Examples of Potential Practice Changes in a ROSC

The following briefly outlines the types of changes that are often associated with recovery-oriented systems.

Potential Practice Changes In a ROSC:

Conduct Strength-Based Community Asset Mapping: Support prevention efforts that use a strategic approach to assess the strengths and assets within communities, rather than focus primarily on needs assessments, gaps, and identified problems.

Promote Community Health and Wellness: Encourage greater focus on prevention, early intervention and community wellness through targeted community education, strategic community partnerships, efforts geared to strengthen/build community recovery capital or community protective factors, and effective community based prevention program implementation.

Assertively Engage All Community Members: Promote prevention, early engagement, and intervention via outreach and community education. For those in need of intervention, emphasize removing personal and environmental obstacles to recovery through meeting basic needs; ensure that the responsibility for motivation to change shifts from clients to service providers; use inclusive admission criteria rather than emphasis on exclusionary criteria.

Develop strong cross-system partnerships to achieve common goals: Build meaningful collaborations across systems such as criminal justice, behavioral health, child welfare, housing, public health, education, transportation, to strategically leverage resources and achieve intersecting goals.

Support the Mobilization of Recovery Community Organizations: Rather than passively supporting peer-run and recovery advocacy organizations, increase community recovery capital for everyone by actively supporting the development and continuation of these organizations.

Conduct Global Assessments: Use holistic, culturally-relevant assessments, use strengths-based assessment procedures and interview protocols; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stage of recovery. Focus the assessment on multiple life domains rather than primarily on the presenting problems.

Facilitate Individualized, Person Centered Service Planning: *Ensure that treatment and recovery/wellness planning processes are individualized, directed by the person/family, and are grounded in the broader life goals that people have for themselves rather than clinical goals.*

Promote Retention: Enhance rates of service retention and reduce rates of service disengagement and administrative discharge by utilizing outreach workers, enhancing peer-based recovery support services in the treatment context, providing culturally competent services, providing a menu of service options so that care is individualized, and incorporating family members and other important allies as desired. Develop assertive approaches to helping people remain connected to natural community-based supports.

Increase Service Access: Assure rapid access to treatment with minimal wait times. During unavoidable wait times, engage people through peer-based supports within treatment. Ensure that there are no limitations to accessing treatment based on past utilization and/or outcomes.

Promote Health Activation: Shift towards philosophy of choice rather than prescription of pathways and styles of recovery/support, greater client authority and decision making within the service relationship, emphasis on empowering clients to self manage their own recoveries and identify their personal life and treatment goals. Similarly, empower the community to identify their strengths that can be mobilized to promote wellness.

Promote Collaborative Service Relationships: Shift the relationship with clients and community members from a hierarchical expert-patient model to a partnership/consultant model. The helping stance changes from "this is what you must do" to "how can I help you?"

Expand the Focus of Services and Supports: Expand the focus beyond sobriety, symptom management, or biopsychosocial stabilization, to assisting individuals with building lives in the community and promoting community health. Focus on what people and communities want to become rather than what we want them to stop doing. Strengthen the family and community contexts so that individuals have increased access to natural supports, which sustain recovery and wellness beyond their involvement in a treatment episode. Facilitate the development of recovery maintenance skills rather than only recovery initiation skills. Provide clinical services that are recovery-focused, evidence-based, developmentally appropriate, gender-sensitive, culturally-competent, trauma-informed and integrated with a broad spectrum of non-clinical recovery support services. Provide prevention supports that strengthen individual, family and community protective factors and reduce risk factors for substance use.

Broaden Service Delivery Sites: Increase the delivery of community integrated neighborhood- and home-based services and expand recovery support services in high-need areas. Utilize and link people to existing community based resources rather than duplicating efforts and re-creating resources within segregated, institutional environments. Assist people in developing a network of natural recovery supports in order to increase their recovery capital.

Peer-based Recovery Support Services: Expand the availability of non-clinical, formal (paid) and informal (non-paid) peer-based recovery support services and integrate them with professional and peer-based services.

Ensure a Sufficient Continuum of Care with Appropriate Dose/Duration of Services: Provide doses of treatment services across levels of care that are associated with positive recovery outcomes. Facilitate continuity of contact in a primary recovery-support relationship over time and across levels of care.

Integrate Post-treatment Checkups and Support: Shift the focus of service interventions from acute stabilization to sustained recovery management via post-treatment recovery check-ups, stage-appropriate recovery education and, when needed, early re-intervention. Shift from passive aftercare to assertive approaches to continuing care.

Promote Community Integration: Facilitate community integration by supporting people in identifying their personal dreams, goals and preferences for their life. Connect them to relevant

resources and walk along side them to develop the interest, skills and relationships that will enable them to enhance their life. Collaborate with indigenous recovery-support organizations (e.g., faith community); assertively link people to local communities of recovery; participate in local recovery education/celebration events in the larger community and advocate on issues that effect long-term recovery in the community (e.g., issues of stigma and discrimination). Mobilize and increase collaboration amongst diverse community resources. Partner with the community in a manner that values and integrates the knowledge, expertise, and strengths of community members.

(Adapted and expanded by Achara Consulting Inc. from W. L. White, *Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices,* Rockville, MD: Substance Abuse and Mental Health Services Administration, *2008.*)