RECOVERY-ORIENTED SYSTEMS OF CARE (ROSC) IN OHIO

Ohio OACBHA
Association of County Behavioral Health Authorities
Treatment Works. People Recover. Recovery Is Beautiful.

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Statewide Assessment Results (2018)

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STATEWIDE ASSESSMENT RESULTS (2018)

BACKGROUND AND PURPOSE

Recovery is Beautiful

Recovery Oriented Systems of Care (ROSC) is a coordinated model of delivery comprehensive supports and services that promote recovery, health, and wellness. Recovery oriented services emphasize an individual's long term quality of life, housing stability, employment, choice, and social relationships, not just a reduction of symptoms. Since 2014, the Ohio Association of Behavioral Health Authorities (OACBHA), has outlined and pursued a vision for transforming behavioral health services across the state consistent with recovery principles.

To assess progress toward implementation of ROSC principles, OACBHA developed the Recovery-Oriented Systems of Care (ROSC) Stakeholder Assessment with their member boards, which was administered statewide in Ohio during the summer of 2018.

The purpose of the ROSC assessment is: (1) to examine the degree to which state and local behavioral health systems are recovery-oriented, and (2) identify areas of strength and opportunities for development and improvement. This report describes the methods, results, and implications of the ROSC assessment

17 Essential ROSC Elements

1. Person-centered recovery
2. Family and ally involvement
3. Individualized and comprehensive services across the lifespan
4. Systems anchored in the community
5. Continuity of care
6. Partnership-consultant agreements
7. Strengths-based
8. Culturally responsive
9. Responsive to personal belief systems
10. Commitment to peer recovery services
11. Inclusion of the voices and experiences of recovering individuals and their families
12. Integrated services
13. Systems wide education and training
14. Ongoing monitoring and research
15. Outcomes driven
16. Research based
17. Adequately and flexibly financed

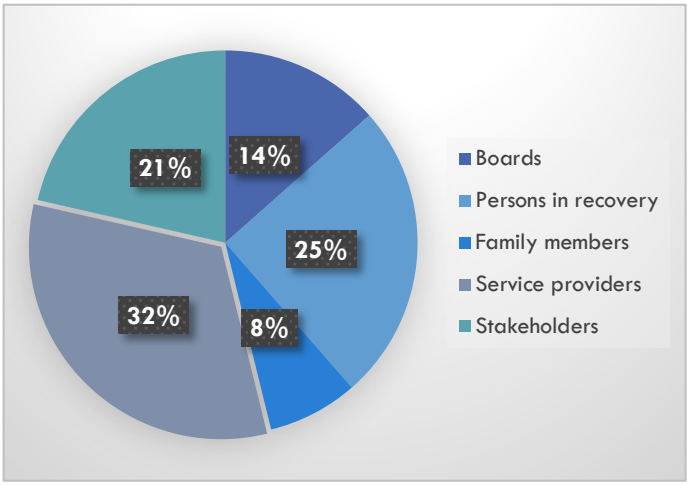
Sheedy C. K., and Whitter M., Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research? HHS Publication No. (SMA) 09-4439. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2009.

METHODS

Participants and Recruitment

Participants comprised of 3,407 individuals including Board members and staff (458, 13%), persons in recovery (852, 25%), their family members (258, 8%), behavioral health service providers (1,101, 32%), and other system stakeholders (728, 21%) (Figure 1). Each of the participating Alcohol, Drug Addiction, and Mental Health (ADAMH) Boards identified key stakeholders and forwarded them a link to an electronic survey (administered by OACBHA), or provided a paper version of the survey. These stakeholders included people in recovery and their families (those who are known to Board staff, and/or serve on local Boards), Board members and staff, front-line clinicians, and executive leadership from mental health and addiction service providers in the community, and representatives from other allied systems (e.g., child welfare, law enforcement, education). Boards used convenience sampling approaches, and drew from existing local directories of Board members, staff, and service providers to identify relevant stakeholders.

Figure 1. ROSC Assessment Participants



Once identified, participants were invited to take part in an online or paper survey (where no identifying information was collected). Paper copies of the surveys were administered directly to clients in provider offices, to facilitate robust service user participation, which is a hallmark of a recovery-oriented system. Most (55%) participants elected to complete the online survey, and 45% completed the paper surveys.

ROSC Assessment Tool

Ohio's ROSC Assessment represents a collaborative community-driven effort to develop and refine an assessment tool that reflects key values consistent with recovery-oriented principles. The tool has been shepherded by the OACBHA's ROSC Implementation Subcommittee (comprised of ADAMH Board directors) and includes 75 items organized into five domains:

1. Focusing on Clients and Families
2. Ensuring Timely Access to Care
3. Promoting Healthy, Safe, and Drug-Free Communities
4. Prioritizing Accountable and Outcome-Driven Financing
5. Locally Managed Systems of Care

Participants rated their agreement on each item along a 6 point scale, where 1=Strongly Agree and 6=Strongly Disagree. For each domain, participants' responses were averaged. (*Note, to aid interpretation, scores were reverse coded during analysis so that higher scores denote greater agreement with ROSC principles). Participants also responded to a series of demographic questions including: County of residence or work, gender, race, ethnicity, marital status, employment status, education, and current work sector (for stakeholders outside the behavioral health system).

OACBHA and the ROSC Implementation Subcommittee learned during the pilot test that not all respondents are able to respond to each item (e.g., stakeholders outside of the behavioral health service system may not be aware of whether the local Board has a person in recovery as a member). Therefore, four versions of the ROSC assessment were constructed: (1) Board members and staff (71 items), (2) People in recovery and the family members (66 items), (3) service providers (71 items), and (4) other system stakeholders (51 items). Decisions about which items to include in each version were determined by drawing on patterns of missing data from the initial pilot assessment (conducted in 2016), and vetting these decisions with the ROSC Implementation Subcommittee.

Analyses

Basic descriptive statistics were used to examine participants' demographic characteristics, and perceptions of ROSC implementation. Bivariate (t-tests, ANOVA, chi-square) and multivariate tests (regression) were used to examine whether ROSC domain scores varied across demographic groups. All analyses were conducted using Stata version 14.

RESULTS

Who Participated?

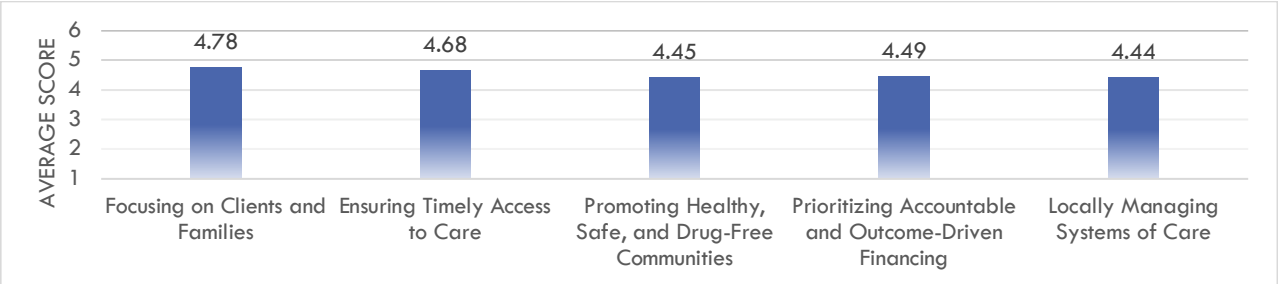
A total of 3,407 individuals participated (opened the ROSC survey link). Participants represented 86 out of the 88 counties in Ohio. On average, 40 individuals participated from each county, although this number ranged from 1 to 275, with a midpoint of 27 participants. Some counties (12) had 5 or fewer total respondents.

Statewide, the majority of respondents (who responded to demographic questions) were female (67%), Caucasian (85%), non-Latinx (87%), working in a full or part-time job (80%), and married (51%). On average, participants were 48 years old, and 56% had a college degree or higher. For Board members staff, behavioral health service providers, and other system stakeholders, most were employed by either a nonprofit organization (54%), or a public agency (34%). [See appendix 1 for detail].

How Well Have ROSC Domains Been Implemented?

Of the 3,407 individuals who attempted the ROSC assessment, 2,822 (82.8%) provided ratings on at least one of the items. On average, participants reported a high degree of ROSC implementation, where the average overall score (M=4.58) fell between somewhat agree and agree on the response scale. Respondents reported the highest scores for focusing on clients and families (domain 1); and the lowest scores for locally managed systems of care (domain 5) (Figure 2).

Figure 2. Average ROSC Domain Scores



We identified key strengths and opportunities for improvement by examining the average scores for each item, and identifying the top three highest and lowest scoring items in each of the five domains. Our findings are summarized in Table 1, and detailed further in Appendix 2.

Table 1. Summary of Strengths and Opportunities by Domain

Domain	Strengths	Opportunities
Focusing on Clients & Families	Using people-first, recovery-oriented, and non-coercive language.	Providing services that address barriers, are located in natural environments, and are trauma-informed.
Ensuring Timely Access to Care	Partnerships to coordinate medical and behavioral health screening, assessment, and treatment planning.	Drawing on peer supports, collaborating with child care centers, and ensuring timely access to the most helpful services.
Promoting Health, Safe, and Drug-Free Communities	Drawing on the best available science and local evidence to inform a continuum of prevention strategies.	Enhancing communities that promote sober lifestyles, celebrate recovery, and decrease stigma.
Prioritizing Accountable & Outcome Driven Financing	Targeting financial resources toward a full spectrum of services and evaluating contracts based on behavioral health-relevant indicators.	Monitoring missed appointments and Involving persons in recovery and their family members in evaluation.
Locally Managing Systems of Care	Engaging people in recovery to construct their own narratives, understand their rights, and in managing systems.	Engaging local businesses, managed care, and peer-run leisure partners.

Do Participants Share Similar Views About ROSC Implementation?

Board members and staff tended to score ROSC implementation the highest (avg=4.9), followed by people in recovery (avg=4.7), and behavioral health service providers (avg=4.65). Stakeholders (avg=4.27) and family members (avg=4.05) rated ROSC implementation the lowest (Figure 3).

Scores for each domain tended to vary by respondent type (see Figure 4). For example, Board members and staff consistently rated individual ROSC domains higher than others and family members consistently rated the ROSC domains lower than others. The greatest disagreement between Board members and families was related to promoting healthy, safe and drug-free communities, and prioritizing outcome-driven financing where these two groups differed by almost one point.

Figure 3. Overall ROSC Scores by Respondent

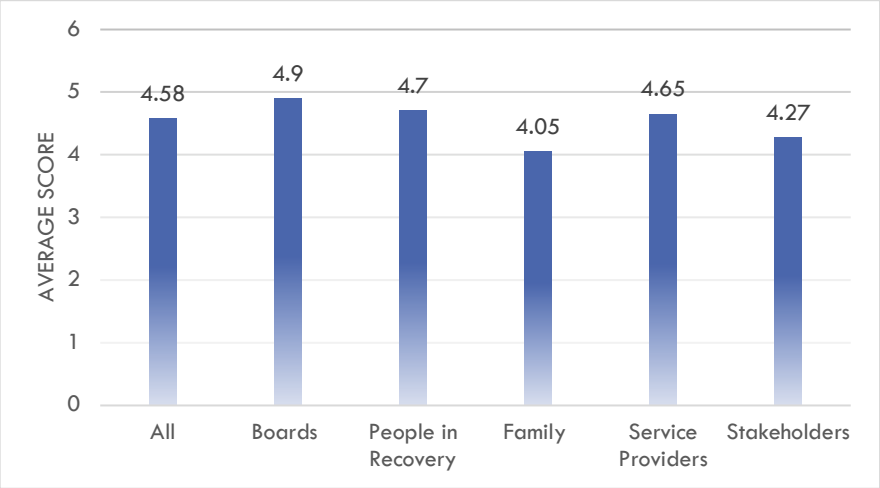
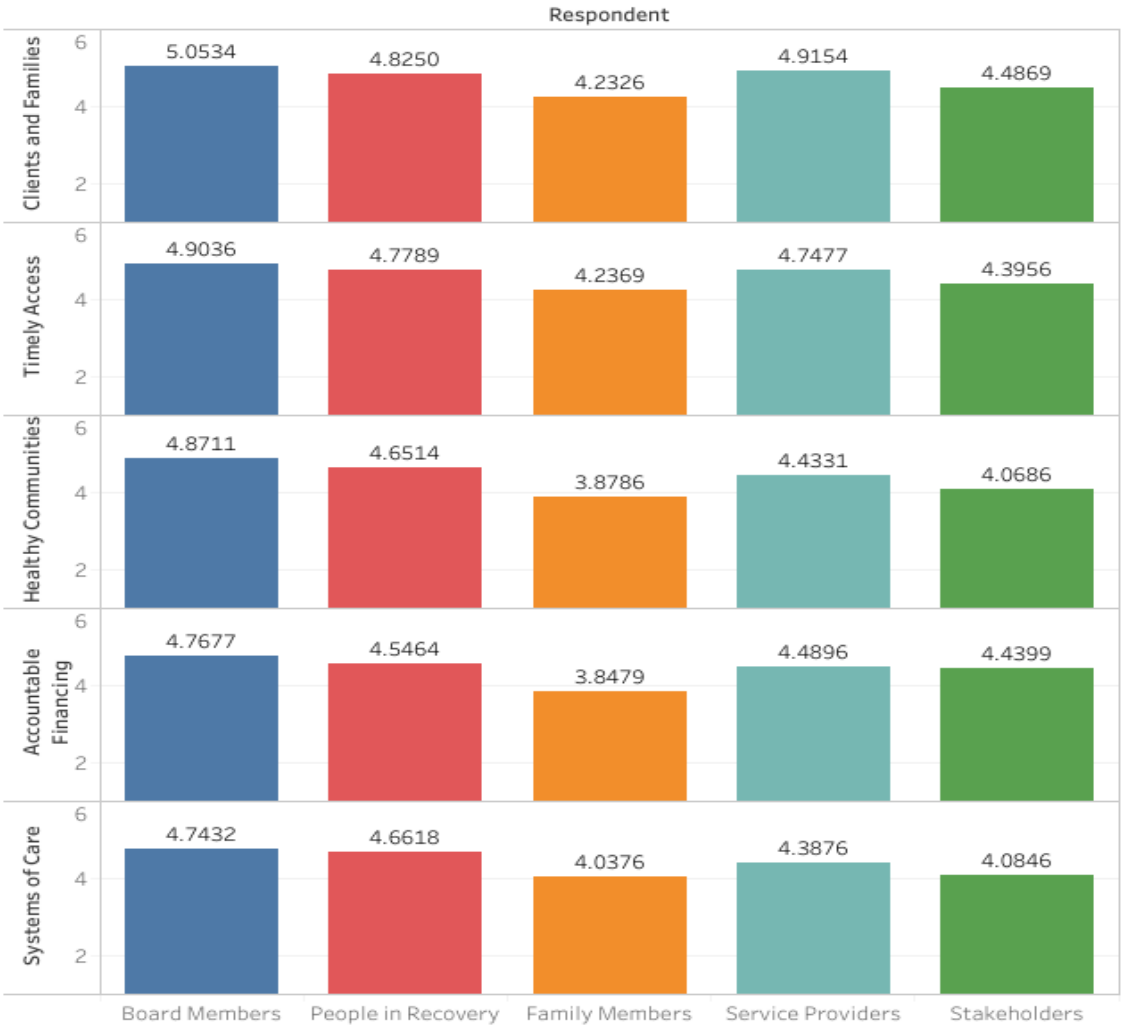


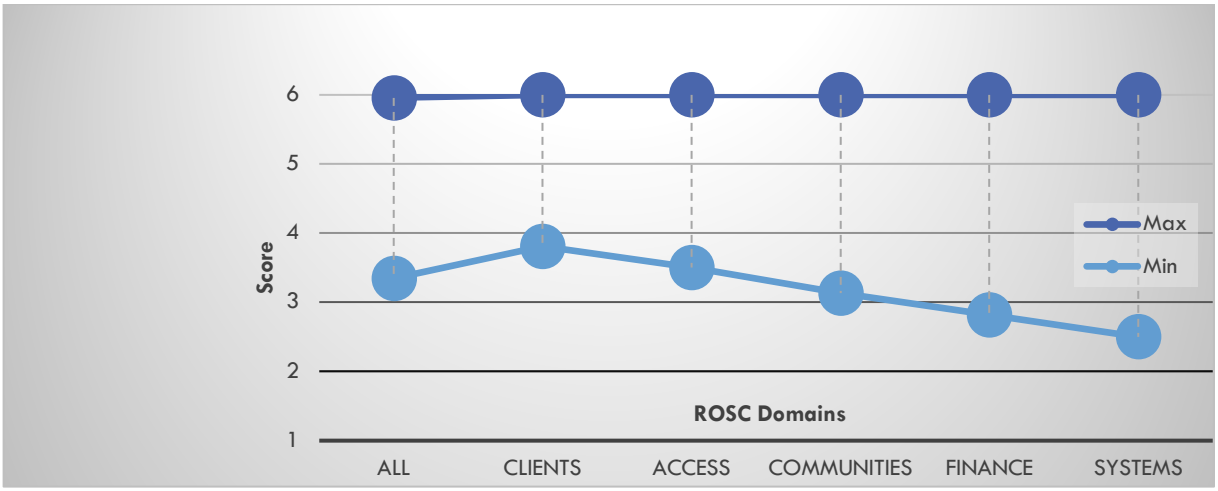
Figure 4. ROSC Scores by Domain and Respondents



How Consistent is ROSC Implementation Across Ohio Counties?

Although the overall state-wide scores suggest a high level of ROSC implementation, ROSC scores varied by county. For instance, overall ROSC scores ranged from a minimum of 3.40 in one county (representing neutral views) to a maximum 5.96 in another (representing strong agreement that ROSC principles have been implemented). The greatest county variation was reported around accountable financing, and local systems of care. In both of these domains, participants from at least one county reported that they "disagreed" or "somewhat disagreed" that ROSC principles were implemented (Figure 5). County-level data are available upon request for each Board-area.

Figure 5. Minimum and Maximum County Average ROSC Scores



Other Results

We also examined whether ROSC scores varied by other key demographics using regression analysis. Controlling for the type of respondent (e.g., Board member, service provider), participants tended to rate ROSC higher when they were younger (b=.004, SE=.00, p=.009), male (b=.13, SD=.04, p=.001), or not employed (b=.22, SD=.06, p=.00). Scores did not appear to vary based on race or ethnicity.

KEY POINTS AND IMPLICATIONS

Strong statewide response to ROSC implementation. Participants generally agreed that local behavioral health systems across the state are organized in a way that is consistent with ROSC principals. Key strengths include respect for people in recovery, integration of behavioral health and medical services, a full spectrum of prevention supports, targeted contracting, and engaging people in recovery.

There are opportunities to improve. Although participants perceived ROSC implementation to be strong, the scores suggest there is still room to improve ROSC implementation in the future. To improve implementation of ROSC principles, local boards might consider exploring strategies for tailoring services to individual needs and barriers to promote timely access, promoting sober lifestyles and decreasing stigma, engaging persons in recovery in the evaluation of contracts, and engaging a wider array of community stakeholders (e.g., local businesses, managed care, and peer-run leisure activities).

Outreach to family members of persons in recovery and external stakeholders. Family members of persons in recovery and external stakeholders tended to rate their systems lower than board members and staff, people in recovery, and behavioral health service providers. This suggests that local systems might use this as an opportunity to further communicate with family members. Boards may also have an opportunity to expand their role as community hubs by reaching out and engaging external system stakeholders in regional planning and improvement initiatives.

Counties vary in their implementation of ROSC. ROSC implementation varies by county, where the greatest variation occurs around accountable and outcomes-driven financing, and local systems of care. Strategies that address these two domains may help promote more even implementation of ROSC principles in every region. (County-level data are available upon request).

NEXT STEPS FOR THE ROSC ASSESSMENT TOOL

Strengths and Limitations of the Methods

The results described in this report should be considered in light of several strengths and limitations. *The first consideration is the sample*. The first statewide administration of the ROSC assessment tool provided key information about the status of ROSC implementation in Ohio based on nearly 3000 voices from across the state. Reflecting a commitment to understand lived experiences, a third of 2018 ROSC participants are people in recovery or their family members. While the large sample of participants is a strength of this assessment, it is unclear how well the results reflect the views of all behavioral health system stakeholders evenly across the state. Since participants were recruited through boards and providers (and thus are connected to the behavioral health system), the ROSC results may not thoroughly reflect the views of the general population, those who are not well connected with their local systems, or those in board areas with lower rates of participation. *The ROSC assessment tool is a second consideration*. OACBHA's ROSC assessment tool was developed to reflect core ROSC principles. While the items in the tool are comprehensive, they may not fully capture all ROSC oriented practices, and some participants may have had difficulty understanding or responding to all of the items potentially contributing to missing data.

Next Steps

There are several next steps for continuing to improve the ROSC assessment process in Ohio.

1. **Refining the assessment tool**. Developing useful and sound community assessment tools is a long and iterative process. The tool can be further refined by clarifying language used in the items, and reducing the number of items to enhance completion rates.

2. **Follow up**. Future ROSC assessments will be useful for evaluating the impact of strategic efforts to implement ROSC principles and ongoing monitoring across the state.

3. **Strategic outreach to improve participation and representation**. The 2018 ROSC assessment engaged over 3,000 individuals across the state. However, some counties and demographic groups were not well represented suggesting the need for improved regional outreach and recruitment efforts.

APPENDIX A. PARTICIPANT DEMOGRAPHICS

	All (n=2,427)	Boards (n=331)	People in Recovery (n=740)	Family Members (n=161)	Service Providers (n=724)	Stakeholders (n=471)
	%	%	%	%	%	%
Gender						
Male	30.82	14.57	30.36	3.61	21.93	17.51
Female	66.71	13.34	24.89	8.21	32.92	20.63
Other	0.16	X	75	X	25	X
Prefer not to say	2.31	10.71	30.36	1.79	46.46	10.71
Race						
American Indian/Alaska Native	1.12	7.41	55.56	7.41	14.81	14.81
Asian	0.21	20	40	X	20	20
Black/African American	6.15	8.72	38.93	4.7	36.91	10.74
Native Hawaiian/Pacific Islander	0.12	X	33.33	33.33	X	33.33
White	85.46	14.35	29.05	6.86	29	20.73
Other	2.85	4.35	57.97	5.8	26.09	5.8
Prefer not to say	4.09	15.15	21.21	4.04	41.41	18.18
Ethnicity						
Latino or Hispanic	2.26	7.69	38.46	11.54	42.31	X
Not Latino or Hispanic	87.16	15.23	24.83	6.44	31.67	21.83
Prefer not to say	10.58	7.82	48.56	4.53	25.93	13.17
Work						
Law Enforcement	2.51	21.05	X	X	5.26	73.68
Employer or Business Sector	3.7	55.36	X	X	25	19.64
Criminal or Juvenile Justice	5.35	12.35	X	X	23.46	64.2
Child Welfare	5.68	11.63	X	X	22.09	66.28
Education	9.25	31.43	X	X	18.57	50
Developmental Disability	2.58	10.26	X	X	17.95	71.79
Housing Services	4.16	11.11	X	X	69.84	19.05
Domestic Violence	1.39	X	X	X	71.43	28.57
Health or Medical Care	29.02	18.68	X	X	60.59	20.73
Peer Support	4.03	14.75	X	X	78.69	6.56
Other	32.32	24.34	X	X	53.37	22.29
Marital Status						
Single	28.93	6.19	57.84	4.6	22.01	9.35
Married	51.12	17.51	12.46	7.65	34.61	27.77
Divorced	9.16	5.91	59.55	9.55	7.27	17.73
Widowed	7.29	24	13.14	5.71	50.86	6.29
No Answer	3.5	17.86	25	4.76	38.1	14.29

	All (n=2,427)	Boards (n=331)	People in Recovery (n=740)	Family Members (n=161)	Service Providers (n=724)	Stakeholders (n=471)
	%	%	%	%	%	%
Employment Status						
Full-time	66.1	14.84	12.96	5.32	40.08	26.8
Part-time	10.51	12.99	46.06	7.87	24.41	8.66
Not Currently Employed	19.08	11.5	75.05	9.98	0.87	2.6
Prefer not to say	4.3	9.62	52.88	9.62	18.27	9.62
Education Level						
None	0.46	X	90.91	9.09	X	X
Elementary School	0.08	X	100	X	X	X
Middle School	0.58	X	71.43	28.57	X	X
High School	13.01	2.55	77.39	9.24	7.96	2.87
GED	2.98	1.39	83.33	5.56	9.72	X
Some College	24.04	9.66	47.41	8.97	23.79	10.17
Bachelor Degree	22.88	16.12	13.41	8.51	33.51	28.44
Master Degree	29.76	20.06	4.6	2.65	44.85	27.86
Doctorate	3.52	27.06	5.88	1.18	21.18	44.71
Prefer not to say	2.69	13.85	30.77	6.15	36.92	12.31
Organization Type						
Other	2.57	33.33	X	X	33.33	33.33
Non-profit	54.49	10.9	X	X	72.76	16.34
Peer-run Organization	0.92	7.14	X	X	71.43	21.43
Faith-based Organization	2.18	30.3	X	X	21.21	48.48
For-profit	5.47	25.3	X	X	39.76	34.94
Public or Government Organization	34.37	36.47	X	X	11.32	52.21

APPENDIX B. HIGHEST AND LOWEST SCORING ITEMS IN EACH DOMAIN

Domain	Highest Scoring Items	Lowest Scoring Items
Focusing on Clients and Families	• Service providers do not use threats or bribes or other forms of coercion (m=5.4) • Boards and service providers use people-first language (m=5.4) • Staff use recovery language (m=5.1)	• Most services are provided in a person's natural environment (m=4.3) • Barriers are addressed for each participant (m=4.5) • Service providers are trained in trauma-informed care (m=4.7)
Ensuring Timely Access to Care	• Partnerships exist around implementation of evidenced-based medical and behavioral health screenings. (m=4.9) • Partnerships exist with on-site or coordinated medical and behavioral assessments with referral as needed (m=4.8) • Behavioral health and primary care are integrated with each treatment plan and the goals of treatment (m=4.8)	• Collaborations exist with child care centers to promote early intervention (m=4.2) • Individuals have timely access to the services and supports that are most helpful for them. (m=4.3) • Peer supports are used to improve access to care and the continuation in ongoing care. (m=4.3)
Promoting Health, Safe, and Drug-Free Communities	• Prevention strategies are reflective of best prevention science (e.g., SAMHSA, SPF SIG), state prevention plans or guidance and local priorities and needs. (m=5.2) • Prevention strategies reflect specifically designed steps to address primary (indicated), secondary (selective) and tertiary (universal) populations in the community. (m=5.0) • Prevention strategies are, in turn, informed by actual needs of community and sound ways that strengthen individual, family and community resilience and health. (m=5.0)	• Cities and townships are receptive to sober lifestyle communities (e.g., housing, self-help groups, consumer advocacy groups, recovery centers, peer support, etc.). (m=4.1) • The community formally acknowledges and celebrates the achievement of people in recovery. (m=4.2) • Strategies to identify and decrease stigma are consistently implemented in communities. (m=4.2)
Prioritizing Accountable & Outcome Driven Financing	• Contracts are outcome-based and evaluated by access, cost, efficiency and attainment of established goals based on severity of population served. (m=4.7) • Resources are developed to enhance and promote prevention, intervention, treatment and recovery support services. (m=4.7) • Behavioral health is included as a health indicator for the community at large. (m=4.7)	• Clients receiving services are actively involved in the evaluation of programs and services offered and received. (m=4.4) • Appointment "no show" rates are monitored regularly and followed up on within 24 hours after the missed appointment (m=4.4) • Family members and citizens in general are engaged in the evaluation of care. (m=4.3)
Locally Managing Systems of Care	• Opportunities exist for people to share their stories and re-write their own narrative through recovery. (m=4.9) • Clients understand their rights to be referred if their individual needs cannot be met. (m=4.7) • People in recovery are members of any managing system (e.g., managed care) or agency and community board. (m=4.7)	• Partnerships exist with local businesses for individuals in recovery to reduce stigma and gain employment. (m=4.2) • Managed Care can assist in care management over the full continuum of care for each individual so as to preclude partial treatment or treatment drop-out. (m=4.4) • Peer-run leisure activities are available and supported throughout the community. (m=4.3)
m = Mean (or average) score		