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Building Recovery-Oriented Systems of Care: A View from the Front
An Interview with Ijeoma Achara, Ph.D.
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William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Introduction

Dr. Ijeoma Achara is a central figure in the movement to shift addiction treatment from varying models of acute biopsychosocial stabilization to models of sustained recovery management (RM) and to wrap RM approaches within larger recovery-oriented systems of care (ROSC). She has worked in two settings—the State of Connecticut and the City of Philadelphia—that have been at the forefront of this movement. Since her relocation to Chicago, Dr. Achara has worked with a wide variety of federal, state, and local organizations on RM and ROSC systems transformation initiatives. Much of this work has been done through the Center for Substance Abuse Treatment's Addiction Technology Transfer Center Network. I have had the great privilege of working with Dr. Achara for much of the past decade and enjoyed this opportunity to discuss her perceptions of the systems transformation efforts underway across the country.

Bill White: Can you summarize your professional background and the circumstances that led to your focus on supporting the development of recovery-oriented systems of care?

Dr. Ijeoma Achara: I completed my graduate work in counseling, clinical, and community psychology first at Boston College and then the Graduate Program for Applied and Professional Psychology at Rutgers University. Early in my career, I did prevention work with adolescents and also specialized in working with children, adolescents, and families with mental health and addiction challenges. I worked in a number of settings including schools, community mental health centers, hospitals,

home-based treatment programs, and addiction treatment centers. The families that I worked with were typically struggling with challenges related to a number of complex social and economic issues.

Although I was extremely passionate about my work, I began to grow increasingly frustrated. It felt like the services that I offered were just a drop in the bucket compared to the broad range of services and supports that people were telling me they needed in order to get and stay well. As a result, I increasingly became interested in policy work. I thought that maybe I could have a greater impact on people's lives if I moved beyond the individual level of intervention and instead targeted systems change, but I didn't know any psychologists who were doing this kind of work and was not sure what it entailed.

My supervisor at the time, Dr. Paulette Hines, in the Office of Prevention Services at the University of Medicine and Dentistry in New Jersey, was extremely supportive of my professional development. She told me about a post-doctoral fellowship at Yale University that was focused on improving systems for people with behavioral health challenges. I was fortunate enough to get the fellowship, during which I worked closely with Dr. Arthur Evans and Dr. Larry Davidson. They both introduced me to the concept of recovery-oriented systems of care (ROSC), and immediately the principles resonated with me.

In 2004, Dr. Evans became the Commissioner of the City of Philadelphia's behavioral health system. He invited me to join him there as the Director of Strategic Planning. In that role, I was focused on coordinating the development of a ROSC in Philadelphia.

Bill White: You've discussed different approaches to developing a recovery-oriented system of care: the additive approach, the selective approach, and the transformational approach. Could you describe them?

Dr. Achara: Yes, I believe that these distinctions are extremely important because the approach taken influences the success of your systems change efforts. In the additive approach to developing a ROSC, recovery support services are added to supplement the existing treatment system, but the treatment system itself remains essentially unchanged. Due to the focus on adding new services, one of the hallmarks of this approach is the belief that new dollars are needed to develop a ROSC. Another characteristic is that treatment and recovery support services are pretty disconnected. They both exist in the system but do not function in a seamless, integrated manner. This approach also does not involve making the policy and fiscal changes that would fully align a system with recovery principles.

In a selective approach to developing a ROSC, there is recognition that treatment practices must also change to be better aligned with recovery-oriented principles, but the emphasis is primarily on developing new recovery-oriented programs or levels of care in specific parts of a system. The system may be peppered with some great, innovative programs that integrate both a recovery management approach to treatment and recovery support services, but those programs are limited to a few pilot projects or model programs. The principles of recovery-oriented care are not yet embedded in all components of the system. This can create confusion for people receiving services who often receive inconsistent messages as they navigate different parts of the system.

In the transformative approach, peer- and community-based recovery support services are developed and integrated into both treatment and community contexts. Also, the nature of treatment itself radically changes to become aligned with a recovery management approach. In the transformative approach, the entire system is aligned to support long-term recovery. This process involves a wide-ranging set of activities, including changing the language that is used, the services that are available, the integration of indigenous helpers, strategies for community education,

bolstering prevention and early intervention efforts, and specific treatment practices such as global assessments and recovery planning. In fact, all domains in the service system are realigned. Also, treatment and recovery support services are not only viewed as equally important, but they are offered in a seamless, integrated manner.

Bill White: Do you have a particular framework that you use to guide your planning for recovery transformation processes?

Dr. Achara: The framework that I use to think about the process of transforming a system into a ROSC is the framework that we used in Philadelphia. Essentially, there are three simple components.

First, there must be conceptual alignment or changing how stakeholders think about behavioral health challenges, recovery, and the principles that promote healing and wellness. This part of the work involves developing a shared vision for the changes that are desired, and this vision is based on a core set of principles and values.

Second, the process of recovery transformation in a system or organization is then focused around aligning specific practices and services with that vision. So, if for instance we really believe there are many pathways to recovery, what does that mean for our services? One implication is that we can no longer have one size fits all, universal programs. We have to provide individualized services and develop programs in which there are flexible menus of services for people to choose from.

Finally, the third component is ensuring that the context is aligned to support the vision and the practice changes. What are the implications for our policy, fiscal, and regulatory processes? How do our collaborations with the broader community need to change in order to support recovery-oriented practices?

Bill White: During your work in Philadelphia, I know that you applied a lot of lessons learned from successful transformation efforts in the corporate world. Can you describe some of those lessons?

Dr. Achara: When Dr. Evans asked me to coordinate the recovery transformation of Philadelphia's behavioral health system, there was no manual to guide the change process. I turned to some of the literature in the corporate world and found that many of the same principles applied. The works of John Kotter and Peter Senge were particularly helpful to me. Two of the key lessons I learned were the importance of developing a sense of urgency and the need to promote conceptual clarity upfront. Kotter maintains that urgency is needed to overcome the generalized complacency that often exists in systems, and I found this to be true. Without a sense of urgency, obtaining the cooperation and buy-in needed to make changes in a complex system can be an arduous process.

The other principle that I found immensely helpful for facilitating systems change was intentionally developing conceptual clarity and promoting a shared vision for change. Things are changing so quickly within the healthcare arena that system administrators and organizational leaders feel a tremendous amount of pressure to keep pace and to be in action. This can and often does lead to well-intentioned, but misinformed decisions and strategies that perpetuate fragmentation and which are not consistent with an ROSC. In a recovery-focused transformation effort, I have learned that the process is just as important as the product. The process of bringing all stakeholders together and creating a collective vision for the future leads to systemic changes that are much more sustainable and effective than mandating the creation of new programs or new kinds of services.

Bill White: In some of your presentations, you talk about the importance of understanding the nature of transformational change. Can you share more about this?

Dr. Achara: In my research about effectively facilitating systems change, I learned about three types of change: developmental, transitional, and transformational. In developmental and transitional change, you have a clear sense of the current challenges and the solutions. You know exactly where you are headed and what the ideal future looks like. In a transformational change process, however, you develop a vision of the future, but many of the details are unknown and only through forging ahead is it discovered. It requires entering a process without a completely defined outcome that is guided by values and often limited evidence.

Second, transformation change entails a shift in culture and attitudes. This is one of the unique characteristics of this kind of change process. It can't be reduced to adding a new service, changing a practice, or integrating more recovery support services. In the book *Addiction Recovery Management: Theory, Research and Practice*, my colleagues and I talk about the fact that recovery planning, for example, is not about a change in language, the forms utilized, or the final product. It is about the process, the shift in power dynamics, and moving from an expert orientation to one of collaboration so that the person can be supported in developing a plan that works for them. The process cannot be effectively implemented without attitudinal changes on the part of service providers.

Finally, because transformational change does entail shifts in mindset rather than just behavior, the process and the human dynamics are much more complex and the process can feel chaotic. This chaotic experience is not only normal, but it can actually help to move the process along as old assumptions about recovery and treatment are reexamined and reorganized.

Bill White: What are the leadership characteristics that you have found are most important for leading a system transformation effort?

Dr. Achara: This is a great question because so much of the success of systems transformation efforts depends on the style of leadership. First and foremost, leading a transformational change process requires courageous leadership. In the process of helping stakeholders navigate a complex change process, there will inevitably be bumps along the way. The nature of those bumps may be different for each community, but they will always surface. Successful leaders expect the challenges and are not deterred by them. They are willing to take risks, they are persistent, and they are comfortable with the ambiguity inherent in a process-oriented approach. I have seen some leaders try and control the process too tightly or micromanage their staff and stakeholders, and it hampers creativity and innovation.

The very nature of a recovery-oriented transformation requires that leaders resist the urge of being prescriptive and telling stakeholders what to do. Transformational change leaders recognize that their role is to set the direction and facilitate a process so that stakeholders together can develop a shared vision. This may be a very different style for some system administrators who are used to a more hierarchical approach.

As human beings, most of us find comfort in familiarity. Even when we know that things would likely be better if they were different, we are nevertheless still drawn to what we know. In order to move people into a space where they are willing to try new things, take risks, and blaze a new trail, inspirational leadership is required. People who have a gift for helping us get out of the weeds in which we are too frequently entangled, and explore the bigger picture are essential. These kinds of leaders motivate us to look beyond our individual interests or perspectives and think about the bigger picture. While one individual may not have the diverse attributes needed to guide transformational change, I think leaders can be intentional about surrounding themselves with people who compliment their leadership style.

Another important thing that I learned from Kotter and the change management literature is that successful transformations

are 70 to 90 percent leadership and only 10 to 30 percent management. Management, which focuses on issues like planning, budgeting, staffing, organizing, and problem solving, produces predictability and order. Leadership on the other hand, which focuses on establishing a direction, aligning people, and then motivating and inspiring them, produces change. I cannot over-emphasize the importance of understanding this distinction and the critical role that leadership plays in successful transformation processes.

Bill White: What recommendations do you have for those system administrators who are thinking about getting started? What are some initial steps?

Dr. Achara: My recommendation is to start with activities that help to increase stakeholders' awareness and understanding of a ROSC. This might involve holding some community meetings to discuss the current state of the system, sharing some of the national trends related to ROSC, and beginning a dialogue about the implications for local efforts. Administrators might conduct a formal assessment of the current strengths in the system and opportunities for growth. Focus groups with different stakeholders are extremely helpful in shaping a vision of the future and can also begin to build a sense of urgency around the need for change. Creating guiding coalitions such as a recovery advisory group or a system transformation steering committee can also be used as a mechanism to keep the process transparent and inclusive.

Bill White: One of the initial activities in Philadelphia was the development of guiding coalitions to lead the transformation process. What were some important factors to consider in developing and maintaining an effective coalition?

Dr. Achara: Because transformational change is difficult to accomplish, I've learned that a major force is needed to keep the process in motion. A guiding coalition comprised of the right individuals can serve this purpose. I think most of us have participated in committees or advisory groups that had important missions but ultimately accomplished little. Avoiding this outcome requires that leaders think carefully about the composition of the group. There need to be enough people in positions of power in the system who have the ability to affect change. This includes people in formal leadership positions as well as people who are informal leaders and who have the ability to influence others. The group needs to have diverse representation in terms of roles within the system and community. An effective advisory group also needs a strong connection to the highest levels of leadership. Are there individuals on board who can make immediate decisions and drive the change process? If not, people may feel that they come up with good ideas, but no one has the power to implement them. Finally, there needs to be a mix of both management and leadership skills in the group. You need both those who track the details and those who can help articulate the vision and inspire others to align themselves with that vision.

In addition to the composition of the group, the actual focus of the work is extremely important. When the recovery advisory committee in Philadelphia was established, the group was presented with clear tasks and questions that needed their immediate input. It's important that the work is related to current, real, and pressing issues within the system and that the work of the group will have an impact in the short-term. One of the tasks of the recovery advisory committee was to re-envision the system's day treatment programs. The committee identified a recovery definition, a set of guiding principles, and then began to articulate what recovery-oriented services would look like for this level of care. This information was used to craft a Request for Information from providers and led to a full RFP and the transformation of the day programs into Community Integration Resource Centers. Committee members were able to see the impact of their work early in the process, which added credibility and kept the momentum going. That

advisory committee is still active with many of the original members 6 years later.

Bill White: As systems transition from developing their vision of a recovery-oriented system of care to changing practices, the process can feel overwhelming. What do you believe helps to ensure consistent progress?

Dr. Achara: It helps if stakeholders and system administrators go through a collaborative process of prioritizing their efforts. When people understand the extent and depth of what is involved in a recovery-focused transformation process, it can feel overwhelming. Many systems go through a strategic planning process with stakeholders during which they identify the areas where they are likely to generate the most short-term wins. As a part of this dialogue, they might consider such questions as:

- What strengths already exist in the system that they can build on?
- Where is the greatest sense of urgency for change?
- What do people in recovery and family members most consistently report they need in order to initiate and sustain recovery?

Exploring these kinds of questions will help to prioritize efforts.

System administrators also have to communicate that the change process is more of a marathon than a sprint. Set realistic expectations that lasting change will take time. Also, try to map out a plan in which you strategically provide the change process with booster shots. Maybe initially you bring in an inspiring and motivational national speaker to help create the momentum for change. Further along in the process, you might highlight several of the local programs that have made significant changes and have subsequently experienced positive outcomes. As the process continues, you might ensure that your contract language and expectations of providers is consistent with a recovery orientation. Providers can go through a similar process of prioritization and strategically validating their staff's efforts and reinforcing the message of recovery transformation.

Bill White: For those systems that are in the throes of an implementation process but are finding it challenging to keep the ship afloat while simultaneously implementing a change process, what would you recommend?

Dr. Achara: I have two recommendations. First, I think it is critical that at the systems level, there is a point person who is dedicated to leading the recovery transformation effort. Without dedicated attention, it is extremely difficult for systems to attend to all of the operational concerns as well as successfully execute a transformational change process. It is important, however, that the operations and planning functions are connected and that they inform one another. Many of the folks who are overseeing the day-to-day operations may not have the time to take on the coordination of a change management process, but they do have extremely valuable information that will help the emerging vision to become a reality in communities. They are the ones who know where the potential pitfalls are and how to work around systemic challenges.

Second, it is also critically important for system leaders to connect the dots. Changing demands and priorities constantly bombard treatment providers and system administrators. They are expected to implement culturally competent services, integrate evidence-based practices, develop trauma-informed systems of care, use health information technology, and the list goes on and on. Given the numerous priorities, it is not unusual for stakeholders to become somewhat numb when exploring new ideas. Many perceive discussions about recovery management and recovery-oriented services as the "flavor of the month." As a result, it's critical to explain how developing a ROSC helps to connect all of the other initiatives underway in the system.

If a recovery transformation initiative is framed as another system priority on par with increasing evidence-based practices for instance, it will just reinforce the view that this is the latest fad. For example, in their list of priorities, I have seen some systems list ROSCs as number 10 after their focus on trauma, veterans, etc. In these instances, the focus on the recovery-focused transformation is more likely to get buried under all of the other important efforts to keep the ship afloat. Other systems, however, explicitly state that developing a ROSC is the ultimate goal and conceptual framework for their entire service system, and they articulate how all of the other initiatives and priorities fit within this framework. In the latter case, people don't see their efforts to keep the ship afloat as disconnected from their ultimate goal of developing a more effective, recovery-oriented service system. It creates a context in which people understand that they are all working toward the same goal, rather than creating an environment in which people feel that there are too many priorities competing for too little time and resources.

Bill White: Can you describe some of the frequent misconceptions that you encounter amongst stakeholders who are working to develop a recovery-oriented system of care?

Dr. Achara: Some of the most frequent misconceptions are related to people's understanding of a recovery-oriented system of care. As I described earlier, some believe that an ROSC primarily entails adding recovery support services to the treatment system. Another misconception is that an ROSC is basically a network of providers who increase their collaboration and partnerships in order to provide more coordinated care. Both of these descriptions fail to align actual treatment services with a recovery management approach. A third misconception that I encounter often is the belief that peer- and community-based recovery support services are competing with treatment and that there is a hidden agenda for these support services to ultimately replace treatment services eventually. Nothing could be further from the truth. If we really believe that there are multiple pathways to recovery, then we have to develop systems of care that support and celebrate those diverse pathways. Treatment and recovery support services complement one another and are equally important within an ROSC.

A final misconception that I frequently encounter is the belief that new resources are needed to develop an ROSC. Many of the changes that are inherent in developing an ROSC are not necessarily new things, but are shifting the way in which we do things. For instance, no additional resources are needed to shift our service delivery approach from an expert-patient model to more of a collaborative-partnership approach. It also does not take additional resources to change our assessment processes from a narrow, problem-focused approach to a more holistic, global process. I have also seen providers effectively develop formal and informal peer-based recovery supports without any new resources, and in the process, they have dramatically changed the cultures of their organizations and the outcomes for the people receiving services. There are some elements of a ROSC that undoubtedly would benefit from an influx of money to support their development. Many of the foundational elements, however, are typically cost neutral.

Bill White: What are some of the common challenges that systems encounter in their effort to develop a recovery-oriented system of care, and how have they successfully overcome them?

Dr. Achara: A common challenge encountered is stakeholders' anxiety about change. One of the strategies that I have observed as being helpful in minimizing this anxiety involves being deliberate about identifying ways to empower people and facilitating opportunities for them to develop a sense of ownership. As a concrete example, it's not uncommon for tension and anxiety to surface when integrating peer-based recovery support services into an agency for the first time. Some counselors

may be confused about role clarity, others may be concerned that there is a hidden agenda to eventually replace them, and others may have worries that working alongside people in recovery will somehow increase their already overwhelming workload. From what I've observed, the level of anxiety about this process is significantly reduced when the clinical staff is involved in the process. In many places, staff members are involved in discussions about role clarity, etc. They may help to develop job descriptions, participate in interviewing, or recommend people for the positions. The same dynamic happens at the systems level. The extent to which people are directly involved, feel some sense of ownership, and have the ability to inform the process seems to influence the level of anxiety that they experience.

Related to dealing with anxiety, it is also important leaders create an environment in which stakeholders feel comfortable expressing their concerns, fears, and confusion without being labeled resistant.

Another challenge that is frequently encountered as systems strive to develop an ROSC are concerns about the enormity of the task of aligning fiscal and policy strategies with the delivery of recovery-oriented services and supports. I think when systems look at all of the services and supports that they would like to align with this direction, it can be overwhelming to determine how best to ensure that the administrative structure is synchronized. I have found that systems are able to make more progress when they take a strategic, incremental approach to aligning the administrative context. Identify the types of changes in the service system that you would like to see. Prioritize those changes. Then for each of those priorities ask stakeholders what is getting in the way, or what might get in the way of integrating this particular approach, service, or support? Some of the policy and fiscal barriers may be obvious upfront. Others will not surface until stakeholders are in action and trying to make the vision a reality. In either case, having an ongoing and open dialogue is key.

Bill White: What is one of the most frequent questions that you currently encounter in the field?

Dr. Achara: Recently, I have received a lot of questions about how prevention services fit into a ROSC. Unfortunately, in many systems, treatment and prevention services still operate in silos, totally disconnected from one another. I believe that developing a ROSC presents an opportunity to reconceptualize how we structure systems so that prevention, early intervention, treatment, and continuing support services are viewed as existing on a continuum and all in the context of the broader community. I also try and remind people that an ROSC is not a treatment template that can be superimposed on any community. It is a value-based framework that guides us in thinking about how to develop a network of formal and informal services and supports. Just as those values and principles have implications for treatment services, they also have implications for the way we approach prevention services. In treatment, for instance, we talk about moving away from a deficit or problem-focused approach to a strengths-based approach. One of the implications of this is that during assessments, rather than focus primarily on the presenting problems and the circumstances and situations surrounding the problem, we expand our focus to exploring individual, family, and community strengths, and the individual's goals, hopes, and dreams. This means having a more holistic approach and expanding the kinds of questions that we ask during assessments to include things like:

- Can you tell me a bit about your hopes or dreams for the future?
- What kind of dreams did you have before you started having problems with alcohol or drug use, depression, etc.?
- What are some things in your life that you hope you can do and change in the future?

- If you went to bed and a miracle happened while you were sleeping, what would be different when you woke up? How would you know things were different?

For prevention services, having a strengths-based approach has similar implications. When I was trained in prevention work, we typically had a very problem-specific approach. We focused on a specific problem in the community such as suicide, underage drinking, or violence, and developed a targeted program geared to that problem. As a part of the approach, we engaged the community by asking questions about the severity of the problem, the extent of the problem, the populations that were most at risk, the areas in the community that were most vulnerable, etc. These are the same kinds of problem-focused questions that we ask in a traditional treatment assessment. A strengths-based approach in prevention services means helping the community to also think about and identify their assets and just as importantly, to develop a vision for their community beyond the specific problem. In a strengths-based approach to prevention, we facilitate discussions in which community members think about not only the behaviors they would like to diminish, but the behaviors, resources, and environments that they would like to expand and create. So, additional questions might include things like:

- What are your hopes for your community? What would you like to see more of?
- What kinds of supports will help to promote wellness and build the kind of community that you hope for?
- If you went to bed and a miracle happened overnight, what would be different in your community when you woke up? How would you know that things were different? What would people be doing?

Questions like these help to expand stakeholders' vision beyond addressing the problem. I have also found that without developing a broader, more holistic vision for the community, community coalitions that develop to address a specific concern are less sustainable. When progress is made on the particular issue, coalition members are more likely to celebrate and eventually disengage because the perception is their work is done. This shift in approach is consistent with SAMHSA's focus on developing prevention-prepared communities, which takes a more holistic, cross-systems approach to prevention. It is also consistent with the Institute of Medicine's 2009 report on Preventing Mental, Emotional, and Behavioral Disorders among Young People. One of the many things that that report left me with is the statement that infusing the prevention focus into the public consciousness will require the development of a shared public vision. To me, this speaks to developing a vision that encompasses what we want to support and build rather than just what we want to stop or diminish.

Bill White: Can you share some of the strategies that you have used to successfully mobilize recovery communities?

Dr. Achara: Efforts geared at mobilizing and empowering people in recovery are among the most powerful strategies that systems can implement to advance their recovery transformation efforts. Our thinking needs to expand beyond integrating peer support services like recovery coaching to creating pathways of opportunity for people in recovery to assume leadership positions both within behavioral health systems and within the broader community. Peer support services should be developed within an overall strategy to create a culture of peer support and leadership within communities. In the absence of this, I have heard peer specialists and recovery coaches in many systems describe feelings of tokenism and frustration at having very limited employment options and general opportunities available to them.

Creating a culture of peer support and leadership ensures that there are numerous

formal and informal opportunities for people in recovery to give back, participate, or be change agents within their communities. This looks different within each community, and it's important for people in recovery to take a lead role in shaping the vision for their individual communities. I just facilitated a day of strategic planning in Michigan with about 75 people in recovery that state administrators brought together to help define what a culture of peer support and leadership would look like in Michigan. In addition to a wide variety of peer-based recovery support services, people talked about wanting leadership opportunities on boards and advisory councils throughout the state, having peers actively involved with dismantling stigma about addiction and recovery by being trained to share their recovery stories in their communities, people in recovery organizing community-wide, highly visible celebrations of recovery, peers having access to formal mechanisms to volunteer their time and expertise in conducting assertive outreach to others in need of services, peers developing and volunteering in community-based recovery centers, people in recovery collaborating with local businesses to create internship opportunities and serve as mentors for others seeking employment; the ideas were endless. The good news is no one treatment provider or system administrator has to have all the answers. They just have to be willing to ask the right questions, listen, and take collaborative action. Systems have a role in helping to facilitate the dialogue so that the solutions can emerge.

One effective strategy that was used in Philadelphia involved developing a storytelling training. This training was facilitated by Joan King, a recovery transformation consultant, who eventually trained other people in recovery to facilitate the training. After participating in the training, many people served as panelists in provider trainings and in both local and national conferences. This training was a simple and low cost investment for the system, but it yielded tremendous results. People in recovery began to network with one another and to advocate for more opportunities to participate as leaders and change agents. The Department of Behavioral Health and Intellectual disAbility Services subsequently developed a leadership academy for people in recovery, a community education initiative called Taking Recovery to the Streets, peer specialist and recovery coaching trainings, and a recovery resource center, among other resources. Most strikingly, two years after starting the storytelling training, a recovery conference was planned by and for people in recovery. Based on their networking and outreach, more than 1600 people in the City of Philadelphia registered for a conference that had capacity for 700 people.

Bill White: What opportunities do you think healthcare reform will present for peer-based recovery support services?

Dr. Achara: In the changing healthcare environment, it will be increasingly important that stakeholders are able to identify the most effective supports and services. As a result of the increased focus on evidence-based medicine, we will need to be much more aggressive about establishing a research agenda related to these services. While there is a large amount of anecdotal data about the effectiveness of peer-based recovery support services, there is so much that we still need to know about their role in long-term addiction recovery.

I also see that there will be an increasing need to develop peer support services that have a behavioral health approach. Within healthcare reform, there is a significant emphasis on integrated services. The focus of this integration is really between primary care and behavioral health. There is an implicit assumption that mental health and addiction services are already integrated or at least coordinated. In my experience, this is unfortunately not the case. As an example, many systems have a mental health peer specialist training that includes minimal information about substance use disorders, and they may have a totally separate addiction recovery coach training, which similarly includes minimal

mental health content. Meanwhile, the people in the trainings who often have challenges related to both mental health and addiction are saying this makes no sense. The focus on whole person health and holistic approaches within healthcare reform challenge us to examine how we can structure our services in a way that is most effective and helpful for the people being served, as opposed to most convenient for running a system.

The increased focus on integrating primary care and behavioral health services presents tremendous opportunities to infuse primary care settings with more peer-based services. Much of the life experience and lessons learned that come from successfully managing a chronic condition like a substance use disorder can be applied to successfully managing other chronic conditions. Peers are positioned to provide support around general lifestyle changes related to managing other chronic conditions. I anticipate that within primary care settings, there will be an increase in screening and brief intervention services, as these will be reimbursable. People in recovery can add significant value by helping to support people who are in the very early stages of developing a substance use disorder and helping them sustain/initiate recovery before developing a long addiction career.

Other opportunities revolve around the role of peers as system navigators. While healthcare reform is intended to increase access to care, experts are maintaining that the actual levels of enrollment in both private coverage and Medicaid will really be determined by ease of enrollment, outreach, and education efforts. Given these challenges, peers can play an expanded role in outreach, helping people navigate the world of personal insurance and enrollment. People in recovery can also serve as a natural bridge to primary care settings and provide warm, assertive connections between primary care and specialty behavioral health services.

Finally, healthcare reform presents tremendous opportunities not only for expanding the roles that people in recovery can play and the specific services offered, it also provides opportunities for recovery community organizations to shape the direction of service delivery and inform discussions about quality of care and the scope of services in a way that we have not seen before. Recovery community organizations can become a more powerful network and more of an integrated part of the larger healthcare system. With this expanded role, I think there will be a need for recovery community organizations to provide training and technical assistance to both specialty behavioral health providers as well as primary care providers on the benefits of integrating peer support services.

Obviously, there are still many mixed feelings about healthcare reform. From my perspective however, one thing is certain, the landscape is rapidly changing. With the changes, there are threats and opportunities for peer-based recovery support services. My hope is that as a behavioral health community, we will be intentional and persistent to ensure that we maximize all of the potential opportunities and in doing so, promote the best quality of care for people with substance use disorders.

Bill White: We have referenced the sustained involvement you have had with the transformation processes in Connecticut and Philadelphia. Are there other bright spots you've seen in your consultation experience that you could acknowledge that are in the process of implementing RM/ROSC-focused system changes?

Dr. Achara: Absolutely, the State of Michigan initiated a recovery transformation process a couple of years ago. Deborah Hollis, the Director of the Bureau of Substance Abuse and Addiction Services (BSAAS), has led a process for developing a shared vision of a ROSC in Michigan. With the support of a technical assistance award from CSAT, the state hosted several ROSC symposia to increase awareness of recovery-oriented services and supports and began exploring the implications that developing a ROSC would have for Michigan. BSAAS subsequently established

a ROSC Transformation Steering Committee, which developed a multi-year implementation plan. Michigan has regional coordinating agencies, and several of them are in the process of developing recovery-oriented systems of care. In Washtenaw County, Michigan, for instance, Marci Scalera is leading an effort to restructure the entire service system to be consistent with a recovery management approach. This includes not only changing the way in which treatment services are delivered but integrating recovery support services and changing the way in which services are funded. The state of Iowa, under the leadership of Cathy Stone at the Department of Public Health, has also initiated a recovery transformation process. That state, along with Michigan, is really exploring how to develop a more integrated, recovery-oriented continuum of care that encompasses prevention, early intervention, treatment, continuing care, and recovery support services. So, prevention specialists are examining what the core principles and values in a ROSC mean for their work also.

Bill White: You have been deeply involved in recovery-focused systems transformation efforts for the past decade. What has this work meant to you at a personal level?

Dr. Achara: At a personal level, this work is deeply meaningful for me. I am extremely passionate about developing systems of care and services that facilitate sustained recovery. My commitment to this stems from my personal experience of witnessing family members unsuccessfully struggle with substance use disorders and seeing the damaging effects in so many areas of their lives. I strongly believe that if they could have accessed a variety of recovery-oriented services and supports, they would still be with us today. My commitment is also influenced by my work with families and seeing the devastating effects of substance use disorders, coupled with limited access to the opportunities and resources that are needed to create a fulfilling and desirable quality of life.

While I have experienced the harmful effects of substance use disorders, I have also been extremely fortunate to witness the absolutely incredible experience of recovery. I have learned from people with lived experience about what helped and hindered their recovery. Being a witness to a personal recovery transformation is life changing. Recovery is contagious, and I'm hooked! I am invested in doing everything that I can to ensure that as many people as possible with substance use disorders can initiate and sustain their recovery process. I feel that I am one more person, joining with thousands of others who are all trying to make a difference in their own way. I strongly believe that together there are no limits and no boundaries on the impact that we can have in communities across the nation, and I feel honored to be a part of this work.

Bill White: Dr. Achara, thank you for your willingness to discuss your work and for all you do for the field.