11:00 am to 12:30 pm EST  Use of Telehealth in Addressing Substance Use Disorders

12:30 pm to 1:30 pm EST   Lunch Break

1:30 pm to 2:30 pm EST   Efforts to Serve Individuals Involved in the Criminal Justice System

2:30 pm to 3:30 pm EST   Recovery Support Initiatives
Use of Telehealth in Addressing Substance Use Disorders

11:00 am – 12:30 pm EST
MISSOURI TREATMENT PROVIDERS’ COVID TELEHEALTH EXPERIENCES (SO FAR…)

MARK STRINGER
DIRECTOR, MO DEPT OF MENTAL HEALTH

NORA BOCK
DEPUTY DIRECTOR FOR COMMUNITY TREATMENT DIV OF BEHAVIORAL HEALTH, MO DMH
COVID ADAPTATION SURVEY CONDUCTED IN MAY 2020

• Sent to BH providers (39 responded)

• Several items on Likert Scale

• Open narrative boxes on all

• Focused on telehealth/telephone transition

• Also regarding rule relaxations/flexibilities, including MAT
TRANSITION CHALLENGES

Items endorsed by >50%:

• Lack of client access to needed technology/internet (82%)
• New clinical service delivery techniques/practice challenges (80%)
• Cost required/financial challenges (69%)
TRANSITION CHALLENGES

Items endorsed by >50%:

• Concerns about client safety from lack of in-person visits (67%)
• Operating new systems/technical challenges (64%)
• Lack of staff/clinic access to needed technology (56%)
OVERALL TELEHEALTH EXPERIENCES

• Clients and staff responding positively to virtual sessions

• Most say attendance has improved (fewer no-shows) for both counseling and medical visits

• Biggest obstacles are client lack of access to phones, data plans, and Wi-Fi
OVERALL TELEHEALTH EXPERIENCES

• **Client Experiences**: Providers report clients slightly prefer both counseling and medical visits via telehealth (vs. in-person).

• **Staff Experiences**: All reported staff have responded fairly well (28%), well (31%), or very well (41%) to delivering services via telehealth.
IF THEY COULD TURN BACK TIME... 

• They would have already prepared most staff to work-from-home with needed equipment, platforms, and training

• They would have ensured patients were familiar with telehealth platforms even if not using them
“We have a significant amount of clients that don’t have access to the internet or have very limited cell phone coverage. Some due to poverty, some due to living in rural areas.”

“Our ability to decrease missed appointments has been the most positive outcome of this whole effort. Eliminating the logistics of the travel has been a life saving initiative to our clients who have desperately needed services.”
“Some of our most vulnerable clients have no access to internet or proper phones that would allow video telehealth. Also, many of them due to their symptoms cannot manage the steps needed to connect to video telehealth. They are very comfortable and able to do phone calls.”
“We would like to use the enhanced level of telehealth services for the foreseeable future with the emergency, but also carry on some variation of it where clients don’t have to report to our building to have a telehealth encounter permanently.”

“It really illustrates that some of the rules previously in place have been barriers to treatment.”
FINAL THOUGHTS

If issues related to COVID-19 continue long-term, the majority of providers report their transition to telehealth would likely be sustainable, with few problems (65%).

* Not survey info: if they were to have to transition back, this would represent a significant investment in equipment lost.
Use of Telehealth in Addressing Substance Use Disorders in South Carolina

SAMHSA & NASADAD Annual Meeting
July 17, 2020
South Carolina Department of Alcohol and Other Drug Abuse Services

South Carolina Publically Funded Treatment Locations

- Opioid Treatment Program (Methadone Treatment)
- County Alcohol & Drug Abuse Authority Service Locations

SAMHSA Behavioral Health Treatment Locator
Telehealth Capacity **Before COVID-19**

- Strong SC Telehealth Alliance
- All County Authority Treatment Sites Have Telehealth Cart
- DAODAS Subsidizing Providers’ Broadband Costs with State Funds
- No Medicaid Reimbursement for Clinical Services
- Approval for Buprenorphine Initiation Limited by State’s Board of Medical Examiners
Tele-Services During COVID-19

- Medicaid/Block Grant/SOR Reimbursement for Clinical Services Approved:
  
  Crisis Management, Individual Psychotherapy, Peer Support, Case Management, and other behavioral health services provided via telehealth or telephone

- Each County Authority allocated $5,000 to purchase cellular phones and minutes for use by patients in need of access

- State’s Board of Medical Examiners approve more prescribers to initiate Bupe. via telehealth

- Counselors are working from home and office using doxy.me for clinical services by laptop
Positive Results

• Patient retention and increased engagement – fewer “no-shows”

• Deeper clinical work with a glimpse at home life and engagement of family

• Patients report high satisfaction and a desire to continue services due to enhanced accessibility, flexibility, and privacy

Challenges

• Group therapies

• Walk-ins for new admissions have dropped dramatically

• Uncertain future
Thinking About the Future

- Greater need for services for South Carolinians who are and will be hurting
- Patients/providers nervous this will suddenly go away after emergency declaration
- Policies that ensure virtual services are included across all health plans.
- SC Medicaid could maintain expanded telehealth coverage beyond emergency period (with CMS waiver or approval)
- SC General Assembly could mandate telehealth coverage and payment parity
- Licensing Boards could approve providers for telehealth service long-term
- We’re all going to have to address barriers preventing vulnerable populations from accessing telehealth services (internet connectivity in rural or low-income communities)
Telehealth Implementation during COVID-19

2020 NASADAD National Meeting

Jeff Kerber, Ph.D., Director - Division of Behavioral Health
DeAnn Decker, Bureau Chief of Substance Abuse
Monica Wilke-Brown, Opioid Response Project Director

IOWA DEPARTMENT OF PUBLIC HEALTH

Protecting and Improving the Health of Iowans
Basic Background: Iowa SUD Service Delivery

• Iowa is a medium-sized, rural, Mid-West state of just over 3 million people

• 99 counties that are grouped into 19 SUD service areas

• Discretionary grants may also be implemented via the IPN providers such as State Opioid Response, Zero Suicide, and Homelessness Grant

• The Bureau licenses all 100 SUD treatment providers in the state

• The Integrated Provider Network (IPN) was competitively procured in 2018 to provide Prevention and Treatment Services for SUD and Problem Gambling
Pre-COVID-19: Telehealth limitations

• Prior to COVID-19, legal telehealth definitions allows only secured video conferencing for medical services from approved originating sites, which limits implementation in BH providers, including the IPN
• Established trusting partnerships already exist between state and provider network, the lines of communication are open
• Funding is fee-for-service reimbursement-based
Quick transition to Telehealth

• March 2020: Iowa BH providers began expansion or implementation of telehealth within 7 days after the emergency declaration from the Governor.
• State SUD leadership offered weekly meetings open to SUD treatment providers for technical assistance, peer-sharing, and Q&A.
• Pandemic caused panic and fear for both workforce, financial impacts, and clients health & safety
• The declaration coincided with federal announcements which allowed flexibility in telehealth implementation to include audio-only, as well as fewer rules re: video
• State SUD licensing staff provided guidance and quick response for questions
• Funding flexibility also allowed for adjustment to be financially feasible
COVID Impact on Iowa SUD Services: Total services decreased 48%

2019
- April-June total SUD services reported (all payors) = 140,490
- Overall ratios are similar for both Medicaid and Block Grant funded services

2020
- April-June total SUD services reported (all payors) = 73,929
- Overall decreases are similar for both Medicaid and Block Grant funded services
# Outpatient Services: Preliminary reports

<table>
<thead>
<tr>
<th></th>
<th>IDPH Outpatient</th>
<th>OP Group Sessions</th>
<th>OP Individual Sessions</th>
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<tr>
<td>2020</td>
<td># of services</td>
<td>% Telehealth</td>
<td># of services</td>
</tr>
<tr>
<td>January</td>
<td>2,717</td>
<td>0</td>
<td>1,149</td>
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<td>February</td>
<td>2,417</td>
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<td>March</td>
<td>2,633</td>
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<td>April</td>
<td>1,988</td>
<td>73%</td>
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<tr>
<td>May</td>
<td>1,610</td>
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<td>183</td>
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<tr>
<td>June</td>
<td>786</td>
<td>89%</td>
<td>160</td>
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<tr>
<td>Totals:</td>
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</table>
Integrated Provider Network Surveys

• Original survey sent in April early 2020
• Follow-up survey sent in late June 2020
• Responses to the first survey represented 14 of 19 IPN providers
• Second survey included 16 of 19 IPN providers
• Asked about Telehealth implementation benefits and challenges
Provider Telehealth Surveys Results: Offering audio-only and/or video options?

April Capacity for Telehealth
• Rapid ramp-up of telehealth service capacity: 86% offered both audio-only/telephonic and video telehealth services
• Several agencies were only able to offer telephonic services at the beginning of the pandemic

June Capacity for Telehealth
• 100% offered both telephonic and video telehealth services
Provider Telehealth Surveys Results:
Which type of telehealth was more common?

April: Audio-Only was more common

June: Video was more common
Provider Telehealth Surveys Results:

16 of 19 agencies responded:

What equipment, software, and/or service contracts have you had to purchase to expand your telehealth services (check all that apply)?
Provider Telehealth Surveys Results: April: Reported Challenges

- technology glitches & limited staff experience with telehealth
- difficulty/delays in telehealth set-up
- patient preference for phone vs counselor prefers video
- shorter sessions over phone
- assessments must still be in person for paperwork
- cannot fully eliminate f2f contact
- stress of changing routines
- some clients do not have phone/equipment for telehealth
- some clients lack internet access, enough minutes/service plans for telehealth
- cannot do UAs/physical exams
- confidentiality concerns with groups via telehealth
- some patients have limited understanding/ability to use technology
- some clients don't answer phone/no show
- audio telehealth lacks cues and context of patient
Provider Telehealth Surveys Results: April: Reported Benefits

- reduced client barriers
- staff appreciate the option for health/safety
- allows outpatient safer option to continue treatment during COVID
- improved clients’ attendance
- clients more engaged
- clients reaching out if struggling
- efficiency with reduced staff travel
- helped limit COVID-related service interruptions
- patients appreciate convenience/ease of access
June Survey: What is not working?

• Groups are more difficult.

• Referrals from the criminal justice system have decreased significantly; and jail-based evaluations have also decreased.

• It is hard to onboard new employees.

• Staff and clients feeling burnout from video conferencing.

• Noticed a change in commitment as the weather improved and more people were outside. No-show rates increased with this change. Individual sessions increased but group attendance decreased.

• Most have not provided phones for patients. Some would like to, but lack funding for it, and expressed concern about controlling usage.
June Survey: What is going well?

• Our group numbers have increased in some programs.

• Almost everything. Service delivery is going well. Demand for services has increased.

• Use of telehealth, in general, has worked well. We have been able to offer multiple options (face-to-face for individuals who needed this, telehealth only through video or audio, and combination groups where some individuals present in person and others join via teleconferencing).

• Flexibility for treatment services. This is particularly helpful when transportation systems were shut down or limited. It also allows us to continue treatment if a patient is not feeling well.

• Made accessibility better in rural areas.

• Support staff and therapists working together as partners though all working remotely. One of the most important components was IDPH assisting with some of the costs associated with getting this in place rapidly and being supportive through meetings. Listening to what providers needed and working with providers in a collaborative manner.
What do both providers and patients need to consider as we adapt to this new normal?
Thank you!

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Jeff Kerber
Director – Division of Behavioral Health
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SAMHSA & NASADAD Annual Meeting

VIRTUAL EVENT
July 13, 15, & 17, 2020

Time for a Break
Efforts to Serve Individuals Involved in the Criminal Justice System

1:30 pm to 2:30 pm EST
OASAS Admissions with Criminal Justice Involvement 2019

• 102,700 admissions had criminal justice involvement

• 46% of Non-crisis (detox) admissions
NYS Criminal Justice System

- State Corrections – 52 Facilities with nearly 40,000 inmates (Down from 68 facilities and over 72,000 inmates -1999)
- County Jails – 57 Jails
- 141 Drug Courts – 100,000 participants since 1995
Challenges

• Opioid Crisis – Improving Access to Assessment and Treatment.
• MAT for Incarcerated Individuals
• Bail Reform – Greatly reduced jail populations (1/1/2020)
• COVID-19 (3/2020)
New Interventions

- HOPE Model – Staten Island – Offer treatment instead of jail at point of arrest. If person engages in treatment charges are dropped.
- Law Enforcement Assisted Diversion (LEAD) model – Variation on the HOPE model.
- 24/7 Open Access Centers – Peer Support.
Buffalo Opioid Court Model

• Losing people to OD before they could be enrolled in drug court
• All arrestees screened for OUD issues.
• Appear in front of Judge in morning
• Immediate assessment and enrollment into treatment – prosecution put on “hold”
• Save the Michael’s of the World – transportation
New Opioid Courts

- 13 New Opioid Courts around state
- Identified by OCA
- Courts identified partner OASAS provider
- OASAS will fund counties $150,000 each for clinical and peer services (SOR grant)
OCA Partnership

• Working together on BJA Grants
  – COAP – Court Appearances and Treatment via video
  – COSSAP – Training Opioid Court Partners in EBP’s, Use of Peers, Program Evaluation

• JCOIN Grant evaluation studies – sharing court and treatment data
RX Stat Meetings

• Led by NYPD – Leadership, Precinct Level, Community Policing, etc.
• Office of Chief Medical Examiner (OCME) provides data/info on OD deaths
• City Dept. of Health, Mental Hygiene, DEA, Dept. of Social Services, Housing, etc.
RX Stat Meetings

• Project to match data from OCME OD Deaths with OASAS Treatment Data
• Matched OASAS cases for 59% - 3 yrs.
• Identified high risk for OD death within 1-7 days after last treatment contact
• Many OD fatalities occurred 5 years after last contact.
State Corrections

• 10 year partnership with State Dept. of Corrections and Community Supervision
• Statutory requirement for OASAS to monitor DOCCS SUD services within facilities
• OASAS provides treatment funding for work release inmates (ineligible for Medicaid)
• Training, Technical Support and guidance on DOCCS SUD protocols and curriculum.
• SOR funding for 4 Naltrexone programs
DOCCS Methadone Program

• Worked with DOCCS to establish Methadone access for inmates entering state custody who were maintained on methadone in county jail.
• Methadone services provided by local OTP – take home doses.
• Seven facilities currently provide access to methadone and the same facilities are implementing buprenorphine programs.
• DOCCS applying for OTP license – First State Corrections Operated OTP.
County Jails

- 57 County Jails and NYC (Rikers Island)
- Rikers has offered Methadone since 1980’s – buprenorphine and naltrexone
- 39 Counties offer Naltrexone
- 13 Counties offer Methadone, 15 Buprenorphine
- 9 offer all three
- OASAS provides funding for Medications and Clinical Services in the jails.
- Training and technical assistance for programs
Key To Success

Relationships with Courts and Criminal Justice partners

- Office of Court Administration – Training, Grants, Guidance, Problem Solving
- State Department of Corrections and Community Supervision – Facilitating adoption of MAT, Monitoring/Guidance on SUD services in facilities, Training of parole officers
- State Sheriff’s Association – Working with county jails, Training on MAT for correction officers
- Dept. of Criminal Justice Services – Probation
- University Partnerships – SAMHSA HEALing Communities and JCOIN grants
NEW JERSEY JAIL MEDICATION ASSISTED TREATMENT INITIATIVE

VALERIE MIELKE, MSW
ASSISTANT COMMISSIONER
NJ DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
History of MAT Initiatives in Jails

- Implementation of MAT in jails has been gradual and steady.
- Initial pilot was in Atlantic County in 2017
- Collaboration between DMHAS, OTP, jail, judge, prosecutor’s office. State funded behind walls, state and Medicaid funded in community
- Medication provided to inmates behind the walls using mobile van. 78% continued MAT post release.
History of MAT Initiatives in Jails

- DOC made available dollars to cover the cost of medication for MAT available to inmates in county jails in SFY 2018.

- 10 counties participated in the initiative, serving a total of 156 individuals.
Current MAT Initiative in Jails

- 2019 Jail MAT Initiative, led by DMHAS, is conducted in seamless collaboration with DOC and DOH
  - Expertise of DOC, who has made MAT available in all prison facilities and has created the continuum of SUD levels of treatment available in two prisons.
  - DOH is providing support and expertise in areas of data sharing/matching across systems (e.g., corrections, treatment, medical examiner, Medicaid)
- Funded with state dollars, SOR dollars and Medicaid (following release)
Implementation Process

- NJ Cabinet members representing DOC, DHS and DOH had a dialogue with Wardens to assess interest in MAT

- A Request for Letters of Interest were sent to all jails on 6/10/2019. All jails responded affirmatively. Telephone conferences were set up with all 21 county jails to discuss their RLI responses (discussed medications, different strategies for implementation, etc.). Contracts executed 1/15/20. One jail withdrew their interest because they were awarded federal dollars. 20 out of 21 counties are participating.

- SOTA provided training about MAT to all Wardens
Approximately 11,000 individuals are incarcerated in a county jail on any given day.

As a result of criminal justice reform, approx. 93% of those detained in jail are released within 24 – 72 hours following booking. Requires two different strategies to engage individuals with MAT.
### Implementation

#### Different Strategies

**Strategies for inmates subject to bail reform**
- LOS < 72 hrs
  - Screening
  - Initiation of MAT (Bup and/or Methadone)
  - Warm hand off to community services

**Strategies for inmates in jail 72 hours – 364 days**
  - Screening & Assessment
  - Initiation of MAT (Bup, Vivitrol and/or Methadone) & therapy
  - MAT behind the walls
  - Warm hand off to community services

#### Common Goals

- Provide individuals with choice to receive MAT and possibly avoid withdrawal management
- Make available EBPs behind the wall that will continue post release
- Seamless connection to community services immediately upon release
- Eliminate overdose deaths post release
• Deputy Assistant Director, Office of Treatment and Recovery Supports joined a regular meeting of Jail Training Coordinators to discuss the jail MAT initiative and their role in supporting successful implementation.

• The PEW Charitable Trusts (PEW) conducted a survey of all jails to get baseline data and determine TA needs and will make available training for wardens and custody staff.
Training & Technical Assistance

- Training and consultation for medical staff is being conducted by the two regional MAT Centers of Excellence at Cooper/Rowan and Rutgers Medical Schools
  - Mentorship
  - Case reviews
  - Prescribing practices
  - Information about community-based services and how to engage
• Monitoring of contracts for fiscal and performance compliance is carried out by DMHAS staff

  ▪ Each jail is required to submit a monthly report enabling DMHAS to identify if the data flags issues that could be addressed with TA, coaching, follow-up with community providers, etc.
Challenges / Outcomes

- COVID-19 has slowed implementation for many correctional facilities and impacted community providers.

- Despite the impact of COVID-19 many jails have expanded MAT staff and are initiating agreements with community providers.
Outcomes

- Monitoring of contracts for fiscal and performance compliance is carried out by DMHAS staff

- Each jail is required to submit a monthly report enabling DMHAS to identify if the data flags issues that could be addressed with TA, coaching, follow-up with community providers, etc.

<table>
<thead>
<tr>
<th>eligible for the program</th>
<th>offered MAT</th>
<th>accepted MAT</th>
<th>placed on Methadone</th>
<th>placed on Buprenorphine</th>
<th>placed on oral Naltrexone</th>
<th>placed on Vivitrol</th>
<th>Total inmates on MAT</th>
<th>on MAT at time of release</th>
<th>warm handoff to OTP/Other MAT</th>
<th>assigned a peer specialist</th>
<th>provided a case manager</th>
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<td>523</td>
<td>481</td>
<td>145</td>
<td>197</td>
</tr>
</tbody>
</table>
Thank you!

Questions?

Valerie Mielke
Assistant Commissioner
DMHAS@dhs.nj.gov
609.438.4352
Implementing & Sustaining Enhanced MAT in Corrections: Considerations for Diversion, Recidivism and Saving Lives

KATHRYN POWER, M.Ed., DIRECTOR
RHODE ISLAND DEPARTMENT OF BEHAVIORAL HEALTHCARE,
DEVELOPMENTAL DISABILITIES & HOSPITALS
Governor Raimondo issued an executive order 15-14 to establish a Task Force to develop strategies to address the opioid epidemic.

Task Force presented the Governor with a strategic plan with the long term goal “To reduce opioid overdose deaths.”

DOC received 2 million dollars to support the strategic plan per year since June of 2016.

<table>
<thead>
<tr>
<th>August 2015</th>
<th>November 2015</th>
<th>June 2016-2020</th>
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</table>
RI-DOC PROGRAM OBJECTIVES

- Identify people in need of treatment
- Initiate MAT for patients in need
- Increase retention in treatment post release
- Coordinate smooth discharge plans
- Decrease mortality
RIDOC PROGRAM GOALS

- Screen & assess everyone upon commitment and prior to release, as OUD appropriate.
- MAT if appropriate for 3 populations:
  1. Continue MAT for up to 48 months
  2. Initiate MAT upon commitment
  3. Initiate MAT 90 days prior to release
- Seamless community transition
- Comprehensive MAT services – Medication, Residential Treatments, Recovery Coaches, Group Therapy etc.
Historically
(MAT prior to 2016)

- Initially, upon commitment---individuals were detoxed cold turkey.
- Individuals prescribed methadone in the community, were detoxed at a fairly rapid pace with the exception of pregnant female offenders.
- Individuals prescribed buprenorphine were offered “comfort medications”
- In 1994, women were allowed to remain on methadone to protect the fetus. Detox protocol would follow after birth
Populations Served

1. **Continuation**: 55%
2. **New Inductions**: 40%
3. **Pre-Release**: 5%

In the first year RI saw a reduction over Overdose Deaths in newly released offenders by 66%
Average Number of recipients

AVERAGE DAILY RI DOC MAT DOSE
Intake N=

Screen N=11,171

Positive N= (14.8%)

Assessment N=2909

MAT N=6204

Methadone N=3742
75% Continued
23% Induction
2% Pre-release

Buprenorphine N=2402
63% Continued
30% Induction
7% Pre-release

Naltrexone N=60

Released N=4978
Methadone: 61%
Naltrexone: ~1%
Buprenorphine: 38%

78% receive MAT within 1 year Post-Release confirmed with PMP/BHOLD*

4/1/2016 – 4/1/2020

Within 4 days *goal <24 hours Prior to release

Not CODAC Patient N=1527

Established CODAC Patient N=528

No Confirmation for N=60 Naltrexone.

N= (14.8%)

MAT N=6204

Naltrexone N=60

4/1/2016 – 4/1/2020

Released N=4978
Methadone: 61%
Naltrexone: ~1%
Buprenorphine: 38%

78% receive MAT within 1 year Post-Release confirmed with PMP/BHOLD*

* BHOLD Data from 6/22/2018
PMP Data from 5/31/2019
Recovery Support Initiatives

2:30 pm to 3:30 pm EST
Florida’s Recovery Initiatives

Ute Gazioch, Director of Substance Abuse and Mental Health

2020 NASADAD Annual Meeting
July 17, 2020
2015 started system transformation through conceptual alignment with ROSC principles and values.

2016 SB12 explicitly added language that the legislature expects behavioral health services to be based on recovery-oriented principles.

2016 BRSS TACS Policy Academy
Florida’s ROSC Vision

ESTABLISH AN INTEGRATED, VALUES-BASED RECOVERY ORIENTED SYSTEM OF CARE WHERE RECOVERY IS EXPECTED AND ACHIEVED THROUGH MEANINGFUL PARTNERSHIPS AND SHARED DECISION MAKING WITH INDIVIDUALS, COMMUNITIES AND SYSTEMS.
Strategic Approach

- Engage stakeholders and establish *Change Agents* throughout the state
- Enhance recovery-orientation within the provider network across all programs
- Increase recovery peer specialists in the workforce
- Increase safe recovery housing
- Increase Recovery Community Organizations
ROSC Change Agents

- **Office of SAMH**
  - Initiative is led by individuals in recovery
  - ROSC is the overarching goal of all strategic planning
  - Contract monitoring includes ROSC principles

- **Managing Entities**
  - Change Agents dedicated to ROSC
  - Community level engagement

- **Ongoing Engagement, Training, Evaluation**
Provider Network

- Statewide ROSC summits to provide training, start conversations, and initiate action plans
- Developed tools and protocols to complete Quality Improvement site visits (FCB)
- Providers use of the Self-Assessment/Planning Tool for Implementing Recovery-Oriented Services and Recovery Self-Assessment-Revised to guide action planning (USF)
  - Define policies and practices
  - Define roles and responsibilities of recovery-oriented behavioral health services
Workforce

- Certification for Recovery Peer Specialists with the following Endorsements
  - Adult
  - Veteran
  - Family
  - Youth

- Florida Peer Services Handbook 2016

- New programs require peer support services

- Legislation
  - Added Recovery Support to comprehensive service array
  - Added Peer Specialist in definitions of providers
  - Eased exemption process for disqualifying charges for Peer Specialists
Recovery Housing

- 2015 – Legislation passed for Voluntary Certification process
  - Provided minimum standards in statute
  - Licensed providers may only refer to certified recovery residences
- Certification provided by the Florida Association of Recovery Residences
  - Utilize the NARR Standards
  - As of May 26, 2020 – 1,333 Recovery Residences with 6,016 beds certified
- Oxford Houses
  - Fund development through the SOR Grant
  - 40 Oxford Houses opened since 2018 (329 beds)
Recovery Community Organizations

- Use SOR Funds to establish RCOs and help them meet CAPRSS accreditation
- Contract with Faces and Voices of Recovery for training and technical assistance
  https://facesandvoicesofrecovery.org/about/news-and-events/florida-recovery-project/
- Partnership with the Florida Alcohol and Drug Abuse Association (Aetna Grant)
- 26 RCOs in various stages of development
Questions?

Contact:
Ute.Gazioch@myFLfamilies.com
(850) 717-4322
Growing and Supporting Recovery Residences: Virginia’s Experience
Overview

▪ Introduction
▪ Virginia Association of Recovery Residences (VARR)
▪ Certification process
▪ Next steps and COVID-19 impacts
▪ Discussion
“Recovery residence” (RR) is a broad term describing a sober, safe, and healthy living environment that promotes recovery from alcohol and other drug use and associated problems. At a minimum, RRs offer peer-to-peer recovery support with some providing professionally delivered clinical services all aimed at promoting abstinence-based, long-term recovery. Recovery residences are sober living environments, meaning that residents are expected to abstain from alcohol and illegal drug use. Each credentialed recovery residence publishes policies on relapse sanctions and readmission criteria and other rules governing group living. Recovery residences may require abstinence from particular types of medications according to individual policy.

Key Components of a Recovery Residence

Housing

Individuals with substance use disorders

Alcohol and illicit drug abstinence based

Peer recovery support

Operates as a family-like Community

Community stakeholder acceptance
Resources to Sustain the Recovery Residence

• Law Enforcement
• Drug Court
• Judicial System
• Community Service Board
• Businesses
• Career/ Work Development
• Faith Community
• Local government

Recovery Support Services

• MAT Services
• 12-Step Community
• Mental Health Services
• Local Non-Profits
• Social Services
The Social Model of Recovery

Community is the key ingredient to all recovery residences

- Emphasizes social and interpersonal aspects of recovery. Values experiential knowledge

- Promotes peer-to-peer connections and mutual aid. Sustained engagement in recovery activities

- Provides sober, supportive environments. Recovery is the common bond

- Emphasizes peer-to-peer rather than practitioner-client relationships instead of treatment plans, uses person driven recovery plans to harness and develop recovery capital

Borkman, et al. (1998) A historical and developmental analysis of social model programs: Journal of Substance Abuse Treatment 15 (1) 7-15
Does Recovery Housing Work?

“New recovery support institutions are emerging beyond the arenas of traditional addiction treatment to support individuals hoping to initiate and sustain long term recovery from addiction. One promising mechanism is the recovery residence.” – William White

“Recovery from addiction is a lifelong process and for many, recovery housing is a linchpin helping people rebuild their lives through effective peer support, mutual accountability and clear social structures” – The National Council for Behavioral Health
Role of NARR/Founding of VARR

- Many thousands of RR exist in the United States that vary in size, organization, and target population. (The exact number is unknown since many RRs are not regulated by government or independent organizations.)
- The National Alliance for Recovery Residences (NARR)’s mission:
  
  to support persons in recovery from addiction by improving their access to quality recovery residences through standards, support services, placement, education, research and advocacy.

- NARR developed the most widely referenced national standard for the operation of recovery residences, and work with 30 state affiliate organizations
- NARR and these organizations collectively support over 25,000 persons in addiction recovery who are living in over 2,500 certified recovery residences throughout the United States
Role of NARR/Founding of VARR

• VARR as a concept began in 2012 under direction and guidance of John Shinholser of the McShin Foundation as a means to provide oversight and standards of quality for recovery residences throughout Virginia, under the umbrella of NARR
• Over the years, VARR experienced challenges with an inconsistent board of directors, lack of funding, and no full-time staff member to support the organization and its operations
• In 2017, expansion of VARR was seen with a new board of Directors, a volunteer Executive Director, and active board members. The board of directors is comprised a diverse group of stakeholders from all groups in the recovery community
• Continued expansion included developing a partnership and support with the Department of Behavioral Health and Developmental Services, as well as other community stakeholders. Through this, VARR was able to help guide efforts for state certification of recovery homes in 2018.
Vision Statement

As Virginia’s only NARR accredited body, VARR monitors, evaluates, and improves standards to build the highest level of quality for recovery residences; so all Virginian’s have timely access to effective recovery support services.

VARR Mission Statement

Our mission is to set high levels of standards for quality recovery residences in Virginia and accredit residences that meet such rigorous criteria in order to support persons in recovery with information and access to recovery residences bound together by the core principles of standards, ethics, and unity.
### Licensing v. Certification

**Licensing**
- Background check required
- Clinical services provided in home or required out of home
- Paid staff or house manager
- Licensed or certified paid staff or case managers
- Residences must have a license to operate

**Certification**
- No background checks required
- No clinical services provided, but access to clinical services
- Recovery residences are not required to be certified to operate
- No certification fee, but membership fee and fee for additional house inspections

*Membership fee does not cover operating expenses of VARR*
## National Look

<table>
<thead>
<tr>
<th>State</th>
<th>Certificate Required for Referral</th>
<th>Certification Standards</th>
<th>Certification Ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida, Law: Section 397.487</td>
<td>Yes; by state operated, funded, or licensed treatment providers</td>
<td>NARR Standards</td>
<td>Florida Association of Recovery Residences</td>
</tr>
<tr>
<td>Maryland, Law: HB-1411</td>
<td>Yes; but only for state funded placements</td>
<td>NARR Standards + Maryland Certification of Recovery Residences Application</td>
<td>Maryland Behavioral Health Administration of Department of Health and Mental Hygiene</td>
</tr>
<tr>
<td>Pennsylvania, Law: Act 59</td>
<td>Yes; by all state agencies or state funded facilities</td>
<td>State developed standards</td>
<td>The Department of Drug and Alcohol Programs of the Commonwealth</td>
</tr>
<tr>
<td>Massachusetts, Law: H.1828</td>
<td>Yes; by state operated or funded treatment providers and re-entry agencies</td>
<td>NARR Standards</td>
<td>Massachusetts Alliance for Sober Housing</td>
</tr>
<tr>
<td>Indiana, Law: SB 402</td>
<td>Yes</td>
<td>NARR Standards</td>
<td>Indiana Association of Recovery Residences</td>
</tr>
<tr>
<td>Ohio, Law: Enrolled HB 483</td>
<td>No</td>
<td>NARR Standards</td>
<td>Ohio Recovery Housing</td>
</tr>
</tbody>
</table>
Voluntary Certification

• In 2018, a voluntary recovery residence certification process was developed to assist persons recovering from substance use disorders and mental health conditions to have a safe, holistic, and mutually supportive environment that demonstrates and works towards the goal of wellness
• CSBs, state facilities, and other state organizations will recommend individuals to certified recovery residences
• Certified residences will be posted on the DBHDS website
• Grant managed funding from DBHDS to VARR certified houses
Certification Process

Nationally Recognized Recovery Housing Organization “Certificate of Compliance”

DBHDS Application and Standards

DBHDS Certified Recovery Residence
Information and Outreach

▪ How can we improve the pipeline of recovery residence referrals through this process?
  ▪ Improvements on website
  ▪ Informational sessions on recovery housing
  ▪ Regional Peer Navigators
  ▪ Fiscal supports from public and private resources to support growth
  ▪ Targeted outreach and establishment of recovery housing areas of the greatest need across the state.
Virginia Standards

- Nationally recognized standards
- DBHDS proposed additions
  - MHFA training
  - Application to determine populations served
  - ARMS platform for data and fiscal evaluation
  - RecCap for data supported analysis of success
    [http://www.recoveryoutcomes.com/rec-cap/]
Next Steps in Virginia, COVID-19 Impact

- RecCAP data collection initiative
- On-going fiscal support of VARR for operations and the ability to support its members with indigent bed funds
- Organized plan for growth to the areas of most need
- VARR members agreed to absorb all loss of income and support all residents that lost their income during the COVID-19 pandemic
- DBHDS used SOR funds to support indigent beds and finance the ARM/RecCap application
Mike Zohab
Mike.zohab@dbhds.virginia.gov
Illinois’
Recovery Oriented System of Care

Illinois Department of Human Services
Division of Substance Use Prevention and Recovery
Dani Kirby, Director
2017 - Division Name Change

DASA
Division of Alcoholism and Substance Abuse

SUPR
Substance Use Prevention and Recovery
ATR Sustainability
Continuing Recovery Support Services in Illinois

• Illinois Access to Recovery (ATR) grant
  • SAMHSA Cooperative Agreement
  • 2004 – 2017
• Invested in establishing partnerships and collaborations, new recovery support services, voucher management system

• Goal: Sustain and grow recovery support services
Illinois’ Approach

• Recovery Oriented System of Care (ROSC) Councils
• RCOs: Recovery Community Organizations
• RSS: Recovery Support Services
• Recovery Residences
Recovery Oriented System of Care (ROSC)

ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve recovery and improved health, wellness, and quality of life for those with or at risk of substance use disorders. The central focus of a ROSC is to create an infrastructure, or "system of care", with the resources to effectively address the full range of substance use problems within communities. The goals of the Illinois ROSC include:

1. Building a culture that builds and nurtures recovery
2. Building capacity and infrastructure to support a recovery-oriented system of care
3. Developing commitment to implement and sustain a recovery-oriented system of care
Recovery Oriented Systems of Care (ROSC) Councils

- 11 geographically distributed ROSC Councils across the state [https://www.dhs.state.il.us/page.aspx?item=117096](https://www.dhs.state.il.us/page.aspx?item=117096)
- ROSC councils build collaborations in their communities that connect anyone that supports recovery
- Each ROSC council has a lead agency that provides the leadership and is supported by SUPR
- Membership includes people with lived experience, local hospitals, treatment centers, FQHC’s, local businesses, mental health, law enforcement, local business owners, policy makers and other community leaders
- ROSC council leadership participate in monthly coaching calls and learning collaboratives to develop a consistent and collaborative approach across the state.
Recovery Community Organization (RCO)

- RCOs are independent, non-profit organizations led and governed by representatives of local communities of recovery. Illinois has 5:
  - Chicago Recovering Communities Coalition: Westside of Chicago
  - United Mental Health and Addictions Coalition: Ford Heights, IL
  - TEECH Foundation: Far Southside of Chicago
  - Northern Illinois Recovery Community Organization (NIRCO): Lake County, IL
  - AMARE: Madison County, IL

https://facesandvoicesofrecovery.org/resources/recovery-community-organizations.html
Medication Assisted Recovery

MAR includes the use of evidence-based FDA approved medications (e.g., methadone, buprenorphine, naltrexone, disulfiram, acamprosate) by individuals with a substance use disorder (SUD) to support their recovery. IDHS/SUPR recognizes that individuals who identify in recovery and take medications to manage their SUD are in recovery.

Recovery Community Cafés and Recovery Community Centers (RCCs)

These are physical locations where people in or seeking recovery can go to receive recovery support, meals, classes and/or referrals to other community resources focused on recovery. This is a safe space or "sanctuary" for people to "hang out" with other people in recovery, and RCC's may have structured activities as well. People do not live at these facilities, but rather RCC's can help individuals build recovery capital at the community level by providing advocacy, training, recovery information and resource mobilization.

RCCs (Cafés) and RCCs (Centers) are very similar, it is largely a choice of what they decide to call themselves and what network they affiliate with.

Recovery Café Network: https://recoverycafe.org/about/share-our-model/
Recovery Community Centers: https://ccar.us/services/recovery-community-centers/
Recovery Support Services (RSS)

• Employment Training
• Employment Coaching
• Peer Coaching
• Recovery Coaching
• Recovery Skills
• Spiritual Support
• Transportation Assistance
Recovery Residences Registry

The Illinois Substance Use Disorder Act was revised in 2018 to include a registry of recovery residences that will serve as a referral resource for individuals seeking continued recovery assistance. Recovery residence is defined as a "sober, safe and healthy living environment that promotes recovery from alcohol and other drug use and associated problems." As such, a recovery residence includes SUPR licensed Recovery Homes, Oxford Houses and other sober living environments that are independent living residences that only provide peer support and a lengthened exposure to the culture of recovery. The registry indicates if the residence is licensed by SUPR and specifies any accreditation or certification that each recovery residence has received from an entity that has developed uniform national standards. While not required, all registrants are encouraged to seek licensure or national accreditation.
I. Peer-run
II. Monitored
III. Supervised
IV. Service provider
Recovery Residence Registry

- Online registration
- 148 known Recovery Residences (58 registered)
  - 92 Recovery Homes (43 registered)
  - 49 Oxford Houses (2 registered)
  - 7 “other” sober living environments
  - 5 “unknown”
- Improvements to Registry – integration with Helpline Portal for easier registration and updates
53 M = Recovery Homes that accept MAT
80 F= Funded SUPR Recovery Homes (46M)
12 U= Unfunded SUPR Recovery Homes (7M)
92 Total Recovery Homes
49 O= Oxford Homes
141 Total Recovery Residences
Recovery Home Requirements

1. Structured congregated environment for individuals with SUD
2. Written linkage agreements with treatment providers
3. Maintain a referral network for mental health, SUD services and other recovery support services
4. Support self help groups
5. Maintain a client record
6. Comply with all licensing requirements as required by IL administrative rule.
Pilot: Enhanced Recovery Homes

1. Structured **family-like** environment: a safe, family-like living environment that recognizes the many pathways to recovery and respects a person centered, peer supported environment (separate entrance from treatment facility, cook meals, congregate in shared spaces and participate in recreational activities).

2. Builds recovery capital so residents can move to independent living.

3. Support and provide linkages for all 3 forms of FDA approved Medication Assisted Treatment.

4. Outpatient treatment services are not an eligibility requirement.

5. Services offered are trauma informed, recognize co-occurring disorders, and respect the individual’s recovery journey.

6. One full time and one part-time staff that will serve as house manager and oversee all recovery activities.
Anticipated Outcomes

1. Ensure access to MAR medications by maintaining referral agreements with organizations that prescribe/dispense medications
2. Individuals with opioid disorders are always offered access to medications
3. Employment within three months of admission
4. Successful transition to living independently at discharge
Contact Information

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