Recovery Oriented Systems of Care:

Building and sustaining a community based model that makes clinical sense.

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Abstract

A trend of resource reduction on local, state and federal levels can be seen throughout various systems. In addition is the ever growing need for addictions treatment. In its current state, research illustrates that the need for treatment exceeds the capacity of existing resources. This trend is expected to continue. In response, efforts can be seen systemically across a multitude of human service providers including Health Care, Criminal Justice, and Community Mental Health Centers. Traditionally, each provider works within its own internal boundaries to create solutions, creating a "siloed" effect. As a result, a complex system is created leaving the navigation of these systems for both providers and consumers difficult. In essence, a continuity of care is impaired. The solution is in the community. The conduit for providers to access and effectively utilize the solution is through a Recovery Oriented System of Care (ROSC) model.

A conflict exists between what has been identified as effective in human services, and what is practice. For example, addiction has been identified as a chronic illness which is treatable. By definition, the chronic nature of addiction means that it persists for a long period of time However, existing treatment modalities treat addiction in an acute care model. As stated by McLellan (2002), "If addiction is best considered a chronic condition, then we are not providing appropriate treatment for many addicted patients." The research of McLellan (2002) further illustrates that matching services and approach with an individual's current stage of change is essential, yet most traditionally based programming is tailored toward those in action phases of change. If services matched this belief, providers would not create expectations that full sustained recovery should be achieved from a single episode of treatment. In addition, prior episodes of treatment and relapse would not be indicators of a poor prognosis. If services were delivered with a belief in the chronic nature of addiction, consumers would not be extruded for becoming symptomatic. Long lasting interventions would be in place, not serial episodes of disconnected treatment. In addition, if service systems were in aligned with what is known to work, relationships would not be terminated following brief interventions (White & Kurtz, 2006). A Recovery Oriented System of Care (ROSC) approach encourages consumers to rely on themselves, and their community. By leveraging informal community supports, combined with both formal and informal treatment resources, ROSC offers an effective and efficient way to assist people through the recovery process.

THE CRISIS

Treatment Need Exceeds Capacity

In 2009, 23.5 people needed treatment for Substance Use Disorders (SUD.) Of these people, 2.6 million received services. Thus, 20.9 million people suffering from a SUD went untreated in 2009 (HHS/SAMHSA, 2010). The state of Indiana, like many states in the United States is experiencing a crisis in the delivery of addictions treatment. Too many individuals are in need of addictions services and with

limited resources to serve these individuals. It is estimated that 80% of incarcerated individuals in the Indiana Department of Correction suffer from a history of substance abuse (National Institute of Justice, 2001).

As illustrated through such statistics, the need for addiction services is great and the resources designed for response are limited. Likewise, the need for addictions treatment exceeds capacity. While the necessity for collaboration and unified treatment grows, so does fiscal need. In addition, our nation and state continues to face a diminishing economy, placing hardships on individuals, families, and communities. Moreover, people with an SUD are more likely to struggle with poverty and be uninsured. As the rate of people in need of addictions treatment increases, the available resources steadily diminish.

Financial Challenges

Financial challenges are continued to be faced by our national, state, and local governments. In 2010, 42 states experienced budget cuts due to revenue short-falls. The average state mental health budget was cut by 8% placing an even greater restriction on the availability of addictions services to those in need (Oss, 2009). With diminishing resources and an increased need for effective addictions treatment the following question must be answered: “How do we do more, with less?”

Multiple System Involvement

Substance abuse is related to the involvement in multiple institutional service delivery systems. Substance abuse in individuals involved in the criminal justice system is four times that of the general population (National Institute of Justice, 2003; HHS/SAMHSA, 2006). In 2004, a survey indicated that 53% of State and 45% of Federal prisoners met diagnostic criteria of drug abuse or dependence (Mumola & Karberg, 2006). The National Center on Addiction and Substance Abuse at Columbia University (2010) has indicated that 1.5 million incarcerated individuals meet DSM-IV criteria for substance abuse or addiction; 458,000 additional incarcerated individuals had either histories of

substance abuse, were under the influence of drugs or alcohol when they committed their crime, committed their crime to get money for drugs, were incarcerated for an alcohol or drug law violation or shared a combination of these characteristics. These groups combine make up 85% of the United States prison population (The National Center on Addiction and Substance Abuse at Columbia University, 2010). Studies have identified that between one-third and two-thirds of children involved in the child welfare system have a substance abusing or dependent parent (HHS/SAMHSA, 1997). Parental drug abuse increases time that children spend in foster care (HHS/SAMHSA, 1994). Untreated substance abuse needs have been identified in hospital emergency department patients and generate much higher hospital and emergency room costs than patients without untreated needs (Rockett, Putnam, Jia, Chang, & Smith, 2005). As illustrate, addiction is a multi-systemic issue with implication existing for all social service sectors.

In response, a multi-systemic approach is required. An example of this can be seen in a study conducted within adolescent addiction providers in 2001. This study examined the prevalence of adolescent substance use disorders across five service delivery systems: alcohol and drug treatment; juvenile justice; mental health; school based services; and the child welfare system. Youth were selected if they were active in at least one of the five service delivery systems. Rates of substance use disorders among adolescents were found in all five service delivery systems: 82.6% in Alcohol and Drug; 62.1% in Juvenile Justice; 40.8% in Mental Health; 23.6% in school based services; 19.2% in Child Welfare (Aarons, Brown, Hough, Garland, & Wood, 2001).

Such research as illustrated above further gives evidence to the reality that majority of people with untreated substance abuse disorders will find themselves in multiple institutional service delivery settings. The acknowledgement of multiple systems involvement creates an opportunity to create collaborative, non-duplicated resources that focus on the integration of these diverse service needs.

A Holistic Approach

Addiction has long been recognized as a chronic disease; however, most treatment for addiction uses acute care interventions rather than a disease management approach. As a result, this has influenced the creation of a "revolving door effect" of multiple acute care episodes. Often the cycle of use repeats often with involvement in the criminal justice system. Without more creative ways to address individuals' comprehensive needs, people caught in this cycle have little hope of a sustained recovery. Effective treatment is holistic, attending to the multiple needs of an individual, not just his or her substance abuse. Neff et al. (2006) illustrate that holistic models that include traditional treatment approaches facilitate effectual treatment outcomes.

A holistic approach requires treatment needs to be individualized and comprehensive, meaning that it attends to the needs of the whole person. It is imperative that an individual's treatment and service plan is continuously assessed and modified to ensure that it meets his or her changing needs. This holistic approach should assess for a wide variety of needs that include but aren't limited to: psychiatric needs, vocational services, physical health, employment, housing, pro-social support, an individual's family and community involvement.

What is a ROSC?

Under the leadership of the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), the substance use disorders treatment field is shifting from an acute care model of treatment to a chronic care approach that is holistic. This new approach is known as Recovery-Oriented Systems of Care (ROSC).

ROSC is a systemic shift from treating illnesses in segregated systems, to improving lives and with systems that are part of a larger network of supports. It requires a deconstruction of systematic silos, and a reconstruction of community collaboration. Within ROSC, addiction is treated as a chronic condition, placing implications on sustained recovery management, timing of intervention, services access and engagement, service planning, and assertive linkage to recovery supportive resources.

ROSC uses multiple service providers and community supports as well as a partnership with the individual and their family. In this partnership ROSC, treatment, community supports, volunteers and associates ask participants what specific needs he or she wants to address at any given time. This partnership helps create a community environment for those working toward achieving and sustaining recovery while providing multiple points of access for multiple systems of support. The approach is designed to touch individuals throughout their recovery and give them what they need when and as they seek help. Programs in other states have been using this approach for several years with great success.

A ROSC supports "person-centered and self-directed approaches to care that build on strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness, and recovery from alcohol and drug problems" (HHS/SAMHSA, 2005: 2). ROSC represent networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families. "The system in ROSC is not a treatment agency but a macro level organization of a community, a state, or a nation" (White & Kurtz, 2006: 13).

ROSC recognizes the inadequate amount of resources to meet the need of treatment. With a limited amount of resources, acute services are being appropriated for those persons with the most severe needs. In a ROSC model, a vested interest is placed in developing and supporting more recovery related resources for consumers and the community.

MODEL FOR SERVICE DELIVERY

In addition to shrinking budgets a multiple system involvement has created an opportunity for innovation in the delivery of addictions services. This innovation recognizes that a more holistic approach that supports a chronic disease model must incorporate clinical treatment with recovery capital needs. The recognition of a blended service delivery model allows for more targeted use of

scarce formal addictions treatment resources while providing the individual in need of services with more comprehensive care.

An environment with scarce formal resources and ever-increasing needs requires treatment providers to think more strategically about how to utilize formal resources. In Indiana for example, last year (2010) providers were faced with multiple budget cuts that affected the ability to provide services to the indigent population, most of which were addictions clients. Being faced with an additional reduction of services for this population, the creation of a more effective model was needed. This was the primary motivation for Centerstone of Indiana to begin to look at how we could develop a ROSC. In preparation for this task focus was placed on reviewing professional literature and research regarding the ROSC model. It was identified that ROSC development seemed to be something that happened outside of treatment. It was recognized that Centerstone would need to develop a more comprehensive plan, integrating the needs of our clients with the expertise of our staff. Without this unique approach, a risk existed that we would not be able to effectively serve our clients. It was thought that if Centerstone did this effectively, we could provide more targeted treatment, at a lower cost and help create much needed partnerships in the community. In addition, Centerstone could offer more community based resources for our clients. Ultimately the vision was to pilot what we viewed would be a best practice model. Knowing that as future budgetary cuts continue and the federal government continues to emphasize recovery, we needed to develop a program that could serve as a model for the state of IN.

In order to facilitate a treatment delivery model that combines formal treatment with recovery capital needs, Centerstone uses the diagram in Figure 1. Assessment of a client determines a client's treatment needs in addition to their recovery capital needs. An individual who has low treatment need and low recovery capital would require services that focus more on building recovery capital in their community and less on formal addictions or mental health treatment. An individual with high treatment

needs and high recovery capital will require more formalized addictions treatment services and less emphasis on recovery capital.

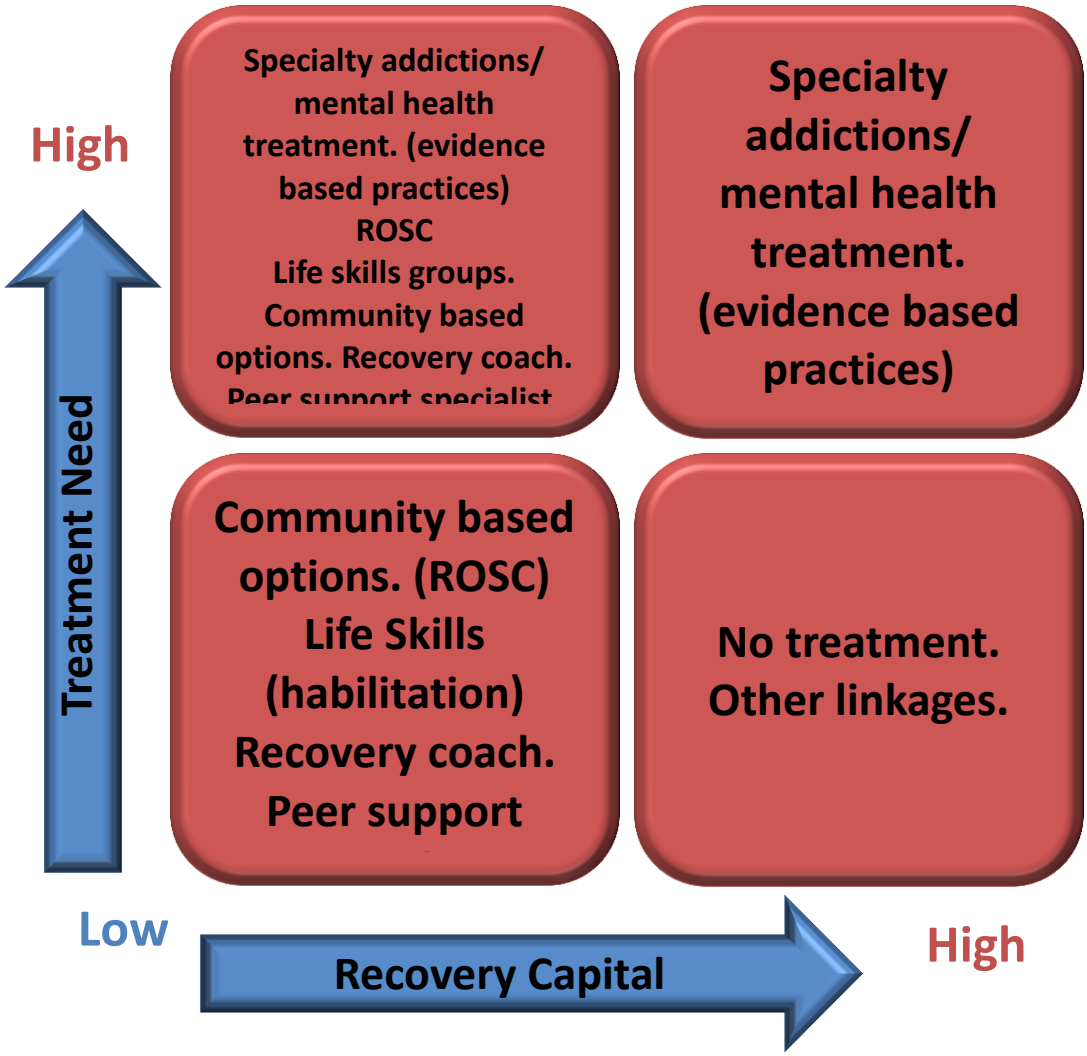

Figure 1

Identifying and diverting clients that have recovery capital needs to our ROSC made tremendous financial sense. For example, at Centerstone all clients are received through the clinic. Many of these clients are referred by the court and have many complex needs that are not efficiently and effectively served by formal treatment approached. Needs that can influence substance abuse and a return to criminal behavior, often identified as Criminogenic Needs (recent release from jail or prison, need housing, employment, life-skills training, pro-social supports) may not require formal treatment

interventions and therefore do not need to be inundating our clinic. Oftentimes, individuals present with community and resource needs and their formal treatment needs are either non-existent or not yet apparent. In essence, Centerstone developed a triage model aimed at assessing and addressing client needs in a more comprehensive fashion. Placing emphasis on a person's Recovery Capital in addition to any formal needs, reinforces effective treatment efforts. Conducting one without the other is undermining to efforts of intervention. Am emphasis is placed on empowering clients to navigate their world in a self-sufficient manner. This is accomplished by equipping people with the information, tools, resources, life skills, and supports necessary for long-term recovery.

ROSC v. Traditional Systems

ROSC embraces the core elements of an effective Systems of Care approach. It remains person-centered throughout the recovery process. Family and allies are incorporated and engaged throughout the recovery process. In addition, a comprehensive approach to service provision is facilitated across the life span of a person's recovery. Recovery systems are anchored within the identified community. ROSC promotes a collective vision with shared resources to intervene positively within the recovering population. Through such partnerships, continuity of care is ensured due to an ongoing collaborative relationship.

When approaching service delivery within a ROSC, individual need for clinical treatment is not separate from their need for long term recovery capital. For example, in a traditional Intensive Outpatient (IOP) group, a client *would* be addressing both their independent treatment needs (i.e. anxiety, depression, trauma, axis II disorders) as well as recovery capital (communication skills, employment, housing, social support.) While this client is in treatment, they may improve due to the support of the group and temporary interventions but these skills are not necessarily contextually specific to this individual and their place in the community. Formal treatment without acknowledgement of recovery capital lacks the capacity to address an individual's long term recovery in

their unique setting making it doubtful that any episode of formal treatment will be effective in the long term. In summation, we are good at helping individuals in the short-term but we are not arming them with long term solutions. Chart 1 (below) compares traditional treatment models and their ideals to ROSC:

Chart 1

Traditional System	ROSC
Focus on action stage of change	Focus on pre-action stages of change
Progress through service continuum in linear manner	Consumers work with a team to meet their needs.
Serial episodes of disconnected care	Continuity of healing relationships across episodes, programs, agencies and systems.
Consumer is blamed/discharged for relapse	Responsibility is placed on the services milieu
Limited aftercare	Continued support and early re-engagement
Pain based motivation	Hope based motivation

ROSC is an empirically-based approach, grounded in extensive research. It is both effective an efficient. The outcome-driven nature of ROSC promotes progression through Stages of Change, and recognizes ambivalence as an opportunity for intervention. Its efficient nature derives from the systems of care approach being both adequately and flexibly financed. With national and state trends financial supporting a ROSC model, the time to adopt this model is now.

ROSC and Recovery Capital

Recovery capital is the sum of supports a person has in his or her life to help him or her reach and maintain recovery from addiction. A job, a supportive family, clean and sober friends, a place to live, and spiritual balance through a church or other religious affiliation are all elements of recovery

capital. The greater the amount of recovery capital available the more likely a person will be successful at attaining and sustaining a life free from substance abuse (White & Cloud, 2008; Cloud & Granfield, 2004; Granfield & Cloud, 1999).

Addiction's treatment is an outgrowth of recovery capital development. Much of what is addressed during addictions treatment is the development of recovery capital. An area of concern is that frequently clients are put into formal addiction's treatment (i.e. IOP) multiple times and what the clinician is actually treating is a client's low recovery capital rather than their treatment need. It is imperative that providers begin to recognize that consumers may have a need for clinical treatment and/or recovery capital development as well.

The concept is that people with high recovery capital are better able to overcome addiction. This is due to having an increase in their protective factors which are responsive to recovery risking situations. For example, when a person experiences a trigger to use, or an increase in stress, he or she has available resources to assist in alleviating their need. Traditional substance abuse treatment approaches may recognize the need for recovery capital but few have ways of helping build it. The primary focus of traditional treatment is educating participants about the effects of substance abuse and helping them find ways of coping, but outside the group the level of recovery capital available is determined by the resources the individual participants find or build on their own.

A ROSC is oriented toward providing a continuum of services and supports that offer clear choices for individuals. Services provided are person-centered, allowing each individual to select those areas of need and interest to them. Recovery coaches become experts in the community, knowing about available resources and sometimes taking people by the hand and assisting them with tasks that they have otherwise been unable to do on their own. In addition to recovery coaches, ROSC uses volunteers, community members, legal system staff and treatment providers in collaboration with participants and their families. This results in an energized recovery community that gives people

multiple pathways to recovery while assisting in their development of recovery capital that is relevant and meaningful to them.

BUILDING COMMUNITY CAPITAL/IMPLEMENTING A ROSC

Laying the Foundation for a Recovery Engagement Center/ Building Community Capital

Implementing a ROSC begins by identifying existing community assets and helping to build local community capital to address and support recovery. This occurs by identifying a community's natural strengths and support systems which includes access to formal treatment and community service providers as well as families, social networks, and community based organizations. In addition, articulating individual strengths within a local community context allows for the cultivation of community capital that is relevant to an individual's sustained recovery.

Within Centerstone, this approach has allowed the provision of a cost-effective approach to care delivery that reduces subsidization through the development of a Recovery Engagement Center (REC). The use of recovery coaches and volunteers, the coordination with other community providers, and the establishment and deepening of community relationships have all allowed us to optimize billing opportunities and work flexibly to provide alternatives and meet more needs while helping clients feel more empowered and involved in their recovery.

A Blueprint to Building a ROSC

I. Internal buy-in (Organizing and selling).

It is easy to make a financial argument in a community as to why a Recovery Engagement Center (REC), using a ROSC model, would be beneficial but it is critical to gather data to support the need. First, organizational buy in is necessary. One must be able to articulate and quantify the benefit to an agency. Recognize the costs and inefficiencies related to continuing to provide treatment to individuals who would benefit more from an intervention that is community based and helps to develop their recovery capital. Using the approach of an engagement center provides a continuum of care that allows for and

promotes community involvement. Through this, the "de-siloing" of service providers can be facilitated while developing a niche for your organization.

It should be recognized that the identification and creation of a continuum of care within the community has the potential to both broaden a client base while providing a more fiscally responsible approach to service delivery. Clients that wind up in clinical settings usually arrive "feet first," to use a medical systems analogy meaning that they are in crisis or have wound up there through other system channels (emergency room, criminal justice system) and not on their own accord. A continuum of care in the community provides an agency the opportunity to intersect with a broader range of clients. Within a continuum of care, partnering with other service providers allows for unduplicated service delivery; assessing treatment needs in addition to recovery capital allows an agency to focus formal treatment resources where they are needed; while serving clients in the community emphasizes the development of recovery capital and long term community supports. A ROSC model allows for the strategic positioning of an agency to meet broad needs of a client and their community in a fiscally responsible way.

Think about how existing resources can be reallocated or develop new ones (like applying for a community grant). Before selling this concept to others in an agency/organization and community, it is important to visualize what internal changes need to happen to support recovery as a chronic, long-term, relapsing disease. The question needs to be asked, "Are we willing to change the way we treat addiction?" "How do we demonstrate our commitment to recovery?" "What constitutes recovery in the context of our community?" "What community capital exists to support recovery?" It is necessary to be committed and aligned to this approach in order to ask for multiple system and community partnership.

II. Commitment.

Once you are able to get the commitment internally from your agency or organization, start collecting the data in your community that supports this vision. As is well known, the cost of substance

abuse is massive and the community is paying for it however it is often not quantified that way. Obtain information from those systems and agencies who also work with your consumers including the jail, probation, judges, hospitals, shelters, police, and child welfare services. If you don't have exact numbers, there is information nationally about the impact of addictions on multiple systems of service that can help you make a cost estimate. Consider the cost to the community for not treating substance use in a comprehensive way. Look to your community to find those who are vested in this issue and serve this population. Once you have this information, create talking points and begin to have conversations with key community stakeholders.

III. Collaboration.

It is important to think of this as a strategic collaboration. It is important to recognize and differentiate, who in the community would make a good partner and who is critical to have at the table. Developing an advisory board is a good way to achieve buy-in and input into community specific needs/wants. It is important to recognize that no two communities are alike and communities, like individuals, have different strengths and weaknesses so openness and flexibility is necessary. It is essential to give each stakeholder a reason for ownership within a program to prevent the re-emergence of silos. From here, look at the resources each party brings to the table. This begins to define how one moves forward.

Some key partnerships in our pilot community have been with the hospital, judges, probation, faith based individuals, employers, and the 12-step community. It was necessary to identify early on who were the individuals and groups who wanted/needed to have a say in addition to developing relationships and building the partnerships with individuals and systems within the community who are ready to commit to this shift in service delivery. Recognize that aspects of the community will be in different stages of change and developing corresponding strategies to address this is important. At the end of the day, a successful Engagement Center needs to meet the needs of the community it serves,

maintain low barriers for its utilization, and have a strong community and consumer voice otherwise it will not be sustainable.

IV. Resources.

One must be willing to commit resources to the development of a ROSC. Consider reallocating current resources, including time. It is important to create a common vision for the involved agencies and community but it is also important to be willing to back up this vision with a contribution of resources.

Implementation Strategies/Resources Developed at Centerstone of Indiana

I. Community Resources.

Such indigenous supports are crucial to the ROSC model. Support from peers, friend, and community is essential in addictions recovery. It is especially beneficial to have multiple sources of support. This not only reduces a consumer's sense of isolation, but also increases their activity in the community, allowing them to obtain an integral role in society. In addition to support from individuals, participation in support groups, meetings, and community gatherings is an important tool for recovery. Consumers frequently report that being able to interact with others who understand their feelings and experiences is an important element for their recovery. Such resources are critical when a high need for recovery capital is identified.

Engaging people within a network of persons in recovery provides an immediate increase in protective factors for continued recovery. In additions, informal relationships are established which last beyond those experienced during the life of treatment. Such relationships offer unique links to resources and other opportunities which may not be established within the formal settings of substance abuse treatment programming.

II. Recovery Coaches

Recovery coaches, who are Centerstone employees, are the backbone of a ROSC. Their primary role is to provide and reinforce treatment efforts and build recovery capital. Recovery coaches must network within the community to help increase community support and resources for those in recovery. Coaches are considered partners and consultants of participants. They provide a link between organizations and systems in the ROSC including therapists, parole officers, family members, friends and the individual seeking recovery. Through a collaborative effort, they work to remove barriers and make a commitment to help an individual throughout the recovery process.

Recovery coaches are unlike any other forms of therapeutic intervention. Within this evidenced-based model, emphasis is placed on the living competencies and strengths of a person in drug or alcohol recovery. Recovery coaches do not diagnose, and are not limited to operating within one single discipline of addictions therapy. This model is complementary to most evidenced-based models, and comprehensive. Recovery coaches reinforce treatment by applying concepts within the community, and teaching life skill competencies.

III. Volunteer-Program

Volunteers are an integral aspect of the ROSC and assist in advocacy, awareness and interaction. The REC divides task areas into these three core areas but also utilizes a tier system to facilitate a progressive volunteer experience. Volunteers in more intensive areas must have a minimum of six months or more of sobriety, but those who have not met this minimum can still assist the community through tasks such as facility cleaning, grounds keeping or inventory coordination.

Tier level volunteers operate within the same standards, procedures, policies and boundaries as coaches and mentors, providing a recovery friendly environment. They work to support the center based upon their strengths and areas of interest. Through a professional, recovery-oriented approach, volunteers are able to provide individualized support for an array of needs. Essentially, the volunteers are self-sufficient, providing a variety of options for people arriving at the REC.

IV. Peer Support

ROSC stresses the inclusion of recovering individuals in service provision, placing emphasis on their experiences and knowledge. This is achieved through peer-based services. Peer-based services are designed to extend treatment efforts toward long-term interventions by utilizing people who themselves are recovering from the same identified condition. Recovery mentors interact with ROSC program participants as peer supports and role models. They are volunteers who have demonstrated the ability to maintain recovery for at least three years. Their personal recovery must continue to take priority. They cannot be on probation, parole or drug court nor have committed a criminal offense within the past three years. They have been trained and have passed a volunteer orientation course as well as a series of tests on confidentiality, safety and ethics. They have also completed 90 days of on-the-job training.

The use of mentors and volunteers is a two-fold beneficial element for consumers of service. First, from their initial day of intervention, consumers are immediately connected to persons of recovery creating a connection point to pro-social community supports. This is a solid option for persons with a low treatment need and high recovery capital need (Figure 1). This style of service allows consumers an atmosphere of being able to relate, and feel understood. Moreover, peer-based services, provides the consumer hope in a tangible form, and a model for what recovery is. Rapport is more easily established. Secondly, consumers see an eventual opportunity for them to go from being in need, to supporting others in need. This fuels purpose-driven actions, and palaces consumers into a role of providing. This added protective factor not only gives purpose, but increases confidence and pride.

Philosophies of ROSC within Centerstone

I. Strength-Based

ROSC requires a consultative partnership between service providers, and the consumer. It is a strengths-based approach. Service providers assist consumers in identifying their strengths,

empowering people to achieve a higher quality of life through their own means. Often times, consumers develop skills of resourcefulness, adaptability, and other strengths as survival skills in active addiction. This can better be identified as resiliency. Resiliency can be defined as the capacity to rebound from adversity strengthened and more resourceful (Walsh, 2006). It is an active process of endurance, self-righting, and growth in response to crisis and challenge (Walsh, 2006). Such resiliency can be utilized as a pedestal to build upon for additional strengths. When looking at barrier reduction, and identified adversity, service providers can assist consumers in recognizing such strengths as evidence to their ability in overcoming odds. The identification of a person's strengths fosters ownership in his or hers recovery. It becomes about the person and he or she finds important. The service provider is essentially in the passenger seat while the consumer operates the vehicle of change.

II. Client Centered.

In a ROSC model, implications for program adjustments are vast. Using a medical model, current evaluation strategies look to inquire information to diagnose, confirm, and treat. Within a ROSC model, assessments and evaluations are essential. With focus being placed on a person's symptoms, ROSC requires an all inclusive approach encompassing the whole person. Through a holistic model, assessments can incorporate a person's environment, how he or she perceives their current state, family inclusiveness, spirituality, social relationships, and more. Assessing in such a way allows insight into the consumer's world, through the consumer's eyes. In this inclusive approach, an appropriate gauge of the consumer stage of change can be made. Equally important, ROSC allows consumers choice from day one.

III. Motivational Interviewing.

Motivational Interviewing (MI) concepts are a primary modality of practice within this model. The change process as identified by Prochaska (1992) is utilized to identify what stage of change a person is in. Once identified a service provider can meet consumers in their current stage of change and

administer an appropriate level of services. The model requires services providers to assist consumers in moving through the stages of change. In a ROSC model, this can be incorporated in a team setting and the necessity of time can exist for change.

IV. Cultural Inclusion/Competency.

Through its individualized nature, a ROSC allows service provision to be administered through a culturally competent fashion. ROSC is more than culturally competent; it embraces cultural differences, empowering individuals to use culture as leverage in increasing his or her quality of life. The REC integrates what already exists in the communities it serves to the services it provides. A service delivery model of this type has the capacity to integrate the cultural values of the communities it serves as a basis to initiate and sustain recovery, integrating cultural capacity within a service delivery model that is inclusive, respectful and includes the voices of our consumers, their families and their communities. Whether it is the individual or community, individuality and uniqueness is promoted through comprehensive responsiveness to personal and cultural beliefs.

V. Merging of Systems

ROSC requires collaborative relationships amongst community providers. Through this model there is realization that no single community entity has the capacity to deliver every service a consumer needs. When organizations and groups operate within segregated silos, barriers to recovery are created. Within the context of a ROSC, community providers share resources and partner to serve those in recovery. Partnerships are key to the ROSC model. Such partnerships with organizations and community groups can be mutually beneficial for all parties involved, including the consumer.

An Example of ROSC: The Recovery Engagement Center

As referenced above, Centerstone has implanted the ROSC model within its Recovery Engagement Center (REC). The REC has experience an increase and stability in attendance within its first year of operation. This is attributed in-part to the formalization of the REC volunteer program. As seen

below, a correlation can been seen between the first volunteer orientation in September and REC attendance:

August	97	February	327
September	216	March	315
October	342	April	310
November	327	May	285
December	394	June	308
January	311	Total Through June (2011): 3,232	

The REC offers a connection point for people in various stages of their recovery. This center has over 40 active volunteers including peer-recovery mentoring system. In reference to the quadrant in Figure 1, people with high recovery capital needs can access an array of service to begin rebuilding this area of life. Centerstone has strategically placed recovery coaches within the REC to assist people in accessing community supports, apply treatment concepts, and learn critical life skills to maintain the longevity of their life changes. The REC is home to various community groups including 12-Step Programming, Health Care Agencies, and support groups for people re-entering from the criminal justice system.

Evaluating Outcomes

Evaluating a ROSC model can prove to be challenging. A community based, multiple system approach to the provision of services requires outcomes that are responsive to the goals of multiple agencies and the community at large. In addition, a client-directed/centered approach means that outcomes should be amenable to the changing needs of a client. A recovery oriented approach emphasizes the process of recovery, which does not align with “some” traditional evaluation techniques that usually examine outcomes of a specific intervention, dose, or service. (There are a number of grounded theory approaches that incorporate qualitative methodologies that almost exclusively emphasize process from multiple perspectives). Evaluating a ROSC model and its impact takes a multilayered approach that is system, community and individually responsive.

Overlapping goals between community agencies who serve similar individuals is common. It is necessary to identify these overlapping goals and to ensure that these goals represent needs that are unique to the community you serve. These will be community specific goals that can be achieved by coordinating the care of a target population in this case, individuals with substance use disorder. Outcomes related to community specific goals can measure the contact that individuals have with system level resources in your community. In order to measure the effectiveness of a ROSC, one should anticipate an increase and/or decrease in the contact that individuals have with pre-defined system level resources in your community. Outcomes associated with community specific goals can include but aren't limited to: reduced use of emergency services; reduced use of inpatient services; reduction in risk associated with infectious disease; increased use of outpatient services; decrease in contact with law enforcement.

Understanding and measuring individual-level outcomes that are sensitive to client-directed/centered approach need to be flexible. There are two suggestions in measuring individual level outcomes when evaluating a ROSC. Aggregate level data is necessary and useful to see patterns across groups and will allow you to demonstrate that a model or an approach is working. When measuring individual level outcomes, it is important to cover life domains such as substance use, mental health symptomatology, education, employment, housing, family, social support, etc. In addition to aggregate level data, it is also important to include a measure of recovery capital which provides a more contextual/process-oriented examination of how an individual is succeeding in the aforementioned life domains. Measuring recovery capital allows for a more nuanced examination of the life domains integral to sustained recovery.

Approaches that attempt to measure large groups with large instruments are useful in reporting aggregate level data however they are not useful in identifying the changing needs of an individual over

time. Recovery planning can be useful for tracking individual outcomes that can change throughout an individual's recovery. Recovery planning takes place as a partnership where the consumer is supported and trained in articulating his or her goals throughout various life domains. Utilizing an evidenced-based planning tool, the service provider and consumer work in a collaborative effort to set clear obtainable goals that are in the consumer's vision. The planning process is ongoing. This approach recognizes that individual goals need to be flexible and various levels of success may or may not be achieved. Setting milestones or benchmarks that provide information about the level to which goals are being met is important, as this helps both the client and clinician see progress as well as helps the evaluator to measure it. An approach of this sort is designed to allow the service provider and consumer insight to answer two crucial questions: "Where are we going?" and "How will we know when we get there?" An agency has the potential to track individual goals that a client sets for themselves as well as the achievement of these goals. This can then be quantified on an individual level as well as on a more aggregate level that would represent a program or an agency.

Recovery is a process; a ROSC approach is meant to be engaging and supportive throughout this process. Therefore, the evaluation of a ROSC should consider this process and in fact, the evaluation is what may articulate the process. This can be specific to the individual as well as specific to the development of a ROSC. For example, one may elicit feedback from individuals about their feelings and opinions concerning their participation in a ROSC, their process in engaging in a ROSC and how ROSC has helped them; letting the individuals articulate *what* exactly a ROSC has helped them with. The implementation of a ROSC can be evaluated and a process can be articulated highlighting what was done and for what reasons? This can help identify successes and barriers to the implementation as well as to the sustainability of a ROSC by being sensitive to the community context, the individuals involved and most importantly, the process.

Conclusion

To summarize, the need for addictions treatment exceeds the capacity of currently available resources. The trend of diminishing resources is expected to continue. Additionally, we know that the cost of addiction is crippling to our communities and society as a whole. Ultimately, the solution is in the community and the vehicle to access the solution is a ROSC model, with the addiction community as taking the lead. ROSC allows providers to provide more comprehensive services with fewer resources. This is true across all human service systems. Adoption a ROSC model within your organization now positions your organization as a leader in your field. In addition, this model strategically places your organization to be prepared for the upcoming Health Care Reform. The time to adopt this model is now, and the approach is effective, efficient, and innovative.

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