



Texas Recovery Initiative DSHS Report on Task Force Proceedings

June 2009

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I. Introduction/Background

The purpose of the multi-phase Texas Recovery Initiative is to gather information and recommendations for designing protocols that implement holistic, recovery-oriented models of care for use within the behavioral health community. The initial phase of the Texas Recovery Initiative included a series of public hearings and workgroup meetings consisting of providers, stakeholders, academics, and recovery support groups. The first three meetings were held in 2007 in Dallas, Lubbock, and Houston. The second phase included Task Force meetings held at the DSHS Headquarters. Members of the Task Force included treatment and recovery support providers (contracted and non-contracted), stakeholders, and representatives of affected state agencies. The final task force meeting was on December 12, 2007. A draft of the initiative report was posted to the DSHS website and public commentary was solicited. The final version of the report includes historical information, guiding principles, and a review of current evidence-based practices for program implementation.

A. Brief History of Substance Abuse Treatment and Recovery in Texas

In the mid 19th century, there was widespread public availability and use of alcohol, morphine, and cocaine in the U.S. Medications available only through a physician's prescription today were sold over the counter. Until the end of the 19th century, most physicians and the public in general did not consider the abuse of these drugs a medical disorder but rather a moral problem. In 1892, the first private mental hospital in Texas, Valleloma Sanitarium, opened in Marshall for the treatment of alcoholics and drug addicts. The first published report about treatment in Texas, by Dr. M.K. Lott on the successful detoxification of an opiate addict, appeared in the *Texas Medical Journal* in 1901.

With the passage of the federal Harrison Narcotic Act of 1914, access to many drugs was limited, and it became illegal for physicians to induce physical dependence or maintain a patient on opiates. This law had several unanticipated consequences. Symptoms of withdrawal among some regular users of these now illegal drugs made it necessary for healthcare practitioners to develop methods for detoxifying those who were physically dependent. Other users resorted to illegal means to obtain drugs and a large and illicit narcotic trafficking business, which persists to the present day, arose. Due to the increasing numbers of addicted persons in federal prisons, two Public Health Service hospitals were established -- the first in Lexington, Kentucky in 1935 and the second in Fort Worth, Texas in 1938. These facilities treated not only withdrawal symptoms but also underlying emotional and social problems associated with drug use.

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Texans continued to develop new methods to deal with the continuing problem of drug abuse and alcoholism in the mid to late 20th century. In San Antonio in 1966, the Patrician Movement initiated one of the first community based programs that included detoxification, a sheltered workshop, and individual and group counseling. Additionally, during the sixties, admissions of alcoholics to state mental hospitals increased, and several separate treatment units were established. However, few illegal drug abusers were initially admitted to these units, and there were only four small methadone clinics (located in San Antonio, Laredo and El Paso) for the entire state.

By the late 1960s, drugs such as marijuana, amphetamines and psychedelics were culturally popularized and became more readily available. In the 1970's and 1980's, cocaine, crack cocaine, and methamphetamines were linked to increased levels of both addiction and violence. With the drug culture exploding, an unprecedented expansion of federal funding through a new grant program, the Substance Abuse Block Grant, became available to the states to address drug and alcohol problems through prevention and treatment programs. In Texas, laws were passed and programs developed to begin to address the problem. Initially, community mental health and mental retardation centers provided substance abuse treatment services, but soon many non-profit agencies began programs through federal and state grants and began to provide these services.

In the 1930's, the establishment of Alcoholics Anonymous (AA) planted the first seeds of the disease precept that describes alcohol dependence as a physical "allergy" of the body and prescribes a method of becoming sober. At the time, there were only two methodologies of legitimate formal treatment: AA, its sister organization Narcotic Anonymous (NA) and their "twelve step" recovery framework as developed by The Hazelden Foundation, and methadone maintenance for opiate addiction.

Over the past forty years, while many new concepts have been introduced nationally, substance abuse treatment has not been empirically examined and has remained primarily based on the tenets of AA and NA. However, significant research toward understanding the actions of addictive drugs on the brain and the neurobiology of substance dependence has been completed. These include large-scale national studies that have demonstrated the effectiveness of treatment practices and have determined which practices are most effective. Research has also produced new medications that can enhance recovery and decrease relapse rates.

Today, Texas is committed to utilizing the best and most cost-effective evidence-based practice models by reviewing the scientific studies that have demonstrated which practices are truly effective. One of the major concept paradigms for social client-based change is the Recovery Management (RM) model.

B. Recovery-Oriented Systems of Care

Recovery is the process of pursuing a fulfilling and contributing life regardless of the difficulties one has faced. It involves not only the restoration but also the continued enhancement of a positive identity and personally meaningful connections and roles in one's community. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices, and opportunities that promote people reaching their full potential as individuals and community members (from an interview with Arthur C. Evans, PH.D. by William L. White, MA). The Recovery Management model includes traditional interventions in a continuum of recovery support services spanning pre-recovery (recovery priming), recovery initiation and stabilization, and the recovery maintenance stages of problem resolution. Particularly distinctive is the model's emphasis on post-treatment monitoring and support; long-term, stage-appropriate recovery education; peer-based recovery coaching; assertive linkage to communities of recovery; and, when needed, early re-intervention.

The goal of Recovery Management is to improve services by looking to scientific evidence and to the collective wisdom of the treatment system to make recovery a reality for the citizens of Texas who are affected by substance abuse. This can be done by recognizing, valuing, and building upon the strengths that already exist in the current substance abuse services infrastructure. A comprehensive recovery-oriented system of care should be the goal of every substance abuse service provider in the state – and this goal can only be realized through a strong partnership between the state authority and individual providers. This partnership will ensure that a recovery-oriented system of care is recognized as a legislative priority and afforded the necessary resources to make services available statewide.

II. Task Force

Task force meetings were held on October 31, 2007, November 12, 2007, and December 12, 2007 in the 7th Floor Board Room at DSHS headquarters. This room is equipped with teleconferencing capabilities to accommodate outside interested parties. A list of task force members is available in Appendix 2.

A. Guiding Principles

Members were given the opportunity to complete a form listing ten principles that they felt were important for the success of an Evidence Based Program. They were also asked to indicate which principle(s) were most important to them. These provided a starting point for discussion and collectively the group agreed on the following guiding principles for TRI efforts.

1. No single treatment is appropriate for all individuals.
2. The system should have adequate and flexible funding to meet client needs.
3. Treatment must be readily available with no wrong doors.
4. The system must have an adequate and well-trained workforce.
5. Peer support services should be an integral part of the service delivery system.
6. The family unit should be an active focus throughout services.
7. Outcomes should be realistic and recovery oriented.
8. Risk management procedures are essential to ensure the safety and security of all individuals.

B. Evidence Based Practices & Model Programs

Evidence Based Practices are interventions that show consistent scientific evidence of being related to preferred client outcomes and have been standardized in duplication. Model Programs are manualized guidelines or rules that indicate what will be discussed in individual and group sessions and in life skills and education.

1. Implementing Evidence Based Practices

The task force identified issues pertaining to the implementation of evidence-based practices in support of recovery-oriented systems of care that include the following.

- Identifying from the larger universe of possible objectives the top three objectives that the service delivery system should be seeking to achieve
- Identifying barriers that would impede the achievement of the identified objectives
- Identifying the best strategies to overcome barriers in order to achieve the objectives
- Identifying at least three, but not more than five, specific practices or programs that could be successfully implemented in Texas under a scenario in which no new funding is available to facilitate system change
- Identifying the most important additional activities, practices and programs that could be successfully implemented in Texas under a scenario in which

additional funding was made available and ranking these in priority order, indicating on a scale of 1 to 3 (from least to greatest cost) the cost associated with each identified activity, practice or program

- Providing a time estimate necessary for system transformation under each of the four scenarios identified above
- Identifying the type and amount of training that DSHS would need to make available to substance abuse treatment providers for the selected practices and programs selected by the Task Force

2. TRI Model Programs and Evidence Based Practices

Through the work of the TRI committee, it was agreed that flexibility in treatment options afforded through the use of evidence-based practices would result in better outcomes than would strict adherence to any specific model programs. However, model programs may be used as a whole or in part as long as the practice is within the scope of intended outcomes associated with the original model design. The TRI workgroup identified nine practices.

3. Recommendations for Evidence Based Practices and Model Programs for Use in the Texas Treatment and Recovery System Include:

Motivational Interviewing (MI) – In an effort to foster an open exchange between the therapist and client, MI actively incorporates a collaborative relationship by emphasizing consumer choice, self-efficacy, and the overall responsibility of the client to determine his or her own life goals. The four principles of MI are: 1) Express empathy, 2) Develop discrepancy, 3) Roll with resistance, and 4) Support self-efficacy. Motivational Interviewing is firmly rooted in the trans-theoretical model of change proposed by researchers James O. Prochaska and Carlo C. DiClemente.

Motivational Enhancement Therapy (MET) – MET seeks to evoke from clients self-motivation for change and to consolidate a personal decision and plan for change. The approach is largely client-centered, although planned and directed. MET is strikingly dissimilar from counseling approaches designed to oppose denial and break down defenses through direct confrontation. MET also differs from behavioral approaches in that no direct advice or skill training is provided. MET is based on principles of cognitive and social psychology. The counselor seeks to develop a discrepancy in the client's perceptions between current behavior and significant personal goals. Emphasis is placed on eliciting from clients self-motivational statements of desire for and commitment to change. The

working assumption is that intrinsic motivation is a necessary and often sufficient factor in instigating change.

Recovery Support (RS) – RS provides services designed to create a recovery-oriented system of care that incorporates long-term recovery management. It is associated with a system of services that include peer support components, such as:

Peer Mentoring, which is characterized by demonstrations of empathy, coaching and support groups;

Informational Support that includes training in life skills such as parenting, stress management, conflict resolution, job skills training, transitional housing, education improvement, and health and wellness information that includes smoking cessation, nutrition, relaxation therapies;

Instrumental Support, which provides concrete assistance in helping meet other needs, e.g., child care, clothing, assistance with entitlements;

Companionship Support, which provides opportunities to participate in alternative activities to encourage recreation and exercise without the use of alcohol and drugs, e.g., recovery coaching and peer support;

Recovery Management, a component of the recovery support system, which is the provision of engagement, education, monitoring, mentoring, support, and intervention technologies to maximize the health, quality of life, and level of productivity of persons with severe behavioral health disorders. Within the framework of recovery management, the management of the disorder is the responsibility of the person with the disorder. The primary role of the professional is that of the recovery consultant, guide, or coach. Recovery Management engages professional staff to facilitate access to services that accommodate the needs of clients and their families and/or significant others identified during the recovery process.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) – This model is designed to identify and offer intervention and treatment services to individuals with suspected substance abuse problems while they are being seen in a primary health care setting. It links treatment for health care to substance abuse services and promotes intervention from substance abuse behavior, thus lessening impact on the primary health care system. Best practices using this model involve health care clinicians in the screening/identification process and substance abuse or behavioral counselors in the intervention and treatment process.

Matrix Model – This approach includes elements pertaining to the areas of relapse prevention, family and group therapies, drug education, and self-help participation. The Matrix Model is highly manualized with set topics for individual,

group, family, and educational sessions. Individuals are seen on an outpatient basis for approximately twelve weeks. Though primarily for stimulant users, the model has been adapted for alcohol and other drugs.

Trauma Informed Treatment – All aspects of this manualized model focus on the client’s physical and emotional well being. Trauma Informed Treatment is recommended for women seeking substance abuse treatment where emotional and physical safety are extremely important due to past physical, sexual, verbal or emotional abuse. In many cases, especially among women, significant past trauma affects most of the behaviors and emotional well being, and drives substance use; the trauma that the client has experienced must be addressed in a gender and culturally specific context. *Seeking Safety* is a commonly used curriculum for working with substance abusers who have experienced significant traumas. This curriculum focuses on respecting and empowering the client.

Relapse Prevention Therapy (RPT) – A cognitive-behavioral approach to the treatment of addictive behaviors, RPT specifically addresses the nature of the relapse process. Given that the development of an addictive behavior is a learned process, changing addictive behaviors can be seen as a combination of extinguishing the connection between pleasure seeking and/or pain reduction and subsequent alcohol or other substance use and helping clients to build a new behavior repertoire in which more adaptive coping behaviors replace addictive behaviors. Utilizing this cognitive-behavioral analysis of addictive behaviors, RPT begins with the assessment of a client’s potential interpersonal, intrapersonal, environmental, and physiological risks for relapse and the unique set of factors and situations that may directly precipitate relapse. Once potential relapse triggers and high-risk situations are identified, cognitive and behavioral techniques are implemented to incorporate specific interventions to prevent relapses or manage them if they do occur.

Medication-Assisted Therapy (MAT) – Under medical supervision, MAT uses medications designed to lessen the effects of withdrawal, stabilize addiction behaviors, and/or remove euphoria associated with use of drugs or alcohol. Examples of these medications include:

Naltrexone is an opiate blocker used orally and by injection that substantially cuts down relapse in abstinent alcoholics who have undergone treatment by decreasing the psychoactive effects of alcohol by blocking the opiate effects with the medication.

Acamprosate, which affects Gaba Amino Butyric Acid Levels and Glutamate (both decreased by alcohol use) and helps return them to normal levels, calming brain function disturbed by alcohol use. In this manner, they decrease cravings for alcohol, thus decreasing relapse.

Methadone is a pure opiate agonist, which serves as a long-acting substitute for the short-acting opiates such as heroin. It is meant to be used as a maintenance medication taken over a long period of time.

Buprenorphine is a mixed opiate agonist – antagonist – which also serves as a substitute for short-acting opiates and can be utilized as a maintenance medication or for short-term maintenance followed by detoxification. It is much milder than detoxifying from pure opiate agonists.

Cognitive Behavioral Therapy (CBT) – When using CBT during treatment, the therapist and client perform a functional analysis by identifying the client's thoughts, feelings, and circumstances before and after drug use. Early in treatment, the functional analysis plays a critical role in helping the client and therapist assess the determinants, or high-risk situations, that are likely to lead to drug use and provides insights into some of the reasons the client may be using drugs. CBT addresses several critical tasks that are essential to successful substance abuse treatment (Rounsaville and Carroll 1992). Techniques used during therapy include:

Fostering the motivation for abstinence – A technique used to enhance the client's motivation to stop drug use by conducting a decisional analysis that clarifies what the individual stands to lose or gain by continued use.

Teaching coping skills – This technique is the core of CBT that assists clients in recognizing the high-risk situations in which they are most likely to use substances and to develop other, more effective means of coping with them.

Changing reinforcement contingencies – By the time treatment is sought, many clients spend most of their time acquiring, using, and recovering from drug use to the exclusion of other experiences and rewards. In CBT, the focus is on identifying and reducing habits associated with a drug-using lifestyle by substituting more enduring, positive activities and rewards.

Fostering management of painful affects – This technique includes skills training that teaches clients to recognize and cope with urges to use drugs. This is an excellent model for helping patients learn to tolerate other strong affects such as depression and anger.

Improving interpersonal functioning and enhance social supports – This technique includes training in a number of important interpersonal skills and strategies to help patients expand their social support networks and build enduring, drug-free relationships.

C. Recommendations for Implementation

The TRI public hearings and task force discussions revealed remarkable consistency in recommendations about the structure, implementation, and support of the Texas Recovery Initiative among stakeholders and DSHS staff. These recommendations coalesce around the following themes.

- A client-centered model of services that is fully integrated throughout the continuum of care
- A separate billable case management (recovery management) service, which trained, non-licensed peers can staff
- A focus on core evidence based practices, giving providers flexibility in the choice of more specific evidence based programs based on client need and local preference
- Adequate funding for the implementation of evidenced based practices through higher reimbursement rates
- A robust program of training and technical assistance to support implementation of evidence based practices, with a special focus on long-term skill building and development of local capacity for training and clinical supervision
- A simple monitoring system implemented by quality management staff well trained in the fidelity of each model

The TRI Task Force divided into three workgroups related to these emerging themes – training, procurement, and monitoring. The recommendations of each group are detailed below.

1. Training

Accomplishing the directives of the TRI requires implementation of training procedures to support the desired outcomes. Recommendations arising from TRI discussions involving training included the following.

- Prioritization of DSHS training resources to support the change in philosophy and focus and the institution of evidence based practices
- Development of long-term training systems to support continued skill-building necessary for staff to achieve competency in the implementation of evidence based practices
- Investigation of strategies for building local training and clinical supervision capacity, including:
 - Adopting or developing curricula for training of trainers, including manuals and supporting training materials

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- Enhancing existing clinical supervision standards
- Investigating the feasibility of Internet-based technology to provide remote coaching in specific competencies, such as Motivational Interviewing and Cognitive Behavioral Therapy
- Developing valid standards and competency testing to recognize clinical staff that have the skills to provide coaching and supervision
- Fostering, through continuing education, peer review, and strategic development of organizational environments, local peer groups to support implementation of specific evidence-based practices
- Convening an advisory group to develop and implement strategies for strengthening the state and local infrastructure as related to long-term training and clinical supervision
- Development of standards, competencies, and training for paraprofessionals who provide recovery management and recovery support services
- Adoption of consistent standards for documentation and provision of related training
- Increasing access to training through the use of technology, including Internet-based training with testing components

Issues discussed relating to licensure, training, and environmental support included the following.

Issue 1: Continued training is necessary to develop skills and competencies. Initial training events must be followed by a series of follow-up workshops.

Issue 2: Web-based training, including interactive testing, can make training accessible across the state. Instead of developing new curricula, DSHS should utilize existing programs, such as the Recovery Support modules available through the Substance Abuse and Mental Health Services Administration.

Issue 3: Expand the number of qualified trainers by using a “train-the-trainer” model.

Issue 4: Clear and consistent standards are needed for documentation. Individual treatment providers and auditors have varied expectations.

Issue 5: Increase rates to support higher salaries for Licensed Chemical Dependency Counselors (LCDCs).

Issue 6: Provide incentives for individuals with lapsed licenses to return to the field.

Issue 7: Reduce the number of required continuing education hours for LCDCs from 60 to 40.

Issue 8: Encourage peers and paraprofessionals to pursue licensure by allowing peer support and recovery support activities to receive credit for work hours under licensure requirements.

Issue 9: Establish training and credentialing standards for paraprofessionals.

Issue 10: Develop strategies to address unresolved staff issues, including neglect of self-care, and implement training to reduce stigmas associated with many clients.

Issue 11: Address systemic problems that frustrate staff and interfere with service delivery. For example, it takes longer to complete the assessment in the Clinical Management for Behavioral Health Services (CMBHS) system than it does in treatment. Auditors also need to have appropriate tools and training relating to the specific evidence based practices in use at the site being reviewed.

2. Procurement

Recommendations related to procurement that arose through TRI discussions included the following.

- Establish clear requirements for the implementation of core evidence based practices (e.g., Motivational Interviewing, Cognitive Behavioral Therapy)
- Provide flexibility for providers to select specific evidence based programs based on client needs and local preferences
- Incorporate requirements for co-occurring disorders
- Allocate funding to pay for recovery management/case management separately
- Develop clear standards and training requirements for providers delivering recovery management/case management services
- Procure recovery management/case management services as an integrated component of licensed treatment programs, including staff employed or contracted by existing treatment programs and dedicated

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to working with clients throughout the continuum of care, which includes the 6-9 month period beyond discharge from all treatment levels of care

- Establish mechanisms for developing, enhancing, and creating access to additional recovery support services such as transitional housing, transportation, childcare, employment and employment training, medical services, mental health services and education
- Establish requirements for treating clients in various stages of recovery (i.e. pre-contemplation, first treatment episode, or relapsed client returning to treatment)
- Direct any new funds to the following priorities, in the order listed
 - Increasing treatment rates to support implementation of higher standards associated with EBPs
 - Funding recovery management/case management services
 - Funding recovery support services, including housing, transportation, life skills training, and peer support services

The purchasing workgroup first discussed recommendations for DSHS purchasing priorities to implement the TRI at current funding levels. It then identified priorities for the use of new funds that might become available to support the project.

The group identified case management as the key to further progress, believing that case management enables providers to leverage community resources more effectively.

Issue 1: Case management must be paid for separately and prioritized as a service. Having dedicated case managers results in more effective case management and allows credentialed staff to provide more clinical services. Payment should be allowed for case management provided by paraprofessionals and possibly trained peer providers. Smaller organizations should be allowed to share a dedicated case manager. This service should be recognized as a priority to supplement treatment efforts and, as such, should have additional funds dedicated to this service while not reducing prevention or treatment funds.

Issue 2: Case management should begin early, even before admission to treatment. This is particularly important given the long time (approximately 90 days) required to access community support services.

Issue 3: Case management must be performed by trained and competent paraprofessionals. DSHS should invest training resources into this function, and

efforts should be made to recruit case managers from among the 70% of counselor interns who fail the LCDC exam. This investment may help to retain them in the field, give them an opportunity to develop their skills, and ideally put them on a ladder for professional development.

Issue 4: Training resources must focus on 1) evidence based practices and programs, and 2) the change in philosophy and focus. To make efficient use of limited resources, the training system must include a robust infrastructure for training of trainers. Furthermore, technology should be used to the fullest extent possible to expand access to training and clinical supervision.

Issue 5: DSHS should consider funding collaboratives that include recovery support service providers.

Issue 6: Implementation should be informed by experience gained through other recent initiatives, particularly Access to Recover (ATR) and Co-Occurring State Incentive Grant (COSIG).

Issue 7: It might be useful to develop multiple tracks of treatment (e.g., first-time client, relapse client), but further study regarding the value of this approach is needed.

3. Monitoring

Task force discussions included recommendations related to monitoring and these included the following.

- Focus monitoring on essential components
- Develop performance measures appropriate to recovery support services
- Design monitoring systems in conjunction with the development of TRI requirements
- Obtain input from the TRI Task Force prior to final adoption of monitoring instruments
- Ensure quality management (QM) staff has sufficient training in the theoretical concepts and fidelity requirements of the specific evidence based practices they are reviewing
- Modify monitoring systems as the TRI initiative evolves

Members of the TRI monitoring group discussed issues related to these recommendations.

Issue 1: Participants from stakeholder groups should be allowed to review and offer input into the matrix that will be used by DSHS quality management staff to monitor the evidenced based principles and programming for treatment services to be implemented in FY2010.

Issue 2: DSHS should review the training of Quality Management (QM) staff to ensure consistency with the fidelity and theoretical principles inherent in each of the models selected by DSHS.

Issue 3: Training for the evidence based models should offer a training of trainers, as well as specific manuals and materials that help counselors maintain the integrity of the principles utilized by the treatment provider. Furthermore, clinical supervision should be strongly encouraged to ensure DSHS funded programs follow the fidelity of the incorporated practices into the substance abuse treatment designs selected by providers.

Issue 4: DSHS funded clients should be given an opportunity to participate in client satisfaction surveys to ensure clients are satisfied with the quality of services they receive and the relationship they have with their counselors.

Issue 5: DSHS should review their process for evaluating the percent of referrals made to other community-based providers rather than just DSHS funded treatment provider referrals.

Issue 6: DSHS needs to look at better ways to offer technical assistance to funded providers and to ensure that for the technical assistance offered, DSHS staff is fully trained in the best practice models being discussed at the provider level.

Issue 7: Funding should allow an increase in rates to improve the quality of services. Funding should also be more flexible and client driven. Further, the money must follow the individual needs of each client receiving DSHS funded substance abuse treatment services.

Additional issues to be addressed

The public hearings and task force discussions revealed a number of related issues that may affect implementation of the TRI. DSHS will continue to work with the Task Force and other stakeholders to address these issues. They include workforce development, including the quantity and competency of LCDCs and limitations of the current services system, including barriers to timely treatment and insufficient capacity.

III. Next Steps

In order to be truly successful, any system needs to continue to evolve. This is particularly true in the dynamic environment that includes the diverse population served by the Texas Treatment and Recovery Systems. The State authority and the providers must attempt to deal with not only the changing array of issues that face individuals attempting to enter and maintain recovery, but also the rapidly expanding body of knowledge about the disease of addiction and the options for resolving our clients' issues and building on their strengths. This process should involve continued collaboration with other agencies, integration of system principles in other initiatives, and a consolidated training program.

Continued collaboration will take place by holding ongoing TRI meetings at an appropriate time. Future meetings will be held as training and RFP development begin. DSHS will also continue to interact with the Association of Substance Abuse Providers, as well as other stakeholders and state agencies that work with persons seeking recovery.

The rollout of the Clinical Management for Behavioral Health Services (CMBHS) will include the ability to capture recovery-oriented services and evidenced based practices. DSHS welcomes continued input into CMBHS as it moves into the production phase, and will take into consideration the guiding principals from TRI in its continued development.

As substance abuse recovery services become part of the DSHS public health system, services for clients with specific needs must be identified. DSHS continues to emphasize integration in all our efforts. Public health messages and materials should be readily available to individuals seeking recovery. Topics such as risks from tobacco use, obesity, and other high-risk behaviors should be addressed. These will continue to be integrated throughout the initiative. The vision begins with expansion of the existing infrastructure through peer case management at the treatment level, community recovery services at the OSAR level and the funding for additional wrap-around ancillary services to support recovery.

Appendix I. Public Stakeholder Meetings

A. Background

The initial phase included a series of community and workgroup meetings consisting of providers, stakeholders, academics, and recovery support groups. The first three meetings were held in Dallas on October 4, 2007, Lubbock on October 11, 2007, and Houston on October 19, 2007, addressing the following topics.

- An introduction to the initiative
- A presentation of the concepts of evidenced based treatment with a specific example of a program that has been implemented
- A presentation of the concepts of recovery-based treatment with a specific example of a program that has been implemented

B. Scope of the Public Hearings

Questions discussed:

- What are the most important steps you would like to take or what changes would you like to implement in your program to move closer to a recovery-based system that uses evidenced based practices?
- What is the biggest barrier you face in making those changes?
- What is the most important thing the state could do to support the field in moving toward such a system?

Summary of input

- **Philosophy and focus**
 - Change the language we use—recovery, not treatment
 - Abstinence-only philosophy is a major barrier to recovery support
 - Cultural change is essential—we need to value and learn to build relationships
 - Address MH and SA issues together
- **Client-centered services**
 - Start with what the client wants—this is the first step in building a relationship
 - Accept harm reduction strategies
 - Involve family from the beginning

- **Integration of recovery support services throughout services continuum**
 - Recovery support services should occur before, during, and after treatment
 - Long-term transitional housing is critical
 - Employment and housing are very important
 - Change the focus of treatment, with greater attention to basic social/life skills
- **Flexibility**
 - Enable a wide array of evidence-based practices to fit local and individual client needs
- **Continuous quality improvement**
 - Don't get locked into a service structure—allow for continuous learning and evolution
 - The system must allow rapid response to new information and feedback
- **Funding and resources**
 - Allow flexible use of dollars to meet client needs
 - Provide long-term funding for recovery support services
 - Work with legislators to educate them and build support for sustainable funding
 - Evidence based practices are more expensive and need increased reimbursement
 - Support programs in community fund-raising
- **Improve networking and collaboration**
 - Facilitate better partnerships with community organizations who offer support services
- **Workforce issues**
 - Address inadequate workforce
 - Reduce turnover
 - Counselor interns (CI) need remedial training—they are not learning essential skills in school
- **Training**
 - Evidence based practices require extensive quality training
 - Pay attention to on-going skills development and clinical supervision.
 - Prepare staff to address life social/life skills
 - On-going TA will be needed
 - Techs (non-professional staff) in residential programs need training

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- **Accountability**
 - Address evaluation and accountability during the planning process
 - Balance the need to achieve client outcomes and the need to prove it
 - Evaluation must allow for adjustment over time, including the reported outcomes
 - Select meaningful fidelity indicators with proven relationship to positive results
 - Select outcome measures
 - Develop special measures for recovery support services
 - Provide trained DSHS monitors
- **Address current limitations of the service delivery system**
 - Lower barriers to timely treatment
 - More treatment beds are needed, especially detox
 - Longer length of stay (LOS) and smaller group size are needed
 - COSIG had some barriers, including overwhelming paperwork
 - All clients need case management (currently limited to HIV)

Appendix 2. Task Force Members

The TRI Task Force Members consist of treatment and recovery support providers (contracted and non-contracted), academics, stakeholders, and representatives of affected state agencies. The members represent a cross-section of providers of front line services as well as administrative personnel from various agencies.

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