

Access to Recovery Service Menus and Recovery Support Services

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Considerations for Designing Service Menus

An Access to Recovery (ATR) service menu is the key instrument of transformation of the traditional treatment system for individuals with substance use disorders (SUDs). Constructing and implementing an ATR service menu is a multi-step process requiring input from many entities, including these individuals. ATR managers must identify, define, and price an array of recovery support services for both traditional and nontraditional providers as well as implement training and monitoring mechanisms to ensure quality of these services, positive treatment outcomes, and genuine independent choice.

Introduction

Under the Substance Abuse and Mental Health Services Administration (SAMHSA), ATR's mandate to fund recovery support services provided by community and faith-based organizations has changed the treatment system for individuals with SUDs. According to the guidelines, recovery support services are no longer relegated to a subordinate role in a treatment system predominantly focused on clinical services. Services formally categorized as "adjunct" and "ancillary" to clinical treatment packages, and usually un- or under-funded as a result of this designation, are recognized for their value in supporting a person's unique recovery journey. Recovery support services have secured their place in the continuum of care for individuals with SUDs.

The resulting ATR service menus and the recovery support services included in these packages are both the catalyst for and proof of a transformed SUD system of care. To fully implement the recovery support services contained in these service menus, ATR grantees have to define, design, implement, train, evaluate, and maintain a provider network to deliver these services in an evolving system of care that is fundamentally different from the traditional treatment system. Expanded ATR networks and the wide variety of recovery support services offered by network providers are also evidence of a transformed system.

How Should Grantees Use this Information?

This Technical Assistance (TA) package provides information, resources, tips, and tools to help ATR 3 grantee key staff understand the role of service menus and recovery support services in the continuing transformation of the SUD system of care. Readers will find information about the experiences of and the lessons learned by ATR grantees as they built, implemented,

evaluated, and refined their own ATR service menus and recovery support service array.

Designing Service Menus and Recovery Support Services

ATR Service Menus—A Transformed Service System

ATR service menus are the vehicles by which the SUD system of care expands the number, types, and providers of evidence- and practice-based services for individuals in recovery. An ATR service menu is an approved list of clinical and recovery support services that have demonstrated success in supporting a person's recovery journey. Service menus are culturally tailored, appropriate for the target population, and cost-effective. Complete ATR service menus include the following:

- A brief description of the service.
- A recommendation regarding the frequency and intensity of the service.
- An approved rate for the service.
- A list of approved providers of the service.

A sample of an ATR service menu is provided in Appendix A.

The cornerstone of an ATR service menu is independent choice by the individual: They choose from a number of approved ATR services and providers, participate in their chosen services from the providers they selected, and decide for themselves if they wish to continue or change the services and/or providers. The ATR mandate of self-directed care by individuals with SUDs is in direct contrast to the more traditional provider-directed treatment system.

Recovery support services are a hallmark of a recovery-oriented system of care, and research suggests that they are integral to the recovery process. Services provided in the community, by the community, and for community members with SUDs are highly effective when coupled with traditional treatment services. As such, ATR service menus, which include recovery support service options, represent a transformed service

system—a system driven by individual choice and supportive of the many paths to recovery.

Clinical Treatment and Recovery Support Services

Clinical treatment services are provided by individuals who are licensed, certified, or otherwise credentialed to provide clinical treatment services, often in settings that address specific treatment needs. Clinical treatment services generally include the following:

- Screening and/or assessment.
- Brief intervention.
- Treatment planning.
- Detoxification.
- Medical care.
- Individual and/or group counseling.
- Residential services.
- Pharmacological interventions.
- Co-occurring treatment services.

Recovery support services are typically provided by paid staff or volunteers who are familiar with how their communities can support people seeking to live free of alcohol and drugs, and who are often peers of those seeking recovery. Recovery support services often include the following:

- Substance use disorder education.
- Family services, such as marriage counseling and parenting training.
- Pre-employment counseling.
- Case management.
- Relapse prevention.
- Face-to-face or telephone-based continuing care counseling.
- Alcohol and drug testing.

- Outreach.
- Individual services coordination, providing linkages to other services (e.g., legal services, Temporary Assistance for Needy Families, social services, food stamps).
- Recovery coaching (e.g., stage-appropriate recovery education, assistance in recovery management, telephone monitoring).
- Family support and child care.
- Transportation to and from treatment, recovery support activities, employment, and other activities.
- Supportive transitional drug-free housing services.
- Self-help and support groups (e.g., 12-step groups, SMART Recovery, Women for Sobriety).
- Spiritual support.
- Employment coaching.

[“ATR (*Initial Announcement*) Request for Applications (RFA) No. T1-04-008,” 2010.]

Because of the system transformation begun by ATR, States are able to use the services mentioned above and/or develop other services that support recovery. For example, because physical well-being is a critical component of long-term recovery, nutrition services and/or physical fitness services may be important recovery support services for some.

ATR service menus and the recovery support services included in them reflect service gaps identified in the system, services that individuals say they need, services that partners and providers can offer, services that communities will support, and services for which State authorities gave funding permission. Most grantees report that their ATR service menus evolved during the early phases of their projects’ development. As part of a continuous quality improvement process, the menus continue to evolve over the course of the projects.

Many Steps to ATR Transformation

Appendix A of the ATR 1 Request for Applications provides a list of potential services that could be included

in grantees’ projects. While this list provides a starting point in building an ATR menu of services that is unique to each project, ATR grantees realized quickly that several processes and steps needed to be completed before the project—with its multitude of service, provider, and payment mechanism changes and robust data collection requirements—could be implemented.

ATR grantees identify three distinct early phases of their projects: application, startup, and implementation. However, the rapid implementation requirement of the ATR grant (e.g., six months from the date of award to issuance of the first voucher for ATR 1 grantees and an even shorter timeframe for ATR 3 grantees) challenged grantees to simultaneously develop processes and products for these different project phases. The chart on the next page illustrates these phases and the processes and tasks associated with each.

Information and Tools

The information, tools, and templates that will assist in the planning, implementation, evaluation, and ongoing refinement of service menus are organized in the following areas:

- Analyzing strengths and needs in the current SUD treatment system.
- Partnering with current and new systems, stakeholders, and providers.
- Providing enrolled individuals opportunities for input into the ATR service system’s development.
- Designing service menus and recovery support services for target populations.
- Developing service definitions, rates, and requirements.

► Identifying Needs of the Community

- Utilize the information that newspapers and other social media sources are reporting as needs of the community.
- Ask the question, Does the public media provide insight into what the needs are and then research the details.

- Developing an expanded provider network.
- Disseminating information about services to individuals, communities, and referral sources.
- Preparing, disseminating, and using a service directory.
- Collecting outcomes and system improvement data.
- Reporting on data and experiences.

Although the information is organized in a linear fashion—what needs to be done first through what is

done later—the work is linear only with respect to the start of an activity. For example, a jurisdiction will have to analyze the strengths and needs of its current SUD treatment system during the planning stage, but the analysis is ongoing throughout the life of ATR and beyond. Similarly, partnerships with new stakeholders and providers will begin during planning, but this activity does not end. Preparing and disseminating a service directory—which includes provider information, such as location, hours of operation, and types of services available to ATR’s enrolled individuals—does not occur until the implementation stage, but continual updates to that service directory will be needed.

<i>ATR Project Phase</i>	<i>Key Staff, Processes, and Tasks in Designing Service Menus and Recovery Support Services</i>
Application	<ul style="list-style-type: none"> • Initial analysis of strengths and needs in the current SUD treatment system • Initial selection of target population(s) • Initial partnerships with current and new systems, stakeholders, and providers • Initial opportunities for individuals with SUDs to have input into the ATR service system’s development • Initial service definitions, rates, and requirements • Initial description of the provider network
Start-up (up to 4 months after award of grant)	<ul style="list-style-type: none"> • Continuing analysis of strengths and needs in the current SUD treatment system • Ongoing partnerships with current and new systems, stakeholders, and providers • Review of selected target population(s) • Additional opportunities for people with SUDs to have input into the ATR service system’s development • Finalization of service definitions, rates, and requirements • Final development and implementation of the expanded provider network • Certification and/or credentialing of the provider network
Implementation (from 4 months to a year)	<ul style="list-style-type: none"> • Development of data reporting tools • Collection of outcomes and systems improvement data on recovery support services • Continuous reporting on data and experiences to advance treatment and recovery support services throughout the project’s jurisdiction, SAMHSA, and the SUD services field

Access to Recovery Implementation Tool Kit, Volume 1, Phase 1, 2010.

Analyzing the Current SUD Treatment System

SAMHSA’s announcement of the ATR grant made clear to potential grantees that ATR was not “business as usual” for SUD treatment. ATR’s emphases on new service types, new service providers, and a new payment mechanism in a new system driven by genuine independent choice by the individual signaled SAMHSA’s intent to transform the traditional SUD system of care.

To successfully compete for an ATR grant, a jurisdiction needs to map and analyze its community’s SUD system of care. One way to accomplish this is to use the W.K. Kellogg Foundation’s Mapping Community Resources Model, which comprises the following six steps:

1. Involve diverse stakeholders in the process.
2. Create a forum where stakeholders can learn about and participate in the mapping process.
3. Set up a planning team to take inventory of the community’s traditional and nontraditional services.
4. Take inventory of nontraditional services, which are assets and capacities largely under community control and influence.
5. Take inventory of traditional services, which are assets and capacities offered largely by public and private organizations.
6. Create the resources map and put it to use.

(Community Partnership Toolkit, 2011)

It is vital to follow up community resource mapping with a gap analysis: Find the gaps in needed recovery support services. To visualize these gaps, chart the results of the community resources map by potential target populations. The chart below was designed with three potential target populations in mind—individuals involved with the criminal justice system, military, and women. This information is useful for proposal preparation, allowing the jurisdiction to clearly articulate to reviewers which resources are currently available, what gaps in recovery support services need to be filled, and perhaps how the jurisdiction intends to fill those gaps through ATR. After being awarded the ATR grant, revisiting this matrix and revising it as necessary will fast-track the ATR grantee in finding which recovery support services are needed to fill the gaps for the grantee’s selected ATR target population(s) below.

Partnering with Systems, Stakeholders, and Providers

In preparation for writing an ATR proposal, the community resource mapping process sparks the development of new partnerships among systems, stakeholders, and providers. During implementation of the ATR grant, relationships with and among traditional systems and providers are likely to be redefined and restructured. New ATR grantees must be prepared to address concerns from a variety of providers. For example, new ATR providers are often concerned about how their programs or services will be monitored, what kind of individual and fiscal recordkeeping and review will be necessary, and how working relationships with traditional SUD

<i>Potential Target Population</i>	<i>Identified Service/ Support Needs</i>	<i>Traditional Service Providers</i>	<i>Nontraditional Service Providers</i>	<i>Service Gaps</i>
Individuals involved in the Criminal Justice System				
Military				
Women				

providers will be developed. Key concerns for traditional SUD system of care providers typically include the ability of new faith-based and nontraditional providers to meet State contracting and credentialing requirements, whether the faith-based providers will be able to maintain the required separation of religious activity and programmatic functions, and what methods the faith-based and nontraditional providers offering recovery support services will be using.

To address these issues, ATR managers must develop expertise on both the existing and new providers. To do this, they may need to seek answers to such questions as follows:

- What do we know and/or need to learn about the community organizations that deliver faith-based or community recovery support services?
- How can we help prepare new providers to become partners in an integrated system of care?
- How do we identify and engage other new community-based clinical and recovery support services providers?
- What requirements for participation do community organizations anticipate as they prepare to become providers in our ATR system of care?
- What is the current relationship between traditional SUD providers and community organizations that deliver faith-based or community recovery support services?
- What recovery support services do individuals use outside of traditional provider organizations and which of these services best support recovery?
- What partnership opportunities exist between your traditional SUD providers and faith-based or community recovery support service providers?

Several strategies may be needed to manage the delicate balance between the established system of care and the expanded one envisioned in ATR. ATR managers can hold face-to-face meetings with traditional providers to jointly review the Request for Applications requirements and service and system requirements. These meetings can be an opportunity to both honor the contributions

of these providers and identify challenges and gaps that are impacting the treatment success of the individuals with whom they work. Invariably, some providers will embrace the ATR transformation and fundamentally change practices; others will superficially change their services and business practices and not really “walk the walk.” It is important to the success of the ATR project and the system change activity to learn to differentiate between the two.

Spiritual Recovery Support Services

While ATR includes a variety of reimbursable recovery support services beyond the traditional package of SUD treatment services, the proposed funding of spiritual recovery support services delivered by faith- and culturally based providers is perhaps the most controversial and worthy of special consideration. Two key issues immediately emerge: the use of Federal funding for these services and the services themselves.

The funding of ATR services through a voucher system under the control of the individual is a significant departure from traditional funding mechanisms. Unlike traditional approaches, in which providers receive funds to deliver SUDs treatment services, ATR vouchers are issued to an individual, who then uses them to purchase an array of clinical and recovery support services through a network of approved providers. This fundamental difference allows the use of ATR funds for services from faith- and culturally based providers by avoiding direct Federal funding of these organizations and placing the choice of providers and services with the individual who receives a voucher.

Many spiritual recovery support services are specific to a particular religious denomination, cultural group, or tribe. Many of these services do not lend themselves to “definition” and “standards of practice” and are often delivered by unlicensed personnel. Traditional SUD service providers will question the value of these services in the recovery process.

ATR grantees will need to ensure that all providers understand the value of spiritual recovery support services in the recovery process and address funding issues and concerns. Some grantees implement strategies such as mandatory monthly ATR network meetings

to encourage interaction among their providers. At these meetings, the providers are invited to present information on their services, practices, and individual outcomes. Individuals who have effectively used spiritual recovery support services in their recovery can also be valuable additions to such gatherings. Meeting attendees regularly report a new appreciation for and understanding of the role and value of spiritual recovery support services in a person's recovery journey.

Providing Opportunities for Input by the Individual

The ATR Request for Applications clearly mandates that ATR projects must “ensure genuine, free, and independent individual choice for substance abuse clinical treatment and recovery support services appropriate to the level of care needed by the client.” It defines choice in the ATR program as “a client being able to choose from among two or more providers qualified to render the services needed by the client, among them at least one provider to which the client has no religious objection.” (*ATR [Initial Announcement] Request for Applications [RFA] No. T1-04-008,* 2010.)

Individual input into the design of an ATR service system is a critical factor in service menu design. Strategies to solicit input may include creating focus groups to gather, review, and incorporate input that helps shape the initial menu of ATR services during the proposal planning stage. In addition, ATR managers use these opportunities to solicit feedback from individuals regarding their positive and negative experiences with the traditional SUD treatment system. They also have individuals identify the recovery support services they need for their recovery, and these are then often included in the ATR service menu.

Individual choice of both providers and services is a fundamental difference between the traditional SUD treatment system and ATR. Individuals served by traditional services may not be encouraged to express or act on their preferences in determining which services they want to use. Service providers may overly influence the choices the individual makes. To minimize this influence, ATR projects develop and implement strategies and processes that support the individual's

independent choice of services and service providers. Some ATR projects use a central intake model, which allows individuals to be assessed for services by a neutral third party that is separate from the provider network. Other ATR projects regularly track provider “self-referrals” to monitor potential variation from the tenet of individual choice. All ATR projects have an established complaint process that allows individuals to report any concern with services or providers directly to ATR staff. Finally, ATR managers use voucher management system reports to spot any other provider and service issues.

Designing Service Menus for Target Populations

A key feature of ATR is funding of a new mix of clinical and recovery support services. While a relatively small dollar amount, an ATR grant can bring much-needed resources to a chronically under-funded SUD system of care, and thus the advocacy for specific recovery support services to be included in the local ATR service menu can be intense. Developing a matrix during the application process, as described previously under Analyzing the Current SUD Treatment System on page 5, will help limit the impact of these advocacy efforts. Potential providers will gain a better understanding of the range of services currently available and the gaps that they may be able to help fill. During the implementation phase, ATR managers will need to clearly understand how the current configuration of services fits with the needs of the target population(s) and, based on this assessment, what types of services appear to be missing from the provider network. They can then work with traditional and nontraditional providers to develop new lines of services as needed.

► Developing Recovery Support Services

- Refer to SAMHSA's sample list of services provided in the Request for Applications to help with initially identifying appropriate providers.
- Talk to people who are familiar with the treatment community and have knowledge of community services that are often under the wire and may have never had the attention of State or governmental funding entities. For example, set up a meeting with your mental health services department within your agency.

Developing Service Definitions, Rates, and Requirements

Essential to the goals of the ATR program is the development, implementation, and monitoring of a number of new recovery support services, including faith-based and nontraditional services. Communication strategies for community and faith-based providers require special attention to relationship building. These providers are typically not looking for a “contract with the State”; they want a relationship with an individual who understands their services. ATR managers need to form relationships with these providers that are based on respect and trust. Approaching the faith community through ministerial alliances has been a useful strategy for many ATR grantees. Irrespective of how collaborative relationships are developed with nontraditional support service providers, ATR managers will likely have to assist these providers in developing service definitions, establishing rates, and defining staffing requirements.

Developing Service Definitions

A fully developed service definition includes the following information:

- Definition of the scope of service.
- Rationale for the service.
- Qualifications for delivering the service.
- Payment criteria for the service.
- Credentialing of the staff so they will be able to deliver the service.
- Codes for the service.

A common way to help a nontraditional support service provider develop the definition of its service is to compare the service to be provided to that found in the traditional service arena.

Establishing Rates

Most ATR grantees pay a higher rate for similar services if they are provided by individuals with some specialized training. For example, ordained clergy typically have expertise and credentialing that is different from that of lay ministers. Both may counsel

individuals about a crisis of faith; however, the ordained clergy would typically do so according to an organized doctrine and in a theologically sound way using the texts of their religious beliefs. Therefore, ordained clergy would be paid at a higher rate than lay ministers, even though both may fall into the category of spiritual recovery support services.

▶ Implementing New Services

- Disseminate a list of services throughout the community for providers to choose from.
- Next, look at the types of services that have the least number of providers.
- Then, pay a higher rate for those services as an incentive for providers to start offering them.

Another approach to establishing rates is to consider the rates for the services of credentialed providers in traditional clinical settings and pay comparably for individuals with similar levels of education in their fields of expertise. Some ATR grantees even extend this strategy to service providers who have expertise in cultural practices. A description of how one ATR grantee expanded the standard pay rate for a clinician to both ordained clergy and cultural elders is provided in the final section of this TA Package.

Defining Staffing Requirements

Requirements for both paid and volunteer ATR staff often include a criminal background screening and proof of legal eligibility to work in the State.

▶ Services Versus Spending

- Look at the level of clinical treatment the client is receiving to ensure that recovery support services aren't interfering with treatment or overwhelming the individual, who may be in an intensive level of clinical treatment. You can do this by consulting with the clinical and recovery support service providers.
- Service limits may come down to how much money is available in your budget, how much funding is available, client targets, and—in some respect—a simple issue of math.

Additionally, ATR grantees develop appropriate licensing and/or training requirements for ATR provider staff. For example, one grantee distinguishes between ATR-approved staff and ATR-qualified staff by requiring qualified staff to have appropriate certification and/or licensure for the recovery support service they are providing. Types of certifications and licenses include professional counselor certification, qualified substance abuse professional designation, commercial driver's licensure (for certain transportation services), and recovery support specialist certification.

Developing an Expanded Provider Network

In conjunction with the establishment of ATR service definitions and rates, grantees also set requirements for provider eligibility for the ATR network. Provider eligibility determination includes requirements at the organization, site, and staff levels. For example, an ATR grantee may require a provider organization to hold a certificate of good standing issued by the Secretary of State. Site level requirements may include such items as current fire inspections, local Government-issued occupancy permits, and nationally approved inspections, including the Housing Quality Standards established by the United States Department of Housing and Urban Development, to ensure the health and safety of staff and individuals.

While jurisdictions will have conducted preliminary work around the identification of new providers for an expanded ATR network to prepare for proposal submission, the majority of the effort in network development occurs during project startup. Many of the new providers in the ATR network will have limited experience in State systems of care. The section of this TA Package titled Partnering with Systems, Stakeholders, and Providers on page 5 includes some hints and tools for outreach to potential providers. The Determining Readiness for ATR RSS Providers tool (Appendix D) can be used by any new provider prior to application for ATR Provider status.

ATR managers will need to develop a number of documents to support the ATR network, including the following:

- Applications.
- Contracts and/or memorandums of understanding.
- Documents on infrastructure requirements.
- Credentialing and approval forms.
- Provider handbooks.
- Documents detailing data collection requirements.

Disseminating Information to Individuals, Community, and Referral Sources

Word of mouth is often the most effective tool in getting individuals enrolled in ATR services. However, the use of several strategies may be required to ensure that referral sources, stakeholders, and partners are familiar with the new ATR network. These may include community outreach campaigns, provider open houses, or town hall meetings. To successfully implement these strategies, it is critical that ATR grantees identify and coordinate with a trusted community entity (e.g., an individual or provider) that is well-known for supporting individuals in recovery. For example, one grantee worked with a faith-based organization in its community, which hosted a lunch-time open house at its location. Referral sources, stakeholders, and partners from the community were invited to tour the site and learn about the services being offered. Another grantee used its central intake model to conduct a formal community outreach campaign, which involved posting ATR service flyers throughout the community, speaking with faith-based and secular organizations during brown-bag lunch sessions, and participating in radio interviews on local stations.

Preparing, Disseminating, and Using a Service Directory

The creation and dissemination of a provider service directory is a necessary task both prior to implementation of the project and when new services and providers are added to the network. Similar to a

service directory, the service menu includes the following information:

- A brief description of the service.
- The recommended frequency and intensity of the service.
- The approved rate for the service.
- A list of approved providers of the service.

ATR project staff members need to determine how to keep these lists updated as providers and services are added to the voucher management system. One suggestion is to maintain an electronic list of providers

Help Your Providers

Create a recovery support services list and a manual to accompany it, which serves as a guide for providers on how to document services.

and services on the ATR project's Web site and prominently feature the Web site address in all of the ATR project's materials. Staff members of many ATR projects assist eligible individuals in using this electronic service directory to select their services and providers during the intake/assessment process. ATR grantees are encouraged to use program structures and processes

such as care coordination to ensure that individuals are aware of the provider and service options.

ATR managers may use service directories to publicize the ATR program across project sites, to communities, and to partners and stakeholders by establishing an ATR project Web site that provides online access to ATR program information and these service directories. ATR managers widely disseminate this Web site address, including the provision of direct links from other Federal, State, and local Web sites, such as those sponsored by the State Substance Abuse Authority.

The State of Hawaii Department of Health Web site and the Missouri Department of Mental Health Web site are helpful examples of project sites that include myriad resource samples, such as provider handbooks and service directories. Samples of the other documents noted in this section are provided in appendices A-D (See the References and Additional Resources section on page 13 for Web site addresses.).

Collecting Outcomes and System Improvement Data

All ATR grant recipients are required to collect the federally mandated Government Performance and Result Act (GPRA) data set. Designed to track change over time across several key indicators for each individual, GPRA data reporting requirements include the following:

- Data collection at three points during an individual's course of ATR services.
- An 80 percent follow-up rate of individuals at six months.
- The ability to upload data into the Federal Services Accountability Improvement System.

To understand ATR service utilization and the contribution of recovery support services to an individual's overall recovery process, ATR grantees must regularly monitor GPRA and voucher management system data. Suggested strategies follow:

- Weekly review of voucher management system data to track service and provider utilization.
- Implementation of an electronic services calendar for each individual to identify possible waste, fraud, and abuse.
- Regular review of GPRA data, with critical analysis of service mixes and individual outcomes.

Each of the strategies listed above enables ATR managers to continuously and consistently track the implementation and utilization of their ATR grant. Voucher reimbursement systems are designed to reflect consumer utilization and, as such, change constantly. ATR managers review voucher management information, including service utilization frequency and duration, to identify both standard and outlier practices. Through the review of voucher management system data, for example, one ATR grantee identified an ongoing lack of housing providers. Steps were then implemented to increase reimbursement rates to, in turn, increase the number of providers offering this service.

An electronic services calendar (or one done by hand) for individuals allows ATR managers to immediately visualize ATR service utilization (e.g., billing)

throughout a week, a month, or the life of a voucher. This calendar can be used to track both individual and provider data, offering a picture of the types of ATR services being utilized and establishing a baseline audit tool for individual record review.

ATR's requirement to collect GPRA data at set intervals allows ATR managers to assess the impact of recovery support services on key individual outcomes, such as abstinence, ongoing criminal justice involvement, employment, and social connectedness. By monitoring and analyzing GPRA data, ATR managers can adjust the types of recovery support services being offered.

ATR data collection represents a unique opportunity in the behavioral health service system. In many cases, ATR data collection represents the first time that a State can actually track outcomes on a cohort of individuals at different intervals.

Reporting on Data and Experiences

ATR managers report on data and experiences to advance treatment and recovery support approaches throughout the project's jurisdiction, the broader SUD services field, and SAMHSA. ATR managers use individual satisfaction surveys, provider and referral source feedback, and service utilization data to monitor and report on program status. GPRA and voucher management system data are provided to ATR partners, referral sources, legislators, and community stakeholders through regular network and provider meetings, regular status reports, and ad hoc data requests. The value of this information, along with GPRA outcome data, enables ATR managers to influence the transformation of the traditional SUD system of care.

Moreover, ATR data provides a rich opportunity to sort and review outcomes in a variety of ways, such as the following:

- Level of care.
- Combinations of levels of care (e.g., clinical and faith-based, clinical and peer).
- Provider.
- Provider type.

ATR data has been used by States and Tribal Nations to make decisions on where State dollars should be used to sustain or expand a service. One grantee's ATR data provided enough evidence of success for the State to decide to sustain its ATR service through State funds. Those programs still exist today, not simply because of their success in ATR but because the data was collected and used appropriately.

Many of the tenets of ATR, especially the emphasis on recovery support services and the implementation of services that produce outcomes, can be found in the latest SAMHSA guidelines on the combined Substance Abuse Treatment and Prevention and Community Mental Health Services Block Grants. The data collected through ATR is largely responsible for this shift.

Grantee Examples

ATR programs can learn from the current grantees who designed, implemented, and revised service menus and recovery support services in ATR 1 or 2. Two examples included here represent service and network information from Hawaii ATR and Missouri ATR. Additional resources from these two States can be obtained from their respective Web sites. (See the References and Additional Resources section on page 13 for Web site addresses.)

Service Menus

Hawaii ATR's service menu exclusively funds recovery support services. However, Missouri ATR's service menu includes both clinical and recovery support services. Recovery support services selected were heavily influenced by the faith-based community in response to the emphasis on faith-based initiatives in ATR 1.

Providers

The Hawaii ATR provider network is open to all providers who meet the basic criteria; these providers are referred to as "authorized" providers. The Missouri ATR provider network, however, is limited to credentialed recovery support service organizations, certified clinical organizations, and housing and transportation providers, which must meet State and Federal requirements.

“We thought, if we are going to find out what the standard pay rate is for a clinician, then that’s the rate we are going to pay an ordained minister and that’s the rate that we are going to pay a kupuna who’s doing cultural practices.”

— Bernice Strand, Project Director, ATR Ohana

In Hawaii, *kupuna* is an umbrella term for the expert, respected elder, or recognized cultural or community leader, but different distinctions exist regarding seniority within the cultural community. Within the category of *kupuna* is the *kumu*, who is equivalent to a formal teacher. However, a *kupuna* who practices traditional crisis resolution may not necessarily be a *kumu* for a different cultural practice. Or, a *kumu* may have less experience than a *kupuna* in the same cultural practice. Also, a *kupuna* on one side of the island may not necessarily be a *kupuna* on the other side. Understanding these distinctions among cultural titles and practices is crucial.

Governing Documents

Given the significant difference between contracting for traditional SUD treatment services and ATR services, each grantee had to work extensively with its respective legal departments to ensure that State financing laws were not violated while implementing the voucher-based reimbursement system required by the grant. Hawaii ATR staff utilizes a general memorandum of understanding, including their service definitions. This memorandum of understanding is renewed yearly proactively by the State. Each service category is extensively detailed in the memorandum, reflecting Hawaii’s state history of comprehensive contracts for any services. Missouri ATR staff utilizes a general contract, as the State credentials their ATR network.

Example of a Recovery Support Service

Spiritual Counseling (Individual, Qualified) helps an individual develop spiritually, which might include, but is not limited to, establishing or reestablishing a relationship with a higher power, acquiring skills needed to cope with life-changing incidents, adopting positive values or principles, identifying a sense of purpose and mission for one’s life, and achieving

serenity and peace of mind. Responsible decisionmaking, social engagement, and family responsibility may also be addressed. Only ATR-qualified clergy may provide spiritual counseling. (Missouri ATR)

Pastoral Counseling may include, but is not limited to, a client meeting with an ordained minister, priest, rabbi, imam, monk, or other advanced-level, qualified, authorized, and endorsed faith expert to study the application of a religious text to recovery, to support during a crisis, to determine a recovery plan, or to receive instruction in religious rituals that provide meaning and can replace behaviors caused by individuals’ substance use. This may include structured discussions about the philosophy of religion or integration of spiritual tenets into daily living and sobriety. Pastoral counseling faith experts incorporate faith and specific religious beliefs and convictions in the treatment and recovery process. Services may be provided individually or in a group setting. Pastoral counseling’s purpose is to provide proactive instruction or interaction between the faith expert and the individual to assist the individual with developing his or her own concept of spirituality and its role in sustaining recovery. (Hawaii ATR)

Example of the Evolution of a Recovery Support Service

Missouri ATR staff noted a lack of recovery housing in some ATR service areas in the State. They consulted with current ATR recovery housing providers to determine the reasons for the disparity. They also conducted a rate comparison to recovery housing providers in other areas of the system and analyzed current housing market conditions. As a result of this research, Missouri ATR staff will adjust the reimbursement rate for recovery housing.

Hawaii ATR staff operationalized seven categories from SAMHSA’s list of recovery support services. They plan to add more services to the 10 they currently offer. After the service menu was created, staff modified the service descriptions as needed. Lessons learned from this process help staff revise the menu, including the notion to bundle some services and unbundle others.

Bundled services: Working with someone to get him or her to navigate through the care continuum and finding a housing resource is a different kind of mentoring from mentoring on how to create a budget sheet or on deciding whether a new apartment is a safe place to go. Yet, all of these services are offered under a bundled service category called “Mentoring.”

Unbundled services: Bundling services under the category of “Spiritual Recovery Support Services” proved insufficient because of the difficulty in distinguishing between, for example, an ordained minister and a deacon, as they have different levels of expertise and credentialing. The lay minister who talks to an individual about faith-related crisis management doesn’t receive the same pay as an ordained minister who is reviewing with the client—according to a theologically sound organized doctrine—the texts of their religious belief. Pastoral counseling is therefore separate from the Mentoring category, while spiritual coaching may be considered a type of mentoring when provided by noncredentialed peers.

A Webinar on Designing Service Menus and Recovery Support Services will be available from SAMHSA in the near future. The information and resources made available in the Webinar, combined with this TA Package, should ease design and implementation processes for new ATR 3 projects and assist other grantees in enhancing their ATR services. Additional technical assistance from SAMHSA/CSAT related to this topic can be requested.

References and Additional Resources

Designing Service Menus and Recovery Support Services (Webinar) (*forthcoming*)

The State of Hawaii Department of Health Web site, <http://hawaii.gov/health/substance-abuse/ATR/providers.html>

The Missouri Department of Mental Health Web site, <http://dmh.mo.gov/ada/ATR>

Substance Abuse and Mental Health Services Administration. (2010). *Access to Recovery Implementation Toolkit (Vol. 1, Phase 1)*. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, http://www.atr.samhsa.gov/ATR3docs/ATR_Vol_1_Phase_1.pdf (accessed October 6, 2011).

Substance Abuse and Mental Health Services Administration. (2010). *Access to Recovery (Initial Announcement) Request for Applications (RFA)*. (No. TI-04-008). Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, <http://www.samhsa.gov/grants/2010/TI-10-008.aspx> (accessed October 6, 2011).

W.K. Kellogg Foundation’s *Community Partnership Toolkit*, <http://ww2.wkkf.org/Pubs/CustomPubs/CPToolkit/CPToolkit/default.htm> (accessed October 6, 2011).

Appendices

Appendix A: ATR III Recovery Support Service Descriptions and Pricing, <http://dmh.mo.gov/docs/ada/ATRIIRSservicessummaryanddescriptions8-1-2011.pdf>

Appendix B: ATR III RS Credential Status Application

Appendix C: MOU Document Requirements for ATR Ohana

Appendix D: Determining Readiness for ATR Recovery Support Service (RSS) Providers