



Abstract

Texas Health and Human Services Commission (HHSC) recently concluded a pilot project that showed that long-term recovery support services (RSS) were associated with reductions in substance use as well as with improvements in employment, independent living, and other measures. The system saved more than \$2 million in costs associated with healthcare utilization alone. Although behavioral health administrators interested in launching an RSS demonstration project may be primarily concerned about securing funding, to realize the full benefits of peer support and other recovery support services, Texas HHSC recommends that state leaders also plan on (1) taking an active role in helping providers, communities, and individuals accessing services create a shared vision of the RSS; (2) helping providers prepare and align their service environments with recovery-oriented approaches; and (3) providing guidance and support to providers throughout the pilot, not just at the start-up phase. Texas HHSC shares details on these recommendations, drawn from its experience launching its successful two-year, statewide RSS pilot project.

How to Reap the Full Benefits of Recovery Support Services

by Philander Moore, Texas Health and Human Services Commission • Ijeoma Achara-Abrahams, PsyD, Achara Consulting Inc.



Within addiction service systems, peer and other recovery support services (RSS) are attracting attention for their ability to improve outcomes for people with behavioral health disorders.¹ Despite their promising impact, addiction-related peer support services have yet to become reimbursable in most of our nation's behavioral health systems. Administrators interested in bringing recovery support services to their systems or launching a demonstration project may be primarily concerned about

1. K. Myrick and P. Del Vecchio, Peer support services in the behavioral healthcare workforce: State of the field, *Psychiatric Rehabilitation Journal*, 2016 Sep; 39(3):197-203.

the pilot

funding. Once monies are located, system leaders may be tempted to think that the major challenge is over and all that is left to do is disperse the funds to providers and wait for the positive results to roll in.

In fact, to reap the full benefits of peer support and other recovery support services, it's not enough to simply fund them. Three additional factors shape the context in which your recovery support services are implemented and thus influence their impact. These factors are

- 1. A shared vision for RSS** created by the state, providers, and other stakeholders;
- 2. Supportive service environments** in which organizational policies and practices are aligned with recovery-oriented approaches; and
- 3. Support for provider organizations** during rollout and through long-term integration of the RSS in the system.

Taking time to generate a shared vision among system stakeholders, aligning the service environment, and providing adequate, ongoing support for providers will determine to a large degree how effective your new recovery support services prove to be.

The Texas Health and Human Services Commission (HHSC/formerly the Department of State Health Services) grappled with these and other issues when planning and implementing an RSS pilot program that launched in 2014. Texas HHSC contracted with Achara Consulting Inc. to assist with planning and implementing the project. In this article, we provide a snapshot of the Texas RSS pilot project and then offer lessons from our experience about the importance of addressing

the above three factors when bringing RSS to your addiction services system.

The Texas RSS Pilot

The Texas Recovery Support Services demonstration project was a two-year effort to increase peer support and other recovery support services to individuals seeking treatment for substance use disorders. Carry-forward monies from a Substance Abuse Prevention and Treatment Block Grant funded our pilot. Our primary goal was to increase the prevalence and quality of long-term recovery from addiction to alcohol and other drugs and to support people in rebuilding their lives in their natural communities. Long-term supports are thought to be especially important for people with lengthy histories of substance use disorder, which describes many of the individuals using our SUD services.



the numbers

Individuals enrolling in our RSS program faced other challenging circumstances. For example, at enrollment:

- **63%** had a high school education or less
- **62%** were not working
- **16%** were living in institutional settings, 10% were in a shelter, and 5% were surviving on the street
- **42%** had been arrested in the year prior to enrollment
- **63%** did not have health insurance

Our project offered an array of recovery support services by a trained cadre of 126 recovery coaches. In addition to receiving short-term coaching, individuals receiving services had an option to enroll in long-term support, partnering with a recovery coach for up to two years. More than 1,260 Texans availed themselves of long-term coaching services (see box 1).

BOX 1

Texas RSS Recovery Coaching: The Numbers

22 providers (peer-run organizations, substance use disorder treatment programs, and community-based organizations across Texas)

126 recovery coaches across the state

1,265 individuals in one-on-one recovery coaching for a minimum of 12 months.

3,178 individuals received short-term coaching and additional recovery supports

5,914 participated in education classes

12,954 assertively linked to community services

1,611 volunteers at RSS programs

Note: Based on data collected May 1, 2014–August 31, 2015

The Texas RSS pilot was an opportunity to demonstrate outcomes of long-term recovery support services for people with substance use disorders (see sidebar). An independent evaluation of the program by the Addiction Research Institute at the University of Texas Center for Social Work Research showed that after receiving long-term recovery coaching for just 12 months, more than 84 percent of participants had reduced their substance use or stopped entirely, and there were equally impressive improvements in employment, independent living, and appropriate use of medical and emergency services (see chart 1, page 4). What's more, healthcare utilization decreased, saving our system more than \$2 million (76%) compared with costs at enrollment (see chart 2, page 4).

Encouraged by these results, HHSC has begun to expand recovery support services across the state and is working to make them Medicaid reimbursable. But as we learned, these results would not have been possible without taking steps to create a shared vision among stakeholders, help providers align their service environments, and provide ongoing guidance and support to implementing organizations throughout the project.



data collection

HHSC collaborated with an independent evaluator—the Addiction Research Institute at the University of Texas Center for Social Work Research—and recommends this approach for others. HHSC worked with our research partner to develop outcome and process indicators and to develop data collection responsibilities and processes. For example, we collected data on individuals receiving long-term recovery coaching in five domains: (1) housing status; (2) employment status and wages; (3) abstinence or reduced substance use; (4) improvement in recovery capital; and (5) healthcare service utilization, and our pilot required providers to collect and report interview data on people who received individual, long-term recovery coaching at enrollment and at a 3-, 6-, 9-, and 12-month check-up. Our partners also helped develop a cost study.

Given that many provider organizations are not accustomed to regular and frequent data collection, HHSC listed sample outcome and process measures as well as reporting requirements in the RFP itself and asked respondents to demonstrate their capacity to collect, manage, and submit data for evaluation purposes. Due to the nature of services provided

prior to the RSS, many organizations did not have experience with follow-up data collection and initially struggled to collect it. Technical assistance as well as experience acquired as the pilot continued improved the collection of follow-up data over time.

One lesson that HHSC learned in retrospect is that it is important to find a way to share your pilot's findings and milestones with relevant communities. The launch of the pilot, information about implementing organizations, research partners, and so on, are as important to share as preliminary and final evaluation results, lessons learned, and next steps. Sharing as much as possible with targeted audiences—including senior leadership, internal staff, media, and other behavioral health organizations—helps generate interest in and support for recovery-oriented approaches. It pays to think ahead about the story you'd like to tell of your pilot project, who the likely audiences are for that story, and what types of measures they will find meaningful or convincing. Legislators may be particularly interested in cost-benefit analyses, for example. Make sure those data are collected at baseline and at other critical times.

Chart 1. Texas RSS Outcomes

Outcome	At enrollment	At 12-month check-up
Housing status; owning or renting their own living quarters	30%	55%
Employment	25%	58%
Average monthly wages of employed participants	\$285/month	\$844/month

Chart 2. Decrease in Healthcare Utilization

Healthcare setting	At enrollment	At 6-month check-up
Outpatient	2295 visits	454 visits
Inpatient	5315 days	604 days
Emergency Dept.	243 visits	96 visits

vision

Create a Shared Vision

There is no single, standardized model for the delivery of recovery support services. Across the nation, for example, peer staff perform a range of duties in an array of service settings, undergo no common training curriculum, and are certified by a variety of standards.² Even within a single community, clinical and peer providers, system administrators, community organizations, and individuals receiving services may have differing expectations for recovery support services.

Our system was no exception. Prior to joining the Texas RSS pilot, some organizations had sent staff into community settings, while others expected individuals to come to an agency in order to receive services. Some recovery coaches had served primarily as resource brokers and provided short-term support, while other coaches worked to sustain relationships with individuals through various phases of their recovery journey. In some residential treatment organizations, peer staff had worked largely as residential monitors to enforce the rules and had hierarchical relationships with the people they served, while in other facilities peers strove to create collaborative relationships.

Other differences became apparent, as well. For instance, although the training and certification of recovery coaches was underway throughout the state by the time HHSC launched the pilot, recovery coach services were relatively new to the system. In implementing the pilot, we faced conflict and confusion about roles, differing



beliefs about recovery, a lack of consistent organizational policies and practices around confidentiality, poorly defined job descriptions, and a lack of organizational support for peer staff. The diversity of experiences and expectations underscores the need for system administrators to develop and communicate a shared vision for what recovery support services will look like in your system.

Prior to developing the pilot project, HHSC took action to expose stakeholders to the principles of recovery-oriented systems of care (ROSC), engage them in developing a shared vision for the service system, identify the values and guiding principles that would form the foundation of the effort, and begin to tackle policy barriers. Some of these specific efforts included the following:

Developing the Texas Recovery Initiative, which is a diverse group of stakeholders charged with creating a vision for a transformed system of care and who are still engaged in making concrete changes in the system.

2. B. Lloyd-Evans, et al., A Systematic review and meta-analysis of randomized controlled trials of peer support for people with severe mental illness, *BMC Psychiatry*, 2014 14(39): 2–12.

preparation

BOX 2

Partnering with our national consultants and local stakeholders to host locally driven ROSC symposia in all regions of the state.

Providing technical assistance and support to 12 regions to conduct their own community listening sessions in an effort to identify strengths, opportunities, and service gaps across the system. Each community developed their own vision of recovery-oriented services based on input from people in recovery, advocates, family members, service providers, and community members.

Supporting the development of 26 ROSC community-planning groups, which have brought diverse stakeholders together in collaborative efforts.

Providing guidance to treatment providers to support their efforts in aligning their services with a recovery management approach rather than with an acute care model.

Beginning the process of aligning our performance measurement system with recovery-oriented outcome measures.

We also took several actions to develop our vision for the RSS project. We conducted focus groups with recovery coaches and their supervisors, held community listening sessions, hosted regional ROSC symposia, and held discussions during meetings of the Texas Recovery Initiative to develop a vision of recovery coaching for the RSS project (see box 2).

Key Elements of the Texas Vision

- Long-term coaching relationships (six months or longer) that focused on supporting people with re-building a life in their community, as well as short-term coaching supports
- An emphasis on community-based work rather than agency-based work
- Conducting assertive outreach and early re-intervention
- Providing continuing support services beyond treatment episodes
- Ensuring that peers are an integral part of the service team at treatment agencies rather than an adjunct to services
- Providing stepped care that intentionally matches the dose of coaching support with the intensity of individual needs
- Providing a menu of recovery support services that people could choose from
- Promoting ownership, goal setting, and continued progress through the use of recovery plans
- Using strength-based assessment processes that explore the recovery capital of individuals, families, and communities



approach

Working with stakeholders statewide to generate a shared vision is time consuming but worthwhile. The process of creating a shared vision, when done right, not only ensures that RSS will be tailored to meet the needs of people in your system, it also generates widespread buy in from stakeholders, which promotes a smooth implementation and sustainability. Prior to disbursing funds to implementing organizations, we highly recommend that administrators invest time to intentionally generate and clearly communicate a vision for peer support services, including the service model and approaches. Although it is important to begin with a clear vision, it will not be carved in stone. Now three years into this process, we have learned a significant amount and we are bringing stakeholders together to revisit and refine our vision. Creating a shared vision is particularly important when there is a need to demonstrate impact.³ It will be difficult to draw conclusions about the impact of your RSS if your implementing partners are all providing different services with various degrees of fidelity to recovery-oriented approaches.

3. Lloyed-Evans, et al., 2014.

Takeaways

- Allow plenty of lead time (at least 6 months) to educate communities and organizations about RSS and to garner widespread support
- Engage stakeholders to identify RSS elements and guiding values
- Provide technical support to communities to ensure widespread buy in
- Communicate the vision and values to stakeholders

Help Providers Prepare and Align Their Service Environments

There are three basic approaches for implementing RSS in your system: additive, selective, and transformative.⁴ A major lesson learned by HHSC was to use a transformative approach to RSS from the start.

Additive approaches introduce some recovery support services to the existing treatment system but do nothing else to make SUD treatment or services more recovery oriented. An additive approach does not require clinical staff, for instance, to conduct more holistic, strength-based assessments or to integrate person-centered treatment planning. Treatment providers within an additive model may work with people in a manner consistent with a hierarchical expert approach rather than in a more collaborative partnership that reflects recovery-oriented strategies. Additive approaches are also likely to demonstrate minimal collaboration between clinical and nonclinical staff, which affects the quality and cohesiveness of service delivery. It can be tempting to think of the additive approach as a safe, “toe-in-the-water” approach that can be expanded upon once results are demonstrated. But the reality is that because the additive approach results in isolated services, it is the least likely to show positive results.

Selective approaches improve on the additive approach in that they strategically align both

4. I. Achara-Abrahams, A. C. Evans, & J. K. King, “Recovery-focused behavioral health system transformation: A framework for change and lessons learned from Philadelphia.” In J. F. Kelly & W. L. White (Eds.), *Addiction recovery management: Theory, research and practice* (New York: Humana, 2010), 187–208.

transformation

clinical and nonclinical services in parts of a system with a recovery-orientation, but the approach is confined to certain programs or segments of the system. Fiscal and policy strategies might also be aligned to support the delivery of recovery-oriented services in these few components of the system; however, there is no intent to align the entire service system with a recovery orientation. Instead, the new, recovery-oriented components of the system may be viewed as isolated recovery projects. Although these stand-alone projects may demonstrate effective results, they are often not enough to influence the broader culture of the system, which retains its traditional approach to treatment and services.

Transformative approaches consciously integrate recovery-oriented principles and practices throughout the entire service system. This approach includes adding peer and other recovery support services, but it goes much further, seeking to radically transform treatment itself and ensure that all administrative and operational processes, policies, and fiscal strategies support the delivery of recovery-

oriented services. A transformative approach promotes *values-driven culture change* throughout the entire system. At an organizational level, transformative approaches mean that agencies involved in our pilot were encouraged to do more than just add a menu of new recovery support services and increase collaboration with community organizations. They were also encouraged to examine all of their operations and service delivery through the lens of recovery and to increasingly align their efforts with a recovery orientation. Because a transformative approach creates mutually supportive practice and policy changes within different segments of systems and communities, we believe the synergy makes this approach more likely than additive or selective approaches to yield positive, measurable results.

In Texas, we learned that it is important to convey the expectation for a transformative approach up front so that everyone is at the table and actively participating from the beginning of the initiative. Clinicians who believe that recovery support services are merely an adjunct to treatment will likely think that RSS is not relevant to their work and therefore should be offered toward the end of the treatment episode. For example, many providers in Texas initially referred individuals to RSS just before discharge. Similarly, clinicians in the Texas RSS referred people to recovery coaching or other recovery support service but did not collaborate with the person's recovery coach or integrate peer staff into the treatment teams. In these circumstances, individuals did not have the benefit of working with a coach during the treatment episode to expand their network of



policy

recovery allies, and clinicians were not able to benefit from what coaches learned about a person's strengths and vulnerabilities regarding their personal, family, and community recovery capital. It's imperative that clinicians understand that integrating recovery-oriented services has concrete effects for them and the people they treat. In Texas, HHSC and the consulting team worked in tandem to continually promote integrated approaches to service delivery.

Because recovery support services are new, varied, and not yet well integrated into most treatment programs, chances are that at least some current policies and practices—yours, and those of your implementing providers—will inhibit rather than support recovery-oriented approaches. In our case, for instance, HHSC wanted to promote peer culture by providing individuals receiving coaching services with leadership opportunities, such as joining a peer advisory council (PAC) or participating in volunteer opportunities at their agency. To allow for this, we had to revisit our policies and historic practices about requiring individuals to be in recovery for two years before they could play a leadership role.

To offer an example on the RSS organizations' side, we found that many providers prohibited off-site work, which hindered the effectiveness of peer staff. To meet the pilot's expectations, all our RSS organizations had to review their policies related to off-site work, transportation, access to petty cash, flexible work hours, and other established norms.

We found it is especially important to engage the senior leadership of each funded organization. Senior executives set the tone for transformation and clarify expectations about creating a new organizational culture. Operationalizing cultural change may require leaders to modify or reinterpret organizational policies and practices or make other senior-level decisions. In retrospect, HHSC would have devoted more time for such engagement early on. Leaders should be encouraged to not only express their support for transformational change at the organization and system levels, but also to actively participate in planning and implementation.

The transformation of an organization cannot be the responsibility of one person. One of the first charges that HHSC gave the funded programs was to create change management teams. The change management team is responsible for exploring ways to increase the recovery-orientation of the organization and to identify strategies to engage staff in the process. Members of the team should represent various levels of staffing and leadership and have influence with other staff. Ideally they should be the individuals in the organization who have the clearest understanding of recovery support services. The team should be empowered to recommend and make changes and to support staff. Team members could include clinical directors, board members, clinical supervisors, peer staff, PAC members, family members, performance improvement staff, and executive staff.

assistance

Takeaways

- Consider committing to a transformational approach
- Ensure that your messaging is consistent with your desired approach
- Provide TA to help organizations align their policies and practices with program values and services
- Mobilize senior leaders at implementing organizations
- Encourage organizations to create change management teams

Provide Guidance and Support Throughout the Pilot

Transformation is complex and unpredictable, and many issues can't be addressed before providers, peers, or administrators experience them in the context of their unique systems and organizations. Our RSS providers benefited from supports that helped them stay the course as they worked through the daily challenges inherent to adopting recovery-oriented services and practices. HHSC asked Achara Consulting to actively support our RSS providers throughout the two-year pilot program. The consulting team organized their TA around the following domains:

1. Promoting a culture of peer support and leadership
2. Conducting assertive outreach and encouraging continued engagement
3. Ensuring recovery-oriented service delivery (holistic assessments, recovery

planning, diverse service menu, community collaborations, ethics and boundaries, etc.)

4. Facilitating community integration

5. Providing continuing support to individuals

Achara Consulting provided intensive training and technical assistance through

- on-site trainings,
- TA calls with each of the providers,
- webinars,
- RSS supervisor affinity calls,
- recovery coach affinity group calls,
- topical calls,
- site visits to providers, and
- site visits to HHSC.

Besides providing individualized TA, we supported providers by creating an RSS learning community. For instance, we may pair a provider who is struggling with a particular issue with another provider who is doing well in that area to offer support and guidance. The providers participated in calls with all of the community members to maximize opportunities to share and learn from emerging promising practices.



critical elements

In general, particular TA topics were determined by observations from HHSC, Achara Consulting, and the organizations themselves. These opportunities for continued learning proved crucial to improving program results. For example, increasing long-term engagement was a central program goal. Although our recovery coaches had been trained and certified, they did not all initially have the skills to assertively engage people and build long-term relationships. So many coaches enrolled individuals into long-term coaching without first building relationships and helping people understand the differences between short-term and long-term coaching. Hence, individuals did not stay connected to services, and the initial rates of continued engagement were very low for many of the programs. In response, Achara Consulting conducted targeted technical assistance and provided recovery coaches with skills and a framework for engaging individuals. As a result, providers experienced significant improvements in their ability to keep people engaged over time. Several organizations, for example, saw their long-term engagement rates (the number of people who remained engaged in the coaching relationship at 6, 9, and 12 months) jump from approximately 35 percent to more than 80 percent after TA. This is just one example of how critical individualized and ongoing technical assistance was to the success of the project. The frequency of the technical assistance was individualized for each organization but occurred, at minimum, monthly.

Also, HHSC invested in providing ongoing support for these organizations for two years. We

could not have anticipated all of the TA needs at the start of the pilot project, but it was critical to have a system in place to provide sustained support. For example, we learned over time that in the context of long-term coaching, as people's needs changed, the skills and approach of the coaches also needed to change. Although coaches had become skilled at engaging people and establishing strong relationships upfront, as people's recovery journey advanced beyond 12, 15 and 18 months, the focus of the coaching shifted from more crises-driven support and resource brokering to helping people re-imagine and rebuild their lives. This shift required a different skill set and dramatically different approaches in order for the coaches to remain relevant and keep people engaged.

One overarching lesson from our experience is that state staff must remain actively involved at every step throughout the pilot project. Avoid the temptation to delegate management of the demonstration project to another organization. In our pilot, at least one HHSC project staff participated in every TA call, enabling them to reinforce key messages from Achara Consulting.



final thoughts

State staff were available on the calls to help address regulatory, policy, and fiscal barriers that providers encountered. HHSC project staff worked with other state staff to align the internal data collection system and the quality assurance approach. The state's close, hands-on approach helped the providers see the state's commitment to transforming our system with recovery-oriented approaches.

Perhaps most importantly, as a last step before awarding the contracts, HHSC invited the final candidates to join the program as co-partners in the learning process. We explained that this project would be a partnership between the state and their organization and that we expected that we would discover the critical elements needed to provide exceptional recovery support services and improve outcomes together. We voiced our expectation that there would be necessary policy changes both at the state level and among the providers, and that we would navigate these changes together. Organizations that did not want such a relationship were given the opportunity to opt out; none did. This invitation created a culture of collaboration from the outset, which proved to be important as implementation progressed.

Takeaways

- Provide ongoing support
- Ensure support addresses major program goals
- Stay engaged at every stage and retain state management for the project
- Approach implementation as a partnership

Summary

Our overarching message is that bringing RSS to your substance use disorder system, particularly via a pilot project, should be done in a way that allows you to demonstrate the best impact possible. Such an approach requires more than adequate funding. Engaging a diversity of stakeholders to create a shared vision for RSS program will encourage buy-in, promote common practices, ensure data can be compared, and promote sustainability. Assisting providers with preparing and aligning their service environments will ensure that policies and practices not only allow for but also *actively support* the delivery of recovery-oriented services and supports in organizations and in the system as a whole.

Finally, we advise states to stay engaged in the process, providing ongoing training and TA to organizations for at least a year but preferably for two. These steps will help the integration of peer and other recovery support services to get off to a healthy start.

For more information, contact

Philander Moore

Manager, SUD Program Services, Texas
Health and Human Services Commission
Philander.Moore@hhsc.state.tx.us

Ijeoma Achara-Abrahams

President, Achara Consulting Inc.
Ijeoma@acharaconsulting.com