroup identified eight major groups of customers that best represented the struggles in accessing services in the Houston community. The groups include:

- Transgender
- Hepatitis / HIV infected
- Elderly
- Dual Diagnosed
- Criminal Justice Involved
- Women with Children
- Veterans
- Family members
- Homeless

The workgroup invited individuals from each customer group to attend meetings and share their experiences. The workgroup also participated in a simulated walk through at Project Life Roads to better understand the processes that those seeking services must complete to access treatment, housing and other basic needs. The following represents the workgroups findings.

Barriers to Sustained Recovery

- Waiting lists
- Sober housing
- Stable employment
- Transportation
- Lack of mental health services
- Cumbersome intake processes
- Complicated and/or misleading eligibility requirements
- Stigma
- Past trauma
- Pride / Fear
- Lack of Trust
- Cultural issues
- Childcare
- CPS
- Lack of knowledge about addiction and recovery within the medical community
- Lack of sober activities
- Out-of-date resource guides
- Anger and Resentment
- Co-dependency

Effective Programs that Support Sustained Recovery

- 12 Step meetings (AA, NA, Al-Anon, Co-Dependency, SLA, etc)
- Peer-to-peer support groups
- Trauma Recovery curriculums (i.e., Seeking Safety; Helping Women Recover)
- Step work with a sponsor
- Service work
- Co-dependency programs
- Dedicated/structured family treatment groups
- Programs that provide free testing & treatment
- Sober living facilities / complexes

New Directions

- Substance-Free Social Opportunities: The Customer Workgroup strongly supports an initiative to build a sober active community in Houston (Houston – Sober Active Community) based on the Phoenix Multisport model www.phoenixmultisport.org.
- Peer Support: Other initiatives should include peer-to-peer mentors and navigators for newcomers to recovery; on-line resource guides that utilize real time updates, and the development of sober cyber media (sober facebook, sober "hook ups", sober networks).
- Medical Education about Addiction: The workgroup also supports an initiative to educate the medical community about addiction and recovery and how medical decisions can interfere with the long term recovery process.
- Walk-throughs: The workgroup encourages agencies to include walk-through exercises in their policies and procedures. Walk-though exercises allow agencies to experience the customer's perspective on accessing services. The exercise should begin with the initial phone call requesting information and making an appointment and include the intake process, assessments, and any other requirements/processes needed to begin services.
- Customer representation: Agencies should consider including customers on advisory boards, planning activities and evaluations to ensure the voice of recovery is included in decisions.

4. PUBLIC POLICY Workgroup

The Policy Work Group was charged with two tasks. The first task was to identify challenges within the current Houston-Harris County structure of care for persons with substance use disorders which could affect the ability of a Recovery-Oriented System of Care model to work successfully. The second task was to suggest new directions that would facilitate a transformation of the current structure into a Recovery-Oriented System of Care.

System Challenges

- Our present system perpetuates stigma
- Addiction is a continuing care disorder not a one-time crisis
- Normally, one has to have a crisis to get treatment
- Public perception is that system doesn't ever work which is inaccurate
- People in recovery do not believe that they have a voice
- Current system has limited ability to offer individualized recovery support plan
- A focus on recovery moves needle toward the solution

Structure Challenges

- System-centered not person-centered (e.g., a person's Parole Officer 'prescribes' two weeks inpatient treatment) – need to work *in partnership* with other systems
- Lack of strong existing connections with all community sectors for facilitated collaboration
- Limited outreach and pre-engagement (e.g., SBIRT, etc.)
- Lack of community-wide education regarding public safety issues and stigma
- Need for workforce restructure (peer recovery coaching, etc.)
- Regulatory and funding conflicts with ROSC model – need to work in partnership with regulatory and funding entities toward successful resolution for all
- Prevention, treatment, and recovery services related to mental illness and substance use disorders are not coordinated

New Directions

- An organized, vibrant recovery community with active involvement by persons in recovery in decision-making about prevention, treatment, recovery
- Increased awareness, education, training - all community stakeholders. We should use People First language. "People First" language provides a format for describing people in ways that emphasize, "They are people, *first*." The American Psychological Association style guide states that, when identifying a person with an impairment, the person's name or pronoun should come first, and descriptions of the impairment/disability should be used so that the impairment is identified, but is not modifying the person. Improper examples are "a borderline," "a blind person," or "an autistic boy;" more acceptable terminology includes "a woman with Down syndrome" or "a man who has schizophrenia." "People First" language provides a format for describing people in ways that emphasize, "They are people, *first*."
- Ensure match between legislation and regulations with philosophy of the ROSC paradigm
- Develop innovative ways to engage persons in the recovery process through outreach and pre-engagement
- Establish recovery community centers and expand sober housing; promote alternatives to jail (e.g., proposed "Haven of Hope" model in San Antonio).
- Review and revision as needed of existing policy statements; development of new policies in support of ROSC model
    - Review current policy regarding volunteers, specifically DSHS Rule §448.217(g)
    - Develop policy statement on Recovery Language
    - Review current state funding policies to identify barriers to ROSC funding
    - Review current policy regarding counselor licensure
    - Develop policy regarding peer recovery coaches

HOUSTON RECOVERY INITIATIVE CONFERENCE

You're invited to a community meeting to create a recovery oriented system of care for persons affected by addiction

Friday, July 30, 2010

9:30 am - 3:00 pm

Check-In: 9:00 - 9:30 am

HEAR ABOUT DRAFT RECOMMENDATIONS AND HELP PLAN FOR CHANGE IN HOUSTON

- **Treatment and Recovery Support Resources**
  Improving integration of treatment with recovery resources for successful living
- **Peer Support**
  Utilizing help from others in recovery
- **Customer Voice**
  Incorporating customer perspective and evaluations
- **Public Policy**
  Identifying legal, funding, and program policies to aid recovery

HEAR FROM NATIONAL EXPERTS FROM OTHER COMMUNITIES WHICH HAVE ALREADY GONE THROUGH THIS TRANSFORMATION IN:

Connecticut
Louisiana
Detroit
Philadelphia

CONFERENCE LOCATION

The Hamill Foundation Conference Center
The Council on Alcohol and Drugs Houston
303 Jackson Hill St., Houston, TX 77007

Please contact Melissa Sawa to register for this free event by July 22, 2010, at MSawa_Temp@council-houston.org or 281-200-9339. Lunch will be provided.

thecouncilon alcoholanddrugshouston℠

United Way

HOUSTON RECOVERY INITIATIVE CONFERENCE

Planning a Recovery Oriented System of Care for our Community

Friday, July 30, 2010

9:00	Registration, Coffee	
9:15	Video on Recovery Oriented System of Care concept	
9:30	Introduction	Leonard Kincaid
	Welcome from The Council on Alcohol and Drugs Houston	Mel Taylor
	Harris County	Judge Ed Emmett
	City of Houston	Peter Messiah
	Texas Department of State Health Services	Philander Moore
9:50	Purpose and objectives of the meeting Introductions of Workgroups - Recognition of Support	Leonard Kincaid
9:55	Introduction of Panel	Richard Spence
10:00	Recovery Overview	Lonnetta Albright
10:15	<u>Panel of experts on Recovery Oriented Systems of Care</u> Luke Bergmann Joe Schultz John Rocco Michael Duffy	
11:15	Q&A from audience	
11:30	<u>Workgroup Recovery proposals for Houston</u>	Richard Spence
	Customer Workgroup	Mary Covington
	Treatment and Recovery Support Resources Workgroup	Kay Austin
	Peer Support Workgroup	Dillon West
	Public Policy Workgroup	Janis Bane
12:10	Q&A from audience	
12:30	Lunch – assignments and discussion	Richard Spence
1:00	Luncheon Presentation: Communities for Recovery: A Texas Recovery Support Organization	Michaelanne Hurst
1:15	Panel feedback/interaction with workgroups	Richard Spence Lonnetta Albright
2:15	Conclusions and charge for the future -- Speaker Panel, DSHS, Workgroup Chairs	
	Opportunity to join the Houston Recovery Initiative	Leonard Kincaid
3:00	Evaluations and Adjournment	

HOUSTON RECOVERY INITIATIVE CONFERENCE

HONORED GUESTS

Ed Emmett
Harris County Judge

Philander Moore
Department of State Health Services

Kerby Stewart, MD
Department of State Health Services

Laura Czepiel
Department of State Health Services

Mel Taylor
President and CEO
The Council on Alcohol and Drugs Houston

GUEST SPEAKERS/PANELISTS

Lonnetta Albright, BS Ed
Executive Director
Great Lakes Addiction Technology Transfer Center (GLATTC)
University of Illinois at Chicago-Jane Addams College of Social Work

John. R. Rocco
Certified Peer Specialist
NorthEast Treatment Centers

Luke Bergmann, PhD, MSW
Director of Recovery Systems
New York City Department of Health and Mental Hygiene

C. Joseph Schultz, M.Ed., Psychology
Director of Pennsylvania Behavioral Health Services
NorthEast Treatment Centers

Michael Duffy, RN, BSN, CD
Consultant, Former State Director
Louisiana Office of Addictive Disorders

Michaelanne Hurst
Executive Director
Communities for Recovery

FACILITATORS

Richard Spence, PhD, ACSW
Research Professor and Director
Addiction Research Institute and Gulf Coast Addiction Technology Transfer Center (GCATTC)
University of Texas at Austin

Laurel Mangrum, PhD
Research Scientist
Addiction Research Institute
University of Texas at Austin

Leonard Kincaid*
Chief Government Relations Officer,
The Council on Alcohol and Drugs Houston

HOUSTON RECOVERY INITIATIVE PLANNING GROUP

Treatment and Recovery Support Resources Workgroup
Kay Austin*, Santa Maria Hostel
Regina Hasan, Unlimited Visions Aftercare
Marilyn Jones, Unlimited Visions Aftercare
Michael Robinson, Riverside General Hospital
Jeff Berry, Career and Recovery Resources
Mary Bushner, Volunteers of America
Nadine Scamp, Volunteers of America
Rupa Shukla, The Council on Alcohol and Drugs Houston

Peer Support Workgroup
Dillon West*, Winner Circle Recovery Coach Academy
Laura Czepiel, DSHS
Ben Bass, El Paso Alliance
Maxine Young, AIDS Foundation Houston

Customer Workgroup
Mary Covington*, STAR Drug Court & Veterans' Court Programs
Sandy Olson, Coalition of Behavioral Health Services
Regina Hasan, Unlimited Visions Aftercare
Laura Czepiel, DSHS
Kerby Stewart, MD, DSHS
Ben Bass, El Paso Alliance
Debbie Drake, Santa Maria Hostel

Public Policy Workgroup
Janis Bane*, Sam Houston State University
Sandy Olson*, Coalition of Behavioral Health Services
Debbie Drake, Santa Maria Hostel
Ray Andrews, Houston Crackdown

Project Associates
Nancy Hayes
Melissa Sawa

***Chair or Co-Chair**

Treatment

We do a good job of *Initiating* recovery but we are challenged with the job of *Sustaining* recovery. The Treatment Work Group identified several priority areas of needed work for sustaining recovery:

1. Programmatic Elements and Funding
2. Housing
3. Policy
4. Other

1

1. Programmatic Elements and Funding

- Some programmatic changes may be implemented without additional resources. Other changes would require new funding strategies.
- Funding solutions are needed for these gaps
  - Recovery support services
  - Aftercare
  - Supportive housing

2

GAPS:

Missing Resource Elements also include:

- In-House 12-Step Recovery Meetings
- Outside 12-Step Recovery Meetings
- Alumni Groups and follow-up contacts.
- Fellowship areas for clients to meet with sponsors
- Community Organizations with donated space for groups and other recovery functions
- Transportation
- Intensive efforts to keep women engaged

3

GAPS: (cont)

RECOVERY SUPPORT RESOURCES

- There are many resources in addition to traditional treatment that may be needed for persons to sustain their recovery plan. These include medical and psychiatric, vocational, housing, and other needs.
- Funding support like "Access to Recovery (ATR)" have worked in the past. Renewal of ATR is recommended.
- Improved linkages with existing community resources can also help meet these needs

4

GAPS: (cont)

RECOVERY SUPPORT RESOURCES (cont)

Treatment programs need to continually seek out new linkages and maintain existing ones in order to enhance access

RESOURCE DIRECTORY

- An online directory should be developed to facilitate quick, accurate, information and referrals for persons in recovery.
- The *Council on Alcohol and Drugs Houston* is working on this kind of directory to improve referral and access

5

2. Housing: A Special area of Need

Recovery Housing Gaps NEEDING ATTENTION:

- Transitional Housing
- Aftercare for Veterans
- Re-Entry for Offenders
- Transitional Housing for Women and their children
- Persons living with HIV/AIDS
- Voc Rehab services for Substance-Abusing clients.

6

3. Treatment Policy (cont)

- *Paperwork Burden*

  creates a barrier to client engagement. One new possibility – networking among providers to share solutions and work-arounds.

- *Workforce:*
  - Deficits in number of available clinicians.
  - Need more competent clinicians and clinicians sensitive to addiction and recovery.

7

3. Treatment Policy

CHALLENGES (continued)

- *Regulatory Obstacles*
- *Concerns regarding boundaries and ethical issues for those providing services*
- *Need for oversight*
- *Need for a Recovery Support Manual (How To's)*

8

Treatment Policy (cont)

NEW DIRECTIONS

- Volunteers
  - Policy solutions should be sought for explicit regulatory permission for programs and volunteers to work with clients after discharge.

  The present regulation language may be a potential barrier to post-discharge services:

  "Providers shall not enter into a personal or business relationship of any type with an individual receiving services until at least two years after the last date an individual receives services from the provider"

9

Treatment Policy (cont)

- Criminal History

Policy solutions should be sought to enable case-by-case consideration of employment or volunteer services by qualified persons with criminal histories – instead of a broad-brush exclusion of many productive applicants

10

Policy (cont)

- Language Changes
  - Emphasis on "Recovery" instead of "Treatment" (for example: *Recovery Planning* and *Recovery Support*)
  - To help implement a strength-focused approach the term *"Recovery Capital"* should be used.
  - *"Patient-Centered services"* should accurately describe our system. We must obtain customer feedback on their needs.
  - *"Empowerment"* needs to be our focus, recognizing that the absence of hope is an obstacle to engagement.

11

4. Other Needed Changes

- Procedure Changes
  - Supportive Peer contacts while on waiting lists
  - Bridge Groups to help transition out of treatment
  - Alumni Groups
  - Discharge includes personal assistance in connecting with alumni groups, peer coaches, 12-step groups.
  - Recovery management checkups following discharge.

12

Other Needed Changes

- Educate referral agencies and criminal justice agencies on "recovery" and "chronic care model" language
- Treatment providers and customers should be actively engaged to solicit their input for setting standards to include provisions for:
  - Re-admissions
  - Volunteer opportunities

13

Other Needed Changes

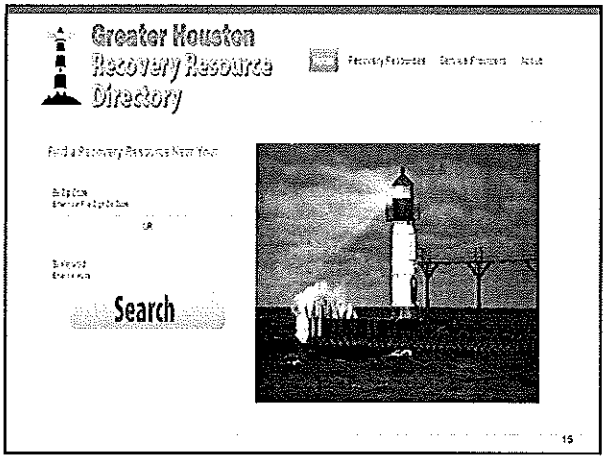
SYSTEM TRANSFORMATION is needed

To move from an Acute Stabilization model

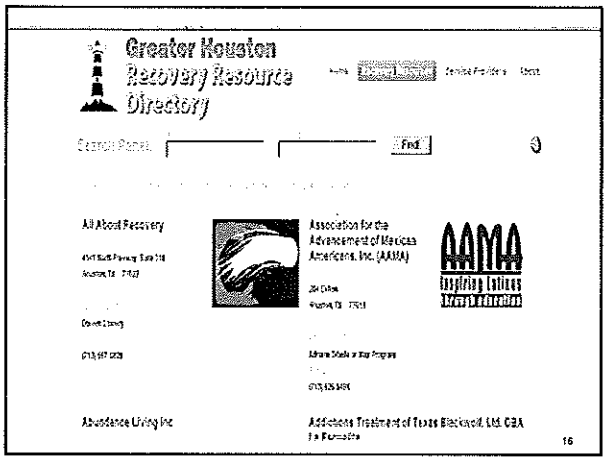
To a Sustained Recovery model

- For Sustained recovery management
- Follow-up , reassessment, and recovery support
- Continuum of care from waiting list through aftercare

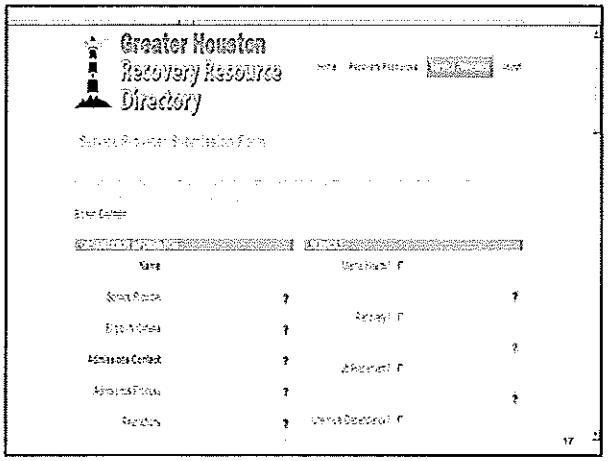
14



15



16



17

Peer Support Workgroup

Building an effective Peer Recovery organizational Base in Houston. This is important in order to enable peer recovery groups meet needs of the recovering community as a whole.

This report will combine needs and recommended future directions.

1

Capacity Building

What is a Peer Recovery Organization? And Why is it needed?

Assistance from other established organizations should be offered to help develop peer recovery organizations in Houston

2

Capacity Building (cont)

Enlisting Houston Resources

Houston has a **large and diverse recovering community** including
- 12 Step groups
- Faith-Based organizations
- Other community groups

These groups have **resources and volunteers** that could be assets in supporting ROSC implementation

3

Capacity Building (cont)

Enlisting Houston Resources

Need to Meet with these recovery supporting groups and educate about ROSC and the HRI movement

Invite them to become a part of the process in planning and sustaining long term ROSC implementation

4

Competencies and Standards

Needs:

1. Develop standards for peer recovery organizations and their volunteers.
2. Develop Certification procedures for Recovery Coaches.
3. Develop Accreditation for *organizations which train and support recovery coaches.*

5

Relationships with Treatment

Treatment Agencies and Peer Recovery Organizations should be separate, but should have memoranda of agreements and work as a team.

The roles of Peer Coaches working within peer recovery organizations, and serving treatment clients, should be covered by these agreements.

6

Future Development

Peer workers can play a role in staffing Houston service gaps to include:

- Telephone-Based recovery checkups and support
- Sober living houses
- Waiting list support

CUSTOMER VOICE

The workgroup identified eight major groups of customers that best represented the struggles in accessing services in the Houston community.

1

Partial List of Populations with Access Challenges

1) Transgender
2) Hepatitis / HIV infected
3) Elderly
4) Dual Diagnosed
5) Criminal Justice Involved
6) Women with Children
7) Veterans
8) Family members

2

Process

- Customers from each of the identified groups shared their views at work group meetings.
- Simulated walk-through of admission to a community program.

3

Barriers to Sustained Recovery

- Safe / Sober Housing
- Stable employment
- Transportation
- Childcare
- Limited mental health services
- Cumbersome intake processes

4

Barriers to Sustained Recovery

- Complicated and/or misleading eligibility requirements
- Waiting Lists
- Outdated Resource Guides
- Lack of sober activities
- Lack of knowledge about addiction and recovery within the medical community

5

Barriers to Sustained Recovery

- Trust issues
- Cultural issues
- Unresolved Trauma issues
- Stigma / Pride / Fear
- Anger & Resentment
- Co-Dependency

6

Effective Programs that Help

- 12 Step Meetings
  - AA, NA, Al-Anon, Co-Dependency, SLA, etc
- Step Work with a Sponsor
- Trauma Recovery curriculums (ie: Seeking Safety; Helping Women Recover)
- Peer to Peer Support Groups & Mentors

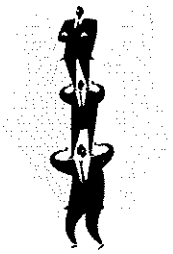
7

Effective Programs that Help

- Service Work
- Co-Dependency programs
- Dedicated/structured Family Treatment groups
- Programs that provide free testing & treatment
- Sober living facilities / complexes

8

New Directions Needed



- Build a Sober Active Community in Houston similar to Phoenix Multisport
- Provide peer to peer mentors and navigators for those new to recovery
- Educate the medical community about medical practices that obstruct or support recovery

9

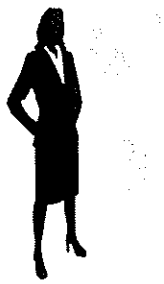
New Directions Needed

- Service agencies should conduct walkthroughs to see how it feels to be a customer.
  - Begin with a telephone call to obtain information and instructions.
  - Obtain an appointment, find out about any requirements
  - Complete the entire intake and assessment process.

10

New Directions Needed

- Online resource guides
- More use of sober cyber media resources (sober Facebook, In The Room, blogs and other sober networks)
- Agencies should consider including customers on advisory boards, in planning activities, and in conducting agency evaluations to ensure the voice of recovery is included in decisions.



11

PUBLIC POLICY

The Policy Work Group undertook two tasks:

1. To identify challenges in the current structure of care for persons with substance use disorders which may limit the ability of a Recovery-Oriented System of Care model to work successfully
2. To suggest new directions that would facilitate a transformation of the current structure into a Recovery-Oriented System of care.

1

Challenges

- Programs are often system-centered not person-centered (e.g., a person's Parole Officer 'prescribes' two weeks inpatient treatment) - need to work *in partnership* with other systems
- Lack of good linkages among community sectors
- The recovery community is not well incorporated or represented in our systems
- Limited outreach and pre-engagement (e.g., SBIRT prevention model: Screening, Brief Intervention & Referral to Treatment)

2

Challenges (cont)

- Lack of community-wide education regarding public safety issues and stigma
- Need for workforce development for peer-to-peer workers (peer recovery coaching, etc.)
- Regulatory and funding obstacles for ROSC – need to work in partnership with regulatory and funding entities to identify policy issues
- Prevention, treatment, and recovery services related to mental illness and substance use disorders are not coordinated

3

New Directions

- An organized recovery community with active involvement by persons in recovery
- Increased awareness and stigma reduction through education of community stakeholders
- Community education to use "People First" language -- Instead of " addict", preferred language is "person with a substance use disorder" or "person in recovery"

4

New Directions (cont)

- Establish recovery community centers and expand sober housing; promote alternatives to jail e.g., proposed "Haven of Hope" model
- Develop and modify policies to support ROSC
  - ~Review current policy regarding volunteers [DSHS Rule §448.217(g)], which prohibits a person in recovery from volunteering at agency in which he/she received treatment for 2 years post-treatment
  - ~Develop a policy statement on Recovery Language

5

New Directions (cont)

- ~Review current state funding policies to identify barriers to ROSC funding
- ~Develop policy regarding peer recovery coaches
- ~Review current employment/licensure rules related to hiring persons in recovery with felony conviction history
- ~Ensure match between legislation and regulations with philosophy of the ROSC paradigm

6

Results of HRI Planning Meeting August 20, 2010
Selection of Priorities for Action

	Importance Votes	Urgency Votes	Most Important	Most Urgent
Treatment --The following service gaps should be addressed:				
1. Lack of aftercare services	7		*	
2. Lack of direct services to family members	5			
3. Lack of sufficient alternatives to jail for offenders with substance use disorders.	4			
Treatment policies and procedures --The following procedures should be implemented:				
4. Search for solutions for paperwork burden which creates barriers to engagement and recovery	2			
5. Encourage clinicians and all others we work with to use Recovery Friendly Language including: *Recovery planning, recovery capital, patient-directed services,* and *empowerment.*	7	2	*	
6. Treatment programs should seek customer input on their policies for re-admissions and use of peer recovery volunteers.	0			
7. Treatment programs should conduct periodic "walk-throughs" to help see services through a clients perspective.	0			
8. Treatment programs should include customers on advisory boards and in evaluation activities to ensure the voice of recovery is considered in program decisions.	8	9	*	**
9. A Customer Council should be formed of persons receiving treatment in Houston.	4			
10. Programs should Implement recovery oriented Procedure Changes before and after treatment including	1			
Supportive peer contacts while on waiting lists.	11	11	*	**
In-House 12-Step Recovery Meetings	2			
Facilitate attendance in Outside 12-Step Recovery Meetings	0			
Bridge groups and Alumni groups to help transition out of treatment	2			
Assistance at discharge in connecting with alumni groups, and 12-step groups	1			
Recovery checkups following discharge	3			
11. Treatment programs should seek out new linkages and maintain existing ones in order to enhance access to recovery support resources.	3			
Recovery Support Services -- The following actions should be undertaken:				
12. An online recovery support service directory should be developed to facilitate quick, accurate, information and referrals for persons in recovery. This is in progress by CADH.	2	1		
13. Housing should receive priority attention with emphasis on the following populations	9	11	*	**
Transitional Housing Programs	2			
Aftercare Programs for Veterans	1			
Re-entry Programs for Offenders	1			
Transitional Housing Programs Women and Children	2			
Housing Programs for Persons Living with HIV/AIDS	1			
DARS Programs for Substance-Abusing Clients	0			
Persons with co-occurring psychiatric disorders	1			
14. Provide employment assistance and vocational training	0			
15. Provide transportation and childcare assistance to enable persons complete treatment and transition to independent living	6	4	*	
16. Develop an active sober recreational and social community similar to Phoenix Multisport. Expand support for the "Houston Sober Recreation Committee".	3			
17. Establish recovery community centers	11	9	*	**
18. Increase usage of online resources for recovery support.	1			
19. Provide support for volunteer and paid peer coaches. Volunteerism can be an important part of an individual's recovery plan, and can be a key to the public support of the program.	11	6	*	

Peer Recovery Support -- The following actions should be undertaken to support peer workers:

20. A community education and professional training effort should be developed to inform the community that peer coaches are different from sponsors and counselors, and that they ma	7	1	*	
21. Peer Recovery workers should receive organizational assistance for better linkage with 12 step and faith based groups, as well as for treatment linkages, training, and peer guidance.	5	1		
22. The large 12-Step community in Houston needs to be enlisted to support and partner with this movement so that they are a positive resource instead of a source of conflict.	9	8	*	**
23. Review and revise regulations to facilitate and encourage volunteer involvement after discharge	7		*	
24. Review and revise regulations to ease counselor and volunteer restrictions for criminal history and allow case-by case consideration of eligibility.	4	2		
25. Treatment clients and providers should be recruited to provide input for treatment and workforce standards and regulations	3			
26. Develop certification procedures for Recovery Coaches	2			
27. Develop accreditation procedures for organizations which support and utilize recovery coaches.	4			
28. Develop standards for peer-recovery organizations and their volunteers.	2			
29. Develop procedures to allow peer workers to provide the following services: a) telephone-based recovery checkups, sober living houses, waiting list supportive contacts	7			

Training and Education -- The following initiatives need to be undertaken:

30. Educate referral agencies and criminal justice agencies and the medical community about the "Chronic Care Model" of addiction, and about the use of recovery language.	9	7	*	**
31. Conduct a community educational campaign for stigma reduction for persons in recovery.	9	5		
32. Expand training and support activities for peer recovery coaches	3			
33. Implement an ongoing program of training for professional development of treatment personnel in the principles and practices of recovery oriented systems of care.	6		*	

Accomplishments To Date:

1. Through this project, a group of community leaders has convened to initiate work with the State and the Houston Council to implement a Houston Recovery Initiative (HRI)

2. The HRI group has held a series of planning meetings, conducted a major stakeholder conference and developed 33 recommendations and six priorities for urgent action.

3. The Texas Department of State Health Services (DSHS) has developed revised proposed wording for a regulation which has been a barrier to ability of volunteers to work in the program from which they received treatment. (Recommendation #23)

4. The Texas Department of State Health Services (DSHS) has already initiated additional support for "Oxford Houses" which are self-governed and self-supported sober housing programs for persons who are in recovery. (Recommendation #13)

5. A participating member agency has submitted a proposal to Harris County to add peer recovery coach positions to their program. (Recommendation #27)

6. DSHS has submitted a proposal to SAMHSA for a program which would support a recovery maintenance program for women in Houston and surrounding areas. (Recommendations #1, #10, #14, #15, #19)

7. Work has begun on a user friendly, client centered, geographic directory of treatment and recovery support services in Houston (Recommendation #12). An initial draft has already been compiled.

HRI Planning Session July 9, 2010
Council on Alcohol and Drugs Houston. (Workgroup Members and guests)

Front (seated, left to right): Jennifer Pinkley, Mona Jiles, Mary Covington, Sydrena Robinson, Don Hall, Ann Clark, Sandy Olson, Mark Norris, Randy Jo Baker
Middle (left to right): Rosey Ruiz, Nadine Scamp, Lillie McCoy, Sarah Sanders, Saundra McNeese, Kay Austin, Alice Peters, Greg Taylor
Back (left to right): Dillon West, Beverly Dotson, Peggy August, Michaelanne Hurst, Andrea Shields, Regina Hasan, Marilyn Jones, Jeff Berry, Charles White, Amelia Murphy, Leonard Kincaid, Pamela Vangiessen, Dick Spence, Lori Mangrum, Rupa Shukla, Nancy Hayes, Michael Robinson