



Texas Recovery Initiative

(Substance Abuse Services Redesign)

****REVIEW DRAFT****

November 2008

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I. Introduction/Background

Introduction

This report presents information developed through meetings convened by DSHS with stakeholders on the Texas Recovery Initiative (TRI). 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, Valleroma 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. 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 the drugs and a large, illicit narcotic trafficking business arose which persists to the present day. 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 underlying emotional and social problems associated with drug use.

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. Also 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 in San Antonio, Laredo and El Paso for the entire state.

By the 1960s, drugs such as marijuana, amphetamines and psychedelics and 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 a new 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 the drug and alcohol problems through prevention and treatment programs. In Texas, laws were passed and programs developed to address the problem along the same lines as the federal government. 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, many new concepts have been introduced nationally, but for the most part substance abuse treatment has not been empirically examined and has remained primarily based on the tenets of AA and NA. However, a significant amount of research toward understanding the actions of addictive drugs on the brain 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, the Texas Department of State Health Services is committed to utilizing the best and most cost effective evidence-based practice models by reviewing the scientific studies which have demonstrated which practices are truly effective. And one of the major concept paradigms for social client-based change is the Recovery Movement (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 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.¹ The Recovery Management model wraps traditional interventions in a continuum of recovery support services spanning the prerecovery (recovery priming), recovery initiation and stabilization, and 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.

As Texas moves into this new century, the Department of State Health Services desires to improve services by looking to scientific evidence and to the collective wisdom of the treatment system to make recovery a reality of 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 is the goal of every substance abuse service provider in the state and this goal can be fully realized by a stronger 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. Stakeholder Meetings

A. Purpose

The initial phase of the TRI included a series of community and workgroup meetings consisting of providers, stakeholders, academics, and recovery support groups that posed the following questions;

- 1) 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?
- 2) What is the biggest barrier you face in the making of those changes?
- 3) What is the most important thing the state could do to support the field in moving toward such a system?

1. Summary of Input from TRI Public Hearings

Questions addressed at the public hearings:

¹ An interview with Arthur C. Evans, PH.D. by William L. White MA

- *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 the making of those changes?*
- *What is the most important thing the state could do to support the field in moving toward such a system?*

Summary of common themes:

- **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
 - Acceptance of harm reduction strategies
 - Family involvement from the beginning
- **Integration of recovery support services throughout services continuum**
 - Recovery support services should be happening before, during and after treatment
 - Long term transitional housing is critical
 - Employment and housing are most important
 - Change the focus of treatment, with greater attention to basic social/life skills
- **Flexibility**
 - 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
 - System must allow rapid response to new information and feedback
- **Funding and resources**
 - Flexible use of dollars to meet client needs
 - Long-term funding for recovery support services
 - Work with legislators to educate them and build support for sustainable funding
 - EBP are more expensive and need increased reimbursement
 - Support programs in community fund-raising
- **Improve networking and collaboration**
 - Better partnerships with community organizations who offer support services
- **Workforce issues**
 - Staffing—inadequate workforce (quantity)
 - Turnover
 - Counselor Interns (CI) need remedial training—they are not learning essential skills in school
- **Training**

- EBP require extensive quality training
- 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
- **Accountability**
 - Address evaluation and accountability during 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
 - Realistic outcome measures
 - Special measures for recovery support services
 - Trained DSHS monitors
- **Address current limitations of the service delivery system**
 - Lower barriers to timely treatment
 - More treatment beds are needed, especially detox
 - Need longer LOS and smaller group size
 - COSIG had some barriers, including overwhelming paperwork
 - All clients need case management (currently limited to HIV)

2. Survey (to be attached under a separate cover)

III. Task Force

A. 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 those that provide front line services as well as administrative personnel from various provider agencies.

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B. Guiding Principles

TEXAS RECOVERY INITIATIVE GUIDING PRINCIPALS

1. NO SINGLE TREATMENT IS APPROPRIATE FOR ALL INDIVIDUALS:

Matching treatment settings, interventions, and services to each individual's particular problem and need is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society. To be effective, treatment must address the individual's substance use disorder and any associated medical, psychological, social, vocational, and legal problems. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture. Services must be grounded in and use the knowledge and skills that fit the background of individuals and families. Gender-responsive services recognize the unique characteristics of an individual's initiation of use, effects of use, histories of trauma, co-occurring mental health and physical disorders and other treatment issues. Culturally competent services are embedded in the language, values, and experiences of a client's culture.

Medications are an important element of treatment for many patients, especially when combined with other evidence based practices. Addicted or substance-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.

2. SYSTEM SHOULD HAVE ADEQUATE AND FLEXIBLE FUNDING TO MEET CLIENT NEEDS:

Portability and flexibility to meet specific client needs, access alternative funding and more funding is crucial. Substance abuse and dependence are social and public health problems impacting all sectors of society and are the root cause of many other problems affecting Texans. The nature of these problems is extensive and chronic.

Economic costs due to substance use and abuse in Texas are estimated in the billions. The true impact of substance abuse takes its toll on individuals, families, communities and society, including child, spousal and elder abuse, disability, reduced productivity, unemployment, poverty and homelessness. The Texas population is increasing rapidly. The Hispanic population growth rate is projected to increase dramatically. Additionally, the aging baby boomers are expected to have a strong impact as Texans over 65 are living much longer. Abuse of all drugs will continue to increase. An increasing proportion of the population is older, including a larger number of substance abusers, many of whom have multiple physical

disorders which will create an added burden on the health care service delivery system. These trends indicate that there will be a greater need for treatment capacity, as well as for services that meet the specific needs of Hispanics and older adults. Outreach efforts must be more creative to reach greater numbers of those in need. Implementing disease management program requirements and research-based practices for prevention and treatment can be costly.

3. TREATMENT MUST BE READILY AVAILABLE WITH NO WRONG DOORS:

Treatment on demand is the goal of the system of care in Texas. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible. The geographic disparities in services, particularly rural areas, strongly affect the ability to adequately provide and deliver timely services. Availability of residential detoxification and intensive residential beds, in particular, are extremely limited and need to be increased throughout the State in order to accommodate the increased acuity of those with substance abuse disorders who are seeking treatment.

4. THE SYSTEM MUST HAVE AN ADEQUATE AND WELL-TRAINED

WORKFORCE: Licensed clinical staff, and peer service providers should have ongoing training and continuous skilled supervision available. A need exists to build a workforce that is clinically competent and highly knowledgeable of the ever changing cultural demographics of the population through education and training. The education and training must be gender responsive and culturally competent. Implementing disease management program requirements and research-based practices for prevention and treatment are needed.

The system's organizational culture needs to encourage learning, a team approach, and consultation necessary for diverse staff members to work together. Family-centered treatment requires an array of staff professionals as well as an environment of mutual respect and shared training.

5. PEER SUPPORT SERVICES SHOULD BE AN INTEGRAL PART OF THE SERVICE DELIVERY SYSTEM:

Peer recovery support services provide social support for recovery. It promotes engagement in the recovery process and reduces relapse once recovery has been initiated. Peer support effectively extends the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery by providing emotional support, informational support, instrumental support and affiliation support. Peer support has long been available to individuals with substance abuse disorders through the 12-step program, through faith-based recovery programs and several other peer-run self-help support systems. Prevention and treatment programs have for many years referred to these peer support systems prior to treatment, during treatment and at discharge to treatment, often bringing peer support meetings into treatment or taking clients out to meetings. However, the ability to obtain and ensure sustained peer support for clients at the level of accountability and reliability desired has been difficult with the available resources.

Therefore, enhancements in this area would definitely benefit long-term recovery efforts.

6. THE FAMILY UNIT SHOULD BE AN ACTIVE FOCUS THROUGHOUT SERVICES:

Family-centered treatment must be comprehensive. Family-centered treatment includes clinical treatment, clinical support, and community support services. It must address substance use, mental health, physical health, and development. Additionally it must address social, economic, and environmental needs. Family is inclusive of the supportive network of relatives and others whom the individual identifies as part of her family. Family-centered treatment helps a family function as a unit. Families are dynamic, and thus treatment must be dynamic. Treatment must be able to address evolving and changing family engagement. Everyone may not participate at the same time, stay the same length of time, or have the same motivations. Treatment must support creation of healthy family systems.

7. OUTCOMES SHOULD BE REALISTIC AND RECOVERY ORIENTED:

Treatment effectiveness should be measured at the end of specific interventions. Remaining in treatment for an adequate period of time is critical for treatment effectiveness. The appropriate duration for an individual depends on his or her problems and needs. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term substance use. Possible substance use during treatment must be monitored continuously. Such monitoring also can provide early evidence of substance use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit substance use is an important element of monitoring. Recovery from substance use disorders can be a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to substance use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

8. RISK MANAGEMENT PROCEDURES ARE ESSENTIAL TO ENSURE THE SAFETY AND SECURITY OF ALL INDIVIDUALS: Safety must come first. Maintaining a safe environment for all individuals, in all client families, is essential. Programs must have policies for addressing inappropriate behavior in children, youth, and adults and protecting confidentiality. Maintaining trauma-informed and trauma-sensitive services and treatment milieu is of paramount importance.

C. Evidence-Based Practices

Objectives of Evidence-Based Practices

The objectives of evidence-based practices include:

- Identifying from the larger universe of possible objectives the top three objectives that we as a service delivery system should be reaching for in order to achieve the goal.
- Identifying barriers that would impede the achievement of the identified objectives.
- Identifying the best strategies to overcome barriers in order to achieve the identified 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. Place these in priority order and indicate 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.

TRI Model Programs and Evidence-Based Practices

Based on the work of the TRI work committee and the DSHS work panel, 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.

- **Evidenced-Based Practices** are interventions that show consistent scientific evidence of being related to preferred client outcomes and have been standardized so they can be duplicated.
- **Model Programs** are manualized guidelines or rules that indicate what is to be discussed in individual and group sessions and in life skills and education.

Recommendations for evidence-based practices and model programs for use in the Texas Treatment and Recovery System include:

Motivational Interviewing – Counseling skills which are client-centered, directive, and explicitly egalitarian treatment approaches. In an effort to foster an open exchange between the therapist and client, Motivational Interviewing 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 transtheoretical model of change proposed by Prochaska and DiClemente.

Motivational Enhancement Therapy (MET) – Therapy that 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 [that are] 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 – 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 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, health and wellness information that includes smoking cessation, nutrition, relaxation therapies.

Instrumental Support provides concrete assistance in helping others get things done, e.g., child care, clothing needs, assisting with entitlements.

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

Recovery Management is 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. It engages professional staff to facilitate access to services which 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 was 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, lessening impact on the primary health care system. Best practices using this model would involve health care clinicians in the screening/identification process and engage substance abuse or behavioral counselors in the intervention and treatment process.

Matrix Model – Treatment materials draw heavily on other tested treatment approaches. Thus, this approach includes elements pertaining to the areas of relapse prevention, family and group therapies, drug education, and self-help participation. It is highly manualized with set topics for individual, group, family and educational sessions. It is outpatient and approximately twelve weeks in length. Though primarily for stimulant users it has been adapted for alcohol and other drugs.

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

Relapse Prevention – Relapse Prevention Therapy (RPT) is a cognitive-behavioral approach to the treatment of addictive behaviors that 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 for the pursuit of pleasure and pain relief. 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 a lapse. Once potential relapse triggers and high-risk situations are identified, cognitive and behavioral techniques are implemented to incorporate specific interventions to prevent lapses or manage them if they do occur.

Medication-Assisted Therapy – Under medical supervision, 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 an opiate blocker used orally and by injection which substantially cuts down relapse in abstinent alcoholics who have undergone treatment by decreasing the psychoactive effects of alcohol by the opiate effects of alcohol being blocked by the medication.

Acamprosate which effects Gaba Amino Butyric Acid Levels and Glutamate both decreased by alcohol use and helps in their return to normal and calms brain function disturbed by alcohol use. They thus 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 to be taken for 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 which 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 the cocaine 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 cocaine use and provides insights into some of the reasons the client may be using cocaine. 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 cocaine use by conducting a decisional analysis that clarifies what the individual stands to lose or gain by continued cocaine use.

Teaching coping skills – This technique is the core of CBT that assists client's 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 cocaine 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 that includes skills training that teaches clients to recognize and cope with urges to use cocaine; 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.

D. Implementation

Implementation of the Texas Recovery Initiative

Public hearings and Task Force discussions reveal remarkable consistency in recommendations about the structure, implementation, and support of the Texas Recovery Initiative. Described in previous sections, these recommendations coalesce around the following themes:

- A client centered model of services fully integrated throughout the continuum of care.
- A separate billable case management (recovery management) service which can be staffed by trained, non-licensed peers. .
- 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 implementation of EBPs through higher reimbursement rates.
- A robust program of training and technical assistance to support implementation of Evidence Based Practices, with 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.

Implementing these recommendations has significant implications for Procurement, Training, and Monitoring.

DSHS is considering the following approaches:

Procurement:

- 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. (This needs to be fleshed out and made much clearer as to intention)
- Additional funding to pay separately for recovery management/case management.
- Develop clear standards and training requirements for those who provide recovery management/case management services.
- Procure recovery management/case management services as an integrated component of licensed treatment programs. These staff will either be part of existing treatment programs or contracted by treatment programs and will be dedicated to work with clients throughout the continuum of care, including 6-9 months 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; and
 - Funding recovery support services, including housing, transportation, life skills training, and peer support services.

Training:

- Prioritize DSHS training resources to support the TRI:
 - The goals and requirement of the TRI, with focus on the change in philosophy and focus; and
 - Evidence-based practices.
- Develop long-term training systems to support continued skill-building necessary for staff to achieve competency and implement evidence-based practices.
- Investigate strategies for building local capacity for training and clinical supervision. Options include:
 - Adopting or developing curricula for Training of Trainers, including manuals and supporting training materials.
 - Enhancing existing Clinical Supervision Standards.
 - Releasing an RFP for development of a clinical management structure.
 - 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 with skills to provide coaching and supervision.
- Supporting local peer groups designed to support specific evidence-based practices through continuing education, peer review, and development of strategies to develop organizational environments to support implementation.
- Convening an advisory or working group to develop and implement strategies to strengthen the state and local infrastructure for long-term training and clinical supervision.
- Develop standards, competencies, and training for paraprofessionals who provide recovery management and recovery support services.
- Adopt consistent standards for documentation and provide related training.
- Increase access to training through the use of technology, including Internet-based training with testing components.

Monitoring:

- Focus monitoring on essential components.
- Develop performance measures appropriate to recovery support services.
- Plan monitoring systems in conjunction with development of TRI requirements.
- Obtain input from the TRI Task Force prior to final adoption of monitoring instruments.
- Ensure Quality Management staff is well trained in the theoretical concepts and fidelity requirements of the EBPs they are reviewing.
- Modify monitoring systems as the TRI initiative evolves.

Additional Issues to be Addressed

The public hearings and task force discussions surfaced a number of related issues that impact 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 Licensed Chemical Dependency Counselors.
- Limitations of the current services system, including barriers to timely treatment and insufficient capacity.

1. Training**TRI Training Group**

Input received during the public hearings clearly identified the challenge of supporting any new initiative with an adequate number of competent counselors and paraprofessionals. Members of the group made a number of suggestions relating to licensure, training, and environmental support.

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

DSHS Comment: DSHS agrees that long-term training and support will be essential to the success of the TRI. This will be one of the top priorities for implementation.

Issue 2: Use technology and existing resources to develop and disseminate training. 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.

DSHS Comment: DSHS concurs that technology is an effective resource for increasing accessibility and reducing cost of training and

Issue 3: Expand the number of qualified trainers by using a Use a “Train-the-Trainer” model.

DSHS Comment: Building capacity for training and competency-specific clinical supervision at the local level is essential. DSHS is already using a “Train-the-Trainer” model, and will expand the strategy to new topics when appropriate programs are available. Other strategies will also be investigated,

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

DSHS Comment: DSHS will develop standards, communicate them clearly to the field, and ensure that auditors are knowledgeable and consistent in interpreting and applying the standards.

Issue 5: Increase rates to support higher salaries for LCDCs.

DSHS Comment: Workforce development is a continuing challenge, particularly with the pay scale associated with provision of chemical dependency treatment services. Currently, it is not possible to raise rates without significantly reducing the number of clients served. However, the higher standards and increased requirements relating to implementation of evidence-based practices and programs, together with effective systems to ensure fidelity, may provide support for an enhanced rate structure.

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

DSHS Comment: It may be possible to encourage counselor who have left the field to return to active practice. At the present time, however, we do not have data on the reasons individuals choose alternative careers. DSHS will investigate the

feasibility of surveying inactive counselors to determine what incentives might be successful in persuading them to seek re-licensure.

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

DSHS Comment: This was accomplished during the last legislative session.

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.

DSHS Comment: State statute defines the types of activities that qualify as credit toward licensure. The Mental Health and Substance Abuse Division will work with the Regulatory Division to provide clear guidance on which, if any, recovery support activities can count towards the work hours required for licensure.

Issue 9: Establish training and credentialing standards for paraprofessionals.

DSHS Comment: Successful integration of recovery support activities will require clear standards for the paraprofessionals who provide those services. DSHS will work with the Task Force to develop appropriate standards and associated training.

Issue 10: Develop strategies to address staff that have unresolved issues of their own and/or neglect self-care and provide training to reduce stigma associated with many clients.

DSHS Comment: DSHS will consider these topics when developing training priorities and encourage professional associations to address them in continuing education venues.

Issue 11: Address systemic problems that frustrate staff and interfere with service delivery. For example, it takes longer to complete the assessment in CMBHS than it does in treatment. Auditors also need to have appropriate tools and training relating to EBPs in use at the site being reviewed.

DSHS Comment: DSHS will continue efforts to streamline electronic documentation and ensure that quality management staff has the tools and training to appropriately review fidelity to EBPs.

2. Purchasing

TRI Purchasing Group

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 clearly identified case management as the key to further progress, because investing in case management enables providers to more effectively leverage community resources.

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 frees credentialed staff to provide 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.

DSHS Comment: DSHS agrees that a strong case management function is necessary to effectively link clients with existing community services and help them build a strong recovery support system

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.

DSHS Comment: This issue will be addressed as implementation strategies and standards are developed. Under the current system, however, it is not possible to pay for any service prior to admission, and it is unlikely that a mechanism can be found to use state funds to pay for pre-admission Recovery Management. However, it may be possible for providers to access other community and peer support services to support clients who are on a waiting list.

ISSUE 3: Case management must be performed by trained and competent paraprofessionals. DSHS should invest training resources into this function, and effort should be made to recruit case managers from among the 70% of Counselor Interns who fail the LCDIC exam. This can help to retain them in the field, give them an opportunity to develop their skills, and perhaps put them on a ladder for professional development.

DSHS Comment: DSHS will develop clear standards and training requirements for Recovery Managers. This will allow individuals from varied backgrounds to provide these services, including peers associated with a recovery organization and counselor interns who are not yet licensed. Outreach to counselor interns who have failed the licensure exam is a promising workforce development strategy.

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.

DSHS Comment: DSHS concurs with these training priorities, and will continue to strengthen and expand the use of technology and Training of Trainers to expand access and build local capacity for training and clinical supervision.

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

DSHS Comment: Consideration will be given to structuring the funding criteria to incentivize the development of strong collaborative relationships at the local level.

ISSUE 6: Implementation should be informed by experience gained through other recent initiatives, particularly ATR and COSIG.

DSHS Comment: ATR and COSIG do offer valuable lessons, as do other grant projects and initiatives. In addition, DSHS will continue to research models and initiatives at the federal level and in other states to inform the planning and implementation of the TRI.

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.

DSHS Comment: Individualization is the key to effective treatment, but currently many programs use the same curriculum and group counseling schedule for all clients. At least three broad categories of clients are generally found in any program: those in pre-contemplation, first-time clients, and clients who have relapsed. Each of these groups should have education and group counseling sessions targeted to their specific needs.

Purchasing Group Recommendations:

The group recommended that any new funds be used for the following, listed in priority order:

- Raising Reimbursement Rates

- Case Management
- Housing
- Training
- Transportation
- Peer Support Services

DSHS Comment: DSHS generally agrees with the prioritization, but believes that all recovery support services should be combined in a single category. Therefore, the priorities for new funds will be 1) increasing treatment rates; 2) case management; and 3) Recovery support services. It is important to note that any increase in the treatment rate will be contingent on increased standards and requirement associated with the implementation of EBPs.

3. Monitoring

TRI Monitoring Group

ISSUE 1: Members of the group suggested that participants from the selected stakeholder group be allowed to review and offer input into the matrix that will be used by DSHS QM staff to monitor the evidenced based principles and programming for treatment services to be implemented in FY2010.

DSHS Comment: The DSHS Quality Management Unit prepares review tools (matrices) specifically tailored to the contract and rules pertaining to the program being reviewed. Review tools are developed by a QM staff team and reviewed by QM managers before being used in the field, and then they are posted on the DSHS website. The tool for this program (TRA) will likely be developed around July 2009. The same review tool is used for all reviews throughout a contract year. Regarding input from selected stakeholder group members, it does not seem practical for them to be a day-to-day part of the tool development, as that will be done during the normal course of business at DSHS; however, the TRI stakeholders could give input to the TRI committee any time in the upcoming months before DSHS develops the review tool. And then when a tool has been developed, it could be discussed with the TRI stakeholders at one of the regular TRI meetings. If changes are proposed by the TRI stakeholder group, they will be considered on a case-by-case basis by the DSHS QM Unit. Additionally, there is always an opportunity for each Contractor to submit a Review Survey after their review and comment on anything related to the review that they want to communicate to their QM reviewer and QM management. That is one avenue that currently exists for any Contractor to offer input to the review process, including the tools (matrices) being used.

ISSUE 2: The group also suggested that DSHS take a critical look at how the QM staff will be trained to be consistent with the fidelity and understanding of the theoretical principles inherent in each of the models selected by DSHS as best practices to be

used in the delivery of substance abuse treatment services for adults and youth funded by DSHS.

DSHS Comment: The DSHS Training and Technical Assistance Unit provides training to Contractors and to DSHS staff. Once the principles and practices and models have been agreed upon and the RFPs have been developed, we will be able to identify what specific type of training is needed (both internal DSHS staff and Contractor training). The DSHS QM staff continuously receives information and training on new and existing review requirements. This new TRA contract will have new elements to monitor, and therefore will be a training focus for QM. There is a QM staff member specifically assigned as Fidelity Coordinator, who will be involved in developing the review tool and monitoring the treatment program for fidelity issues.

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

DSHS Comment: The Training and Technical Assistance Unit is responsible for coordinating training on evidence-based models, including training of trainers and manuals and materials to support Contractors in implementing new programs and procedures. Training and clinical supervision are often a contract requirement. Contractors are already required to have an internal quality management plan, and staff training and clinical supervision should be a part of that internal plan. DSHS Quality Management will review Contractors for fidelity, and for compliance with rules and contract. That will be done through a variety of means, including desk reviews, Contractor self-assessments and onsite reviews.

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

DSHS Comment: Client satisfaction surveys are usually a part of a Contractor's internal quality management plan. In addition, during DSHS Quality Management reviews, client interviews are conducted with a small sample of clients. The Contractor's client satisfaction survey results and the impact on the Contractor's policies and procedures are also considered during DSHS reviews.

ISSUE 5: DSHS needs to review their process for evaluating the percent of referrals made to other community based providers not just DSHS funded treatment provider referrals.

DSHS Comment: Contract performance measures are not determined by the Quality Management Unit, but are monitored by the DSHS Contract Managers and are reviewed by DSHS Quality Management. Currently BHIPS has a referral form, including a follow-up section, that can be used for both DSHS-funded providers and other providers. However, non-DSHS providers do not have access to BHIPS to view the referral electronically. The referral functionality will be the same in the future for users of CMBHS. BHIPS is the “official record” for substance abuse contractors and can be used to document any referral and follow-up.

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

DSHS Comment: The Training and Technical Assistance Unit and the Quality Management Unit are separate units within DSHS. QM does some focused TA related to onsite review findings, and also makes recommendations to the TTA Unit for training topics that would benefit providers statewide. Training requests may also be submitted to the TTA Unit by any Contractor at any time. Both the TTA Unit and Program Implementation Unit assist with training QM staff, for example QM staff receive training in Prevention and Intervention best practices models, the CYT youth outpatient treatment model, and mental health Wraparound Planning services.

ISSUE 7: Funding needs to be reviewed for an increase in rates to improve the quality of services, funding needs to be more flexible, and funding must be client driven. Also, the money must follow the individual needs of each client receiving DSHS funded substance abuse treatment services.

DSHS Comment: Funding (increase in rates) is not within the scope of the Quality Management Unit. QM reviews, both desk reviews and onsite reviews, include a review of billing to ensure that service delivery occurred for the dates, times and amounts billed.

Monitoring Group Recommendations:

- Keep the monitoring system simple;
- Ensure that QM staff is trained in the fidelity of each model, and
- Ensure that the health and safety needs of the clients are being met.

DSHS Comment: These three recommendations are all achievable, and completely in accordance with the Principles selected by the TRI Taskforce Group. The Quality Management Unit supports these recommendations.

IV. Evolution of Substance Abuse Treatment

Continued Evolution of the Recovery System

In order to be truly successful, any system needs to continue to evolve. This is particularly true in the dynamic environment working with the diverse population served by the Texas Treatment and Recovery Systems. While the State authority and the providers attempt to deal with the changing array of issues that face individuals attempting to enter and maintain recovery; we are also are faced with a rapidly expanding body of knowledge of the dynamics of the disease of addiction, and options for resolving our client's issue, as well as building on their strengths. This maintenance should involve continued collaboration with other agencies, integration of system principles in the other initiatives; including the Clinical Management for Behavioral Health Services project (CMBHS), 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 roll out of the CMBHS program 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 will need to 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 recover.