The State of Recovery-Oriented Systems of Care in Utah

Executive Summary

After developing an operational view of Recovery-Oriented Systems of Care (ROSC) a statement of principles with a subsequent rewriting of the Utah Preferred Practice Guidelines and modification of the DSAMH Directives, the ROSC sub-committee asked itself, 'What next?' The subcommittee determined it was time to assess the statewide impacts of these efforts and see what challenges providers faced with implementing the recommended changes. Over the course of 5 months, 4 interviewers met with the managers and providers of 16 behavioral health organizations, asking about their success and challenges with implementing ROSC, including Engagement, Ongoing Assessment, Ongoing Planning and Recovery Support Services.

Conclusions

Significant changes have taken place within many of the behavioral health organizations that were visited. These changes, which are indications of movement towards ROSC principles, include:

- an evolution of how providers are viewing their clients, their behavior and their conditions;
- how providers view themselves, their role and their relationship to their clients; and
- adaptations of organization's records systems, processes and roles.

In spite of the obvious progress being made, significant challenges and barriers remain. These include:

- inadequate funding for services;
- limited access to resources, for both providers and clients;
- real or perceived regulations, particularly related to documentation;
- stigma;
- rules related to those with legal histories;
- fragmentation and silos in the systems of care;
- overwhelmed staff and burnout; and
- systems that are overwhelmed with expectations of programs and initiatives.

In addition to these challenges and barriers, when the results of the interviews are considered in aggregate, a most notable and very concerning conclusion can be made; there is a remarkable degree of variation across the state with the implementation of these ROSC principles. With this variation in mind, an obvious question arises: Is this variation acceptable, or is statewide consistency of implementation of ROSC principles necessary for having effective Recovery Oriented Systems of Care throughout the state?

Recommendations

The goal for the interviews and creation of this report was to identify recommendations for where the ROSC subcommittee, Clinical Directors, UBHC Executive Directors, and DSAMH could next focus efforts in pursuit of a Recovery Oriented System of Care within the state of Utah. With this in mind, the following recommendations are made:

1. The question posed above regarding the value of statewide consistency of implementation of ROSC and other initiatives needs to be answered by a conscious and open discussion of the key stakeholders involved, which should include, at least: The Executive Directors of UBHC, the Clinical Directors of UBHC and the leadership of DSAMH. In those areas of the country where ROSC has been implemented statewide as an overarching paradigm, it is clear that success was the result of a shared vision and leadership by those who had the ability and will to see that it took place. The leaders of behavioral health in Utah who have the ability to see that ROSC principles are implemented consistently across the state must answer the question if they have the will to do so or not.

    a. If leadership within the state determines that statewide consistency of implementation of ROSC is important and that they have the will and ability to achieve that outcome, then:

i. ROSC should be identified as the overarching goal for the state and should serve as the guide and provide coherency in the selection of initiatives, programs, projects and grants, etc. (hereafter referred to as 'initiatives').
ii. Specific goals and standards should be developed to define what successful implementation of ROSC will look like, both statewide and within in each locality.
iii. A model for statewide implementation of ROSC should be identified to assure that implementation takes place in all centers with consistency and a certain degree of uniformity. The model should also have a mechanism for assuring that implementation is actually resulting in service delivery as designed.
iv. Using the ROSC goals that have been established, predetermined outcome measures should also be established. The methods of gathering those measures should also be defined in advance and used universally, rather than determined locally.
v. State and local leaders should acknowledge that provider organizations and their providers are 'overwhelmed.' With this in mind, existing initiatives should be evaluated within the ROSC framework and should be prioritized on the degree to which they serve the ROSC goals. Only those initiatives that clearly help meet the ROSC goals should be continued. The others should be considered for termination or deferment. New initiatives should be evaluated in similar manner and only those which will help achieve the ROSC goals should be initiated. And this should be done in a thoughtful and planned way.

b. If the leadership determines that statewide consistency of implementation of ROSC cannot take place as recommended above, then it is recommended that:
i. State and local authority leaders acknowledge that the current array of initiatives are overwhelming provider organizations and their providers. Even in the absence of ROSC as a guiding model, the leaders should create a model for priority and coherency to guide selection and implementation of initiatives.
ii. State and local organizations at least apply a ROSC 'frame of reference' to guide and evaluate their implementation of existing and new initiatives. With this in mind, whatever is implemented is done with ROSC principles incorporated to the extent they can be. To facilitate this, the ROSC subcommittee should consider building on existing work to create a more comprehensive ROSC Principles Statement or even a checklist which organizations could use to help determine the extent to which those things they are implementing are consistent with the ROSC paradigm.

2. An effort which has the potential of yielding positive results throughout the state would be addressing the impact of client's mental illness and addiction history on access to resources essential to recovery, namely, housing and employment. In particular, people with felonies who have made remarkable changes in their lives are still held hostage by those felonies. The ROSC subcommittee could help or even lead efforts within the state to engineer change in legislation, public perception, and procedures of government agencies, landlords and employers to reconsider these individuals when they are applying for these resources. Some centers, as referenced in the report, have made progress in doing this.

3. An often verbalized request, particularly of mid-level managers and service practitioners, was to know what the other centers in the state are doing related to the practices that were being discussed. It is for this reason that so much of the detail has been included in the full report. Hopefully this will have some fulfillment of that request. However, since that was not the original intention of this project, it is recommended that the Clinical Directors and/or DSAMH develop a more formal mechanism of providing a side-by-side comparison of what centers are doing. This could be done in the form of a matrix or online tool for quick reference, with supporting narrative description where appropriate.