

**Recovery Support Services Oversight and Diversification:  
Existing and Emerging Practices**

Briefing Paper for Stakeholder Conference Calls

Prepared by the Legal Action Center  
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## **Background**

Significant work has been done in recent years to create a new range of recovery support services (RSS) and to ultimately move our nation's alcohol and drug treatment system towards a recovery-oriented system of care. The Substance Abuse and Mental Health Administration (SAMHSA) and the Center for Substance Abuse Treatment (CSAT) have initiated and supported a number of important initiatives, including the Recovery Community Services Program (RCSP) and the Access to Recovery (ATR) Program.

SAMHSA /CSAT has also facilitated ongoing discussions to assist the full range of stakeholders – including faith-based and community organizations, communities of recovery, consumers of services, State agencies and treatment providers – in exploring the best ways to expand RSS and implement a recovery-oriented system of care. SAMHSA/CSAT's Partners For Recovery (PFR) convened a National Summit on Recovery in Washington, D.C in September of 2005 which produced the "National Summit on Recovery Conference Report." This document included recommendations for SAMHSA/CSAT, system professionals, treatment providers, researchers, evaluators, mutual aid organizations and recovery advocates. In January 2007 SAMHSA/CSAT held a meeting on RSS with key stakeholders from across the country, focusing specifically on determining the best ways to move forward in expanding and diversifying those critically important services based on lessons learned to date.

Significant work has also been done in the private sector by individuals such as Dr. Tom McLellan and William White, both strong advocates for a recovery management approach to alcohol and drug treatment. For example, research and work has been done to address effective treatments for drug and alcohol addiction, some researchers suggesting that addiction should be treated as a chronic disease rather than as a series of episodes.

The Legal Action Center (LAC) previously assisted SAMHSA with two important issues related to RSS in ATR grantee States. LAC clarified the applicability of the Federal alcohol and drug confidentiality law, its implementing regulations, and State confidentiality laws to ATR RSS providers and provided a preliminary overview of how ATR grantee States were approaching oversight of these groups. LAC then drafted a report for SAMHSA summarizing these findings, and followed up with additional research, including:

- learning more about ATR grantee jurisdictions' oversight practices,
- examining how three States that do not have ATR grants -- Arizona, North Carolina, and Vermont -- are approaching oversight and quality assurance for RSS, and
- discussing critical issues and experiences with a range of stakeholders.

## **Goals of This Paper**

LAC prepared this briefing paper at SAMSHA's request. It is intended to serve as the keystone

for a dialogue among important stakeholders, including Single State Agencies (SSAs), consumers and providers of recovery support and treatment services, and State associations of alcohol and drug abuse service providers, to determine whether it would be useful to work together to identify best practices concerning effective and appropriate oversight over publicly-funded RSS that assures quality without imposing overly burdensome requirements that could stifle growth and diversification, and if so, determining key issues to be examined and best ways to examine them.

LAC will convene conference calls with important stakeholders on February 7 and 8, 2007 to discuss these questions. This briefing paper provides background and highlights some issues for discussion.

Part I of the paper offers a summary of LAC's findings, in-depth profiles of what five states are doing, and a very brief description of RCSP and useful data the program has generated. Part II of the paper sets forth an initial list and description of stakeholders' key issues and challenges to accomplishing the goals of developing oversight and quality assurance mechanisms that do not impose overly burdensome requirements that could stifle growth and diversification.

## **Part I: How States are Overseeing and Assuring Quality of Recovery Support Services**

### ***Introduction***

LAC found that ATR grantee jurisdictions developed and now use a wide variety of oversight mechanisms to ensure the quality of RSS, including (but not limited to):

- Licensing of organizational providers
- Credentialing or certification of organizational providers
- Accreditation of individual practitioners
- Accreditation of curriculum utilized in providing recovery support services
- Contractual requirements
- Development of practice guidelines

In conducting these oversight and quality assurance functions the jurisdictions are looking at a wide range of different factors. There is a fair amount of overlap, but also considerable difference among the jurisdictions' approaches.<sup>1</sup> At least ten ATR grantee jurisdictions have established some type of eligibility and oversight process specifically for RSS providers,<sup>2</sup> as has Arizona. The types of eligibility standards and oversight mechanisms in the foregoing

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<sup>1</sup> Our research is based on conversations had with providers and regulators in these jurisdictions, and on materials gleaned from their official websites.

<sup>2</sup> California, the California Rural Indian Health Board, Connecticut, Florida, Illinois, Missouri, New Jersey, Tennessee, Texas and Wyoming.

jurisdictions vary widely, from formal licensing or credentialing processes to the provider attesting to its own competence. Missouri is the only jurisdiction which permits *only* non-traditional providers (including community- and faith-based organizations) who are *not* currently State-certified providers of alcohol and drug treatment and recovery services, to become ATR-credentialed RSS providers. By contrast, Louisiana, has elected to allow only State-licensed, certified or credentialed alcohol and drug treatment programs and professionals to provide RSS through its ATR program.<sup>3</sup> The other jurisdictions have established ATR program eligibility criteria that encourage both State-licensed and non-licensed providers to participate in their ATR programs, and offer those who are not licensed a variety of means for becoming eligible to provide RSS.

Of the eleven jurisdictions that have established standards and oversight specifically for RSS providers, at least five – Arizona, Connecticut, Florida, Missouri, and Wyoming – require some level of formal licensing, certification or credentialing, and Illinois is in the process of developing a certification (as is North Carolina for individual peer support specialists). Arizona requires Community Services Agencies to be certified in order to provide RSS. Connecticut requires that RSS providers obtain certification for each individual RSS, and subjects them to on-going site reviews. Florida requires RSS providers to obtain “Credentialed Status” as an “ATR Treatment Recovery Support Program” from the ATR Program.<sup>4</sup> Missouri has two different ATR credentialing procedures, one for faith-based organizations through an independent non-profit statewide interfaith corporation and another through the state Department of Mental Health. Wyoming requires RSS providers to be licensed or approved by the State after meeting specified criteria.

The remaining ATR jurisdictions --the California Rural Indian Health Board, California, Illinois, New Jersey, Tennessee, and Texas – do not require formal licensing, certification, or credentialing, but have established policies and procedures for establishing the eligibility of, approving, and overseeing RSS providers. Their basic requirements are as follows:

The California Rural Indian Health Board requires RSS providers to meet traditional healer /spiritual advisor qualification standards.

California and New Jersey require RSS providers to meet specified eligibility criteria.

Illinois requires that, unless licensing/certification requirements exist for a particular service, RSS providers must meet specified eligibility criteria. The SSA is working with a State licensing body to develop a certification.

Tennessee requires that RSS providers either be accredited by a nationally recognized organization (e.g., CARF, JCAHO) for specific program services, or meet ATR eligibility criteria.

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<sup>3</sup> It appears that Idaho also requires prospective providers of both clinical treatment and RSS to meet the State’s ordinarily applicable licensing/certification requires for alcohol and drug service providers as a condition of participating in their ATR program.

<sup>4</sup> The Florida Faith-Based Association assists with ATR certification of faith-based providers.

Texas requires that RSS providers attest to the State ATR program that they have the requisite training, qualifications, and experience and agree to provide their services in accordance with specified ATR program requirements.

The challenge for ATR grantees and other jurisdictions has been how best to balance their interest in assuring accountability and service quality without imposing overly burdensome regulatory requirements upon potential RSS providers – especially those community-based and faith-based organizations that are often newly engaged participants in the State’s publicly funded substance abuse delivery system.

In the process of establishing their oversight and quality assurance standards, the eleven jurisdictions described above who have elected to establish a new and unique set of standards for RSS have outlined the following general areas of concern:

- Administration, Organization and Organizational Identity
  - Has the provider registered with the Secretary of State, and does it remain in good standing?
  - Is there an existing governing body that provides appropriate fiscal oversight and oversight of service quality and delivery?
  - Does the provider have organizational experience in providing services, including RSS, to community and individuals in ATR program’s target populations?
  - Do faith-based organizations maintain the organizational structure, policies and procedures necessary to comply with State/Federal “Charitable Choice” requirements, including
    - protection of service recipients’ religious freedom and choice;
    - prohibition of use of Federal funds for religious activities,
    - separation of religious proselytizing from publicly funded services;
    - segregation and organization of fiscal accounting to preserve religious organization’s freedom from governmental intrusion while allowing government audit of publicly funded services?
  - Does the provider have coherent organizational policies and procedures?
  - Does the provider maintain, or is it eligible for, risk management strategy/insurance, including:
    - Organizational liability insurance
    - As appropriate, professional liability insurance for staff?

- Personnel – Staff and Volunteers
  - Do staff maintain appropriate professional licenses or accreditation ?
  - Do staff and volunteers get appropriate training, experience and supervision to assure
    - competence in addressing drug and alcohol problems,
    - cultural competence, and
    - competence in fulfilling ATR program requirements?

Are staff and volunteers held accountable for providing RSS using these competencies?
  - Does the provider have an e framework to ensure appropriate and ethical interactions between provider staff/volunteers and ATR clients?
- Physical Plant and Safety
  - Do program offices comply with applicable safety codes at all locations?
  - Are programs working to correct identified physical plant deficiencies?
- Fiscal Accountability
- Record-keeping and Documentation
  - Do providers have adequate management information systems?
  - Do providers have the capacity to comply with Federal and ATR program data collection, tracking and reporting requirements?
- Service Recipients’ Rights, Responsibilities; Protections and Remedies for Abuse and Neglect of Service Recipients
- Misuse of Funds/Property
- Confidentiality
  - Do providers give confidentiality training to staff and volunteers?
  - Do providers train staff and volunteers on applicability of Federal confidentiality law and regulations to specific RSS being provided?

- Do providers have appropriate confidentiality policies/agreements in place for ATR service recipients?

The following profiles examine some States' experiences with RSS in greater depth

## Arizona

### OVERVIEW

In 2000, Arizona's behavioral health services division underwent a major shift in focus, moving from a more traditional delivery model, and more traditional services, to the delivery of more person and family-centered services. The State began a greater focus on the strengths that an individual brings to the recovery process. The State began offering RSS in 2000 as part of this transition.

This major system shift was a long-term process, taking place over several years. Initiated by strong leadership, this shift was also motivated by a number of initiatives, including:

- a federal Medicaid waiver issued to the State which provided an opportunity to define and reimburse services in a new way (though initially the waiver applied only to children's services);
- passage of a statewide ballot initiative which significantly increased the number of people eligible to receive Medicaid services and the need to maximize Medicaid funds; and
- settlement of a class action lawsuit which required the state to substantially improve the system of behavioral health services delivered to children.

One of the goals of this system re-design was to recognize and include RSS provided by non-licensed individuals and agencies. Accordingly, Arizona created a new category of provider – the Community Service Agency (CSAs). CSAs are community-based and/or faith-based organizations that provide non-traditional support and rehabilitation services. In addition, specific to drug and alcohol services, Arizona created alcohol and drug “Recovery Support Specialist” (Support Specialist) positions beginning in 2003, with technical assistance from SAMHSA. Support Specialists serve as mentors and recovery coaches in many alcohol and drug treatment agencies, and are intended to enhance the effectiveness of alcohol and drug treatment.

Additionally, some Arizona localities developed specific RSS to address the unique needs of Native Americans, offering RSS such as sweat lodges, talking circles and traditional healing.

Arizona continues to transform its behavioral health service system and recently created an entire bureau in the Division of Behavioral Health Services to focus exclusively on RSS (including housing and employment) as well as the provision of support to consumer and family-operated agencies. The bureau will also address issues related to stigma and provide a voice for consumers, individuals in recovery and individuals in need of recovery.

## **OVERSIGHT**

### **Certification/Financing**

Arizona's commitment to a recovery-oriented approach to treatment resulted in the development of a new "Medicaid Covered Services Guide" in 2001. This guide included State reimbursement rates and protocols for the provision of peer and family RSS. The design of these new reimbursement rates and protocols, accomplished with the assistance of a consultant, was perceived as critical to the incorporation of recovery-oriented services in the treatment system. Once recovery support services were included in the guide, implementation of these new services progressed quickly.

Arizona created CSAs in 2001. While CSAs are not State licensed, they are certified by the State through an application process overseen by the Single State Agency (Arizona Department of Health Services/Division of Behavioral Health Services-- ADHS/DBHS). CSAs are described in the Medicaid Covered Services Guide as "natural community supports" in that they have used practical and informal approaches – not just the traditional behavioral health system – to provide RSS. Additionally, substance abuse Support Specialist positions were piloted in 2003. This pilot project was expanded in 2005, with 21 agencies now involved in developing and utilizing Support Specialists. A certification process for Support Specialists was developed in cooperation with META Services, a consumer-run agency in Phoenix, and implemented by the University of Arizona's Recovery Thru Integration, Support & Empowerment (RISE) unit which is responsible for administering the Recovery Support Specialist Training Institute, discussed in more detail below. The State's goal was to double peer support staff in 2006. The certification process for the Support Specialists is managed by the Regional Behavioral Health Authorities (RBHAs) which are discussed in further detail below.

Arizona is currently in the process of finalizing a Peer Recovery Support Specialist Practice Protocol.

### **Management**

ADHS/DBHAS has organized its array of "covered services" into a continuum of service domains which serve as the framework for program management and reporting. In addition, Arizona has, for several years, had a system of RBHAs which are responsible for assessing the service needs in their region, developing a plan for meeting those needs, and managing the delivery of services through regional provider networks. Following the inclusion of RSS in the "Medicaid Covered Services Guide", RBHAs were immediately able to implement these covered services.

### **Training**

Training has been a very important component of Arizona's behavioral health system. Training was perceived as critical to ensure that there was a qualified workforce available for the Support Specialist positions. The Recovery Support Specialist Training Institute (Training Institute) was created to meet that need. The Training Institute includes:

- a seven-day initial intensive training

- a minimum of 8 weekly practicum meetings
- 120 service hours

The first two days of the Training Institute focus on the Wellness Recovery Circle (WRC), a group activity to assist people throughout their journey for recovery. The purpose of the WRC is to provide education, coping strategies and a forum for discussing topics related to recovery such as mental illness and substance use disorders. Arizona is also in the process of developing a training program for both providers and peers to expand peer support services for people with co-occurring disorders.

### **ONGOING CHALLENGES AND LESSONS LEARNED**

Representatives from Arizona noted that that a system re-design as large as that undertaken by their State takes time and should be looked upon as a long-term process. Additionally, this type of major philosophical shift is a challenge for many professionals. A major system re-design should involve all community stakeholders, seeking their input from the onset. State flexibility is also necessary as revisions and adjustments are often required. Finally, it is critical to recognize and address the cultural differences of various populations and to identify and remove barriers when serving rural communities. Rural communities in Arizona have a history of utilizing practical and informal methods for recovery support and this practice continues since available resources remain limited.

**Contact Person:**

Ms. Vicki Staples  
 ADHS/DBHS/Clinical and Recovery Services  
 Phone: 602 364 4628

## **Connecticut**

### **OVERVIEW**

Connecticut has been a national leader in the development of, and movement toward, a recovery- oriented system to address drug and alcohol addiction. In 1999, Commissioner Thomas Kirk of the Connecticut Department of Mental Health and Addiction Services (DMHAS) asked Advocacy Unlimited, Inc. and the Connecticut Community for Addiction Recovery, Inc. to work together to develop a set of core values to assist the State as it began the process of redesigning its service system. The State formally designated “recovery” as the overarching goal of its service system in 2002 when Commissioner Thomas Kirk signed Policy Statement No. 83 “Promoting a Recovery Oriented Service System.”

Contributing factors that moved Connecticut in this direction included:

- the recommendations of the Governor’s Blue Ribbon Commission;

- a federal emphasis on recovery from both the President’s New Freedom Commission and SAMHSA;
- expectations of advocates, consumers and people in recovery; and
- an expanding research base showing improved effectiveness of treatments and natural supports.<sup>5</sup>

Representatives of the Connecticut Department of Mental Health and Addiction Services (DMHAS) indicated that redesigning its system of care was a major undertaking. It took several years to implement and focus on the following strategies:

- a new, strong emphasis on consensus building;
- the incorporation of existing initiatives such as ATR, CCAR Recovery Community Centers and managed care;
- transitioning providers to recovery-oriented performance outcomes in a non-punitive manner;
- the use of technology transfer strategies to identify, develop, implement and sustain “best practices”; and
- reorienting all systems to support recovery.

Though DMHAS officials indicate there are a number of significant challenges associated with this ambitious system of transformation, considerable progress has been made. This includes the creation of a network of Centers of Excellence which are provider agencies involved in the introduction and piloting of innovative practices in key recovery-oriented service areas. The Centers serve as “learning laboratories” for knowledge acquisition and knowledge transfer.

The Connecticut Community for Addiction Recovery (CCAR) has also been a key stakeholder and leader in the development of peer recovery support services. CCAR currently operates four Recovery Community Centers. These centers offer a wide array of peer recovery support services, including assertive telephone follow up. They described themselves as “a recovery oriented sanctuary anchored in the heart of the community.” CCAR has established a strong partnership with the State and has been very involved in statewide planning and in the development of State policy.

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<sup>5</sup> Materials provided the State of Connecticut use the term “natural supports.” LAC has interpreted this phrase to mean practical and informal methods for providing recovery support services.

## **OVERSIGHT**

### **Certification**

DMHAS's oversight of RSS includes a certification process for all RSS providers as well as ongoing site reviews. In order to be eligible for reimbursement, RSS providers must complete certification applications for each recovery service they intend to provide. As part of the certification process, DMHAS assists the provider in evaluating the agency's capacity to provide services and to comply with all program requirements, including compliance with required documentation.

### **Site Reviews**

DMHAS conducts site reviews that include examination of service documentation as well as invoices submitted for reimbursement. In addition, DMHAS developed Practice Guidelines for Recovery-Oriented Behavioral Healthcare which were finalized in the Spring of 2006. DMHAS views these guidelines as important tools to achieve and maintain a recovery-oriented system of care. These recovery practice guidelines address 11 domains including consumer involvement, individualized recovery planning, and utilization of recovery support staff. DMHAS also developed and utilizes an "Agency recovery self-assessment tool," recovery-oriented performance measures and a contractually-required consumer survey.

### **Monitoring**

DMHAS utilizes existing managed care technology available through the General Assistance Behavioral Health Program. These managed care tools include:

- prior authorization
- continued stay review
- provider credentialing
- trend analysis
- outlier identification

DMHAS's goals are to blend technology and values with an emphasis on culturally competent services based on psychosocial necessity (not just medical necessity), and to integrate RSS to insure continuity of care. In order to develop the monitoring process, DMHAS also re-evaluated its expectations and made adjustments as necessary.

### **Financing**

As part of its systemic redesign, DMHAS aligned its fiscal resources to support recovery. Connecticut has developed rate schedules for all RSS offered. These services include:

- Case Management
- Vocational/Education Services
- Transportation
- Peer-based services

In addition, providers are required to compete for service contracts and compliance with recovery-oriented performance outcomes is now a condition of reimbursement.

## **ONGOING CHALLENGES AND LESSONS LEARNED**

DMHAS found that creating a recovery-oriented system of care requires service system changes at all levels. Creating effective payment methods for non-traditional services that support the many paths to recovery remains an ongoing challenge. However, use of managed care technologies as tools has helped accomplish public sector goals.

Moreover, DMHAS indicated that new service providers who are not familiar with fee for service reimbursement, struggle with the amount of paperwork and documentation required. As a result, site visits include specific suggestions on how to improve documentation. A change of this magnitude is non-linear and requires patience.

### **Contact Person:**

Mr. Paul J Dileo, Chief Operating Officer  
Connecticut Department of Mental Health and Addiction Services  
Phone: 860 418 6855  
Email: [paul.dileo@po.state.ct.us](mailto:paul.dileo@po.state.ct.us)

## **Florida**

### **OVERVIEW**

Florida's ATR program was implemented in five regions of the State through an incremental process. These five regions represent a full range of major urban cities, mid-size and small towns. In addition to the specific ATR program goals, Florida established a broader, more ambitious goal of "changing the service delivery system from a treatment system to an addictions recovery model." This model includes "the provision of recovery support services during and after treatment." Florida's SSA Director indicated that any new State funding which was not earmarked for a specific purpose by the legislature would be invested in RSS

To implement the Florida ATR program, the SSA involved a significant number of external partner organizations, including:

- a statewide organization of faith-based organizations (Florida Faith-Based Association);
- the statewide association of substance abuse service providers (Florida Alcohol and Drug Abuse Association, or FADAA);
- the Southern Coast Addiction Technology Transfer Center (SCATTC);
- a behavioral health managing entity (the Central Florida Behavioral Health Network); and
- a faith-based training organization (NET Institute).

The SSA Director indicated that the Agency has a long history of partnerships with each

of these organizations: each played a significant role in the implementation of the ATR program.

## **OVERSIGHT**

### **Certification: Creation of Standards**

Florida requires organizations to be “certified” or obtain ‘credentialed status” in order to provide recovery support services as an “ATR Treatment and Recovery Support Program.” The Department of Children and Families (DCF), Florida’s SSA, was responsible for the development of these standards. To accomplish these standards, DCF included all major stakeholders. DCF is responsible for certifying RSS. DCF staff believes that this approach to oversight is quite effective.

Both licensed service providers and RSS providers in Florida appear to have no problems with the standards established, though there was apparently some initial confusion regarding the term “certification” which Florida has traditionally used to refer to certification of individual addiction counselors.

### **Certification: Implementation of Standards**

DCF staff stated that the major challenge associated with implementing standards for RSS was not in their development but rather in their broad-scale application. Though the certification/credentialing process was conducted by DCF, the agency also contracted with a separate organization, the Florida Faith Based Association, to assist with the credentialing process. This involved conducting onsite reviews, utilizing a monitoring checklist and making recommendations for approval or corrective action. Recently, Florida hired a faith-based services coordinator to continue to perform these functions.

### **Financing**

In order to implement and assure flexibility in the ATR Program, DCF utilized a statutory provision (Fl. Stat. Chapter 397.401(4) F.S.) which allowed the agency to waive the rules that usually govern treatment and prevention services in order “to allow service providers to demonstrate and evaluate innovative or cost effective substance abuse service alternatives.”

DCF created 31 ATR “cost centers,” which include both treatment and RSS. Reimbursement rates for the new RSS were developed based on a review of a number of service providers’ historical experiences as well as through discussion and negotiation with these providers. It should be noted that many of the “new” providers had previous experience in delivering services similar to Florida’s Department of Corrections, such as transitional housing. Adjustments to the reimbursement rates were also made as necessary.

### **Management**

Specific ATR program management responsibilities were subcontracted to an existing administrative services organization (ASO), the Central Florida Behavioral Health Network. This ASO is responsible for data collection and management, issuance of

vouchers and service reimbursement. This outsourcing arrangement allowed DCF to focus its limited staff resources on policy setting and implementation, trouble-shooting and reporting to the federal government, and, as the DCF Director stated, “being more strategic purchasers.”

### **DIVERSIFICATION OF PROVIDERS**

State officials are pleased with their efforts to diversify service providers. They indicated that more than 160 new community- and faith-based providers are enrolled in the program and the majority of these new service providers are faith-based organizations. DCF staff felt that the most-effective strategy in recruiting new providers was “word of mouth”. ATR-participating faith-based organizations were most capable of addressing the concerns and questions of other faith-based organizations regarding paperwork, regulations, etc. DCF also noted that the leadership of Florida’s NET Institute (a faith-based training organization) and the Florida Faith-Based Association played a significant role in recruiting new service providers and assisting them as they adjusted to working with a government agency.

Prior to the ATR program, working relationships already existed among leaders from Florida’s faith-based community, Florida’s licensed service providers and the State. In 2002, the SCATTC formally brought together representatives from several key organizations for a facilitated dialogue.

DCF staff saw training of these new service providers as another crucial element in the successful implementation of the ATR program. Again, DCF looked to long-standing partners, the SCATTC, the Florida NET Institute and FADAA, to provide the bulk of this training.

### **Sustainability**

DCF officials indicated that a number of changes are now being made to Florida’s system of treatment services which are at least partially a result of the ATR program. These include:

- creation of a new cost center for non-ATR funded recovery support services;
- use of recovery coaches will continue;
- use of effective management tools by the ASOO;
- a rewrite of the rules governing substance abuse services, initiated by DCF, with a focus on “ recovery and resiliency”; and
- using the Florida Addictions Certification Board to conduct a role delineation study to identify and define the competencies needed to provide RSS.

## **ONGOING CHALLENGES AND LESSONS LEARNED**

State officials and community organizations identified a number of ongoing challenges related to implementing the ATR program, including:

- establishing effective communication between licensed treatment service providers and non-traditional recovery support service providers;
- the need for increased business, record keeping and reporting skills among many of the non-traditional RSS providers; and
- the need for a code of ethics for the non-traditional RSS providers.

DCF staff stress that implementation of a new program which involves changes of this magnitude is a multi-year process and there is a need for patience. The State must have the capacity for some administrative agility and flexibility. The existence of ongoing partnerships with the faith-based community, the statewide association of service providers and training organizations has been pivotal in the successful implementation of the ATR program.

### **Contact Person:**

Darran Duchene, Director of Treatment Services  
Florida ATR Coordinator  
Phone: 850 921 8464  
Email Address: darran\_duchene@dcf.state.fl.us

## **North Carolina**

### **OVERVIEW**

North Carolina's efforts to expand RSS for persons with substance use disorders are currently moving forward within the broader context of a major initiative aimed at transforming the State's system of mental health, developmental disabilities and substance abuse services. This reform initiative is the result of State legislation passed in 2001, as well a national initiative focused on a mental health system transformation. Similar initiatives have focused on the developmentally disabled population. Included among the principles of this sweeping reform was a commitment to a recovery-oriented, person-centered system of care.

Currently, North Carolina reimburses three RSS. These are:

- 1) ACTT Team services
- 2) Community support services

### 3) Social setting detoxification services

Though movement towards a recovery-oriented system of care is still in its initial phase, North Carolina is committed to funding as many RSS as possible in the future. The State has a deep understanding of the value provided by peer RSS.

## **OVERSIGHT**

### **Certification**

North Carolina is in the process of implementing a certification program for Peer Support Specialists which will apply to both mental health and substance abuse peer workers. North Carolina's Peer Support Specialist Certification Program is being developed and will be managed by the University of North Carolina at Chapel Hill's School of Social Work. The program expects to begin accepting applications in July 2007. A number of individuals who are providing RSS were "grandfathered" into the certification program as of July 1, 2006. They too will be required to receive training and become certified in the next two years.

### **Financing**

As indicated above, three peer RSS currently receive reimbursement. The ACTT service and the community support services are funded by Medicaid for Medicaid-eligible individuals and by the State for non-Medicaid eligible individuals. State funding supports the social setting detoxification services. In order to meet federal and State funding requirements, ACTT team services must include a certified peer support specialist; both community support services and social setting detoxification services are permitted but not required to have on staff a certified peer support specialist.

### **Training**

A number of training programs are currently available for Peer Support Specialists, including a program at the Behavioral Healthcare Institute which includes classroom training as well as distance learning.

### **Role Delineation Study**

Because the curriculum and standards for these programs vary widely, the State, through the University of North Carolina at Chapel Hill, is currently conducting a role delineation study for the Peer Support Specialist position.

## **ONGOING CHALLENGES AND LESSONS LEARNED**

Developing a State policy and funding framework for new services and new service providers is a major ongoing challenge. Additionally, housing continues to be identified as a critical need to support long-term recovery.

### **Contact Person:**

Bonnie Morell, Best Practice Team Leader  
North Carolina Division of MH/DD/SAS

Phone: 919 715 2774  
Email: [Bonnie.Morell@ncmail.net](mailto:Bonnie.Morell@ncmail.net)

## Vermont

### **OVERVIEW**

Four years ago, the Vermont provided resources to create several statewide Recovery Centers as part of Governor Jim Douglas's comprehensive DETER initiative (Drug Education, Treatment, Enforcement and Rehabilitation). The plan provided close to \$3 million in new funding for programs and services with an emphasis on prevention. Currently, nine Recovery Centers provide prevention services, and additional funds have been made available to assist with transitional housing and half-way house services.

In 1998, Friends of Recovery - Vermont (FOR-VT) began building a statewide coalition of people in recovery from drug and alcohol addiction. The Vermont Association for Mental Health was the original host agency for FOR-VT, which was one of the original RCSP grant recipients. FOR-VT has built a strong and positive partnership with the State and has developed a significant voice in the public policy arena. FOR-VT has focused on advocacy and public education and has also supported the development of community peer recovery centers as well as outcome-based programs which emphasize evaluation and data analysis as tools for long-term recovery.

### **OVERSIGHT**

Like many states, Vermont is currently wrestling with issues related to appropriate oversight of RSS. Though State funds were provided for Recovery Centers, no additional infrastructure now exists for oversight, monitoring, etc. In addition, the role of the Recovery Centers has been an evolving one.

Vermont's Division of Alcohol and Substance Abuse funds the Recovery Centers and directly helps each one by providing guidance and problem solving assistance. The State of Vermont is also currently in the process of developing "recovery management principles and techniques" which will be utilized by the Recovery Centers.

Oversight of RSS is also informally provided by an Executive Board of Directors which consists of representatives of each of the Recovery Centers, a representative of the State Division of Alcohol and Substance Abuse and the Director of FOR - VT.

### **Data Collection and Analysis**

Each of the Recovery Centers gathers demographic data which is analyzed by FOR-VT. The data include information such as the number of hours a Center is open each week, numbers of visits paid by consumers, consumer satisfaction with services provided, and information on whether or not the Recovery Center helped with long term recovery,

gaining employment or finding housing. The data is helpful in identifying barriers to achieving long-term recovery as well as in monitoring progress.

## **ONGOING CHALLENGES AND LESSONS LEARNED**

Vermont’s development of RSS is a “work in progress. ” There is a need to assist new RSS providers in developing strong business skills.

### **Contact Person:**

Michael Tipton, Adult Services Program Specialist

Vermont Department of Health

Telephone: 802 651 1564

Email: [mtipton@vdh.state.vt.us](mailto:mtipton@vdh.state.vt.us)

## **Part II: Moving Forward to Assure RSS Quality Without Stifling Growth and Diversification**

LAC’s research of State practices and experiences concerning RSS oversight and quality assurance, which included conversations with a range of stakeholders (faith-based and community organizations, communities of recovery, State agencies, treatment providers and others), yielded a number of themes and challenges, listed below. The lists represent compilations, *not* consensus among the stakeholders on any one issue. While each listed theme or challenge was suggested by more than one stakeholder, we did not attempt to determine whether all or even a majority of those we talked to supported any particular one, nor did we list them in any special order. We present them simply to facilitate further discussion and exploration.

### ***Themes***

- Stakeholders must work together to identify best ways to assure RSS quality without inhibiting ability of those services to grow and diversify.
- Utilization of a consensus-building process which brings all stakeholders to the table from the very beginning is critical
- Providing oversight to newly-created RSS entities requires flexibility and innovation as everyone learns from experience and new challenges arise.
- The development of standards and other oversight mechanisms must be accompanied by the availability of adequate training resources

- The lack of additional, stable funding specifically for RSS is a major challenge
- The development of new RSS and the movement towards a recovery-oriented service system must be perceived and addressed as a long-term, multi-year process
- The ability to utilize already-existing partnerships to assist in the development of RSS and implementation of system changes is very beneficial
- In a number of States, the existence of provider networks and administrative service organizations made a significant contribution to efforts
- In a number of States, movement towards the development of new recovery support services and system re-design occurred as the result of a confluence of initiatives
- In a number of States, the creation of substance abuse RSS and system re-design was occurring in varying degrees of relationship to a parallel effort in the mental health service system

### Challenges

- The need to preserve the uniqueness and integrity of peer-to-peer RSS
  - The need to ensure that people in recovery with criminal records – who truly are peers with other people in recovery with criminal records – are eligible to provide peer recovery support services
- The need to ensure that treatment services are not inappropriately replaced by RSS and that there is not an “over-emphasis on support services over clinical services”
- The need to avoid the professionalization of peer recovery support workers
- The possibility of increased community and legislative controversy related to the zoning of recovery houses
- The need for reliable evaluation data related to the efficacy of RSS
- The need to move RSS standards from process measurement to a greater focus on performance outcome measurement and quality of life impact

- The ongoing need to address laws and regulations that are inconsistent with a recovery-oriented system of care
- The need to distinguish the differences between the needs of individuals with mental disorders and those with addictive disorders
- The need to consider increasing the advocacy/policy role of RCSP grantees
- The need for some States to continue to build a stronger partnership with the recovery community.

***Next Steps: Is There a Role for SAMHSA/CSAT in Facilitating Discussions to Identify Best Practices and/or Models?***

LAC’s research and dialogue with key stakeholders, including lively and informative discussions at the SAMHSA/CSAT meeting in Fort Lauderdale in January 2007, has set the stage for key stakeholders to assist SAMHSA/CSAT and LAC to determine if it would be useful for SAMHSA/CSAT to facilitate a process to identify best practices concerning how most effectively to exercise appropriate oversight over publicly-funded RSS to assure quality without imposing unnecessary and overly burdensome requirements that could stifle the growth and diversification, and, if so, what the process should examine and how it should be conducted. Key questions and issues to address in making those determinations include:

- There are several levels of oversight and quality assurance that States could potentially implement, including basic consumer protections to prevent fraud, abuse, and mistreatment of clients; examination of skills and background (including criminal records) of potential RSS providers ; assurance that RSS are useful, are provided adequately, and achieve positive outcomes. Which of these types of oversight should be undertaken by State governments? Does it depend on whether the State or other governmental entity is providing funding or other reimbursement for the services?
- There are different types of organizations and individuals providing RSS, including faith and community-based organizations, communities of recovery, and treatment providers. Some provide professional or paraprofessional services, some provide peer and/or voluntary services. There are also a wide range of RSS being provided. Should there be different levels of oversight depending on the organization or individual providing the service and/or the type of service being provided?
- What are the best ways to balance the need to provide various levels of oversight

and quality assurance, and the need to foster the growth and diversification of RSS and the organizations and individuals providing those services?

- At the Florida meeting and in a number of other conversations between LAC and stakeholders, many people supported the idea of having SAMHSA/CSAT facilitate a process to bring the various stakeholders together to explore all these issues with the goal of determining best practices and/or models on how best to assure quality of recovery support services without stifling their growth and diversification. Some suggested it would be best to first bring together the range of RSS providers to discuss these issues, and then bring those providers together to discuss key concerns with State governments. Would it be useful for SAMHSA/CSAT to facilitate such a process, and if so what shape should that process take?