TRAUMA-INFORMED, RECOVERY-ORIENTED SYSTEM OF CARE TOOLKIT

PREPARED BY THE NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
FOR THE INDIANA FAMILY AND SOCIAL SERVICE ADMINISTRATION

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ABOUT THE TOOLKIT

The opioid crisis has affected families across the nation, including the families of more than 700 Hoosiers who died as a result of an opioid overdose in 2016. But many of these deaths were avoidable. There are effective tools, methods and approaches to prevent and treat opioid and other substance use disorders and the related damage. Long-term recovery from opioids and other substances is possible – approximately 25 million adults in the U.S. are in remission from a substance use disorder.[1] Evidence strongly supports that substance use disorders and underlying trauma are closely linked and that trauma has long-lasting detrimental effects on individuals and significantly increases the risk for substance use disorders and other chronic diseases.[2] Trauma should be identified and addressed in all health care settings, but it is especially important for people with substance use disorders.

Recovery-oriented systems of care provide comprehensive services to individuals with substance use disorders and support person-centered and person-directed long-term recovery. Integrating trauma-informed approaches into recovery-oriented systems of care is a natural coupling of two complementary and critical care modalities.

In response to Indiana's opioid crisis, the Indiana Family and Social Service Administration launched the Trauma-informed, Recovery-oriented Systems of Care (TI-ROSC) pilot project in January 2018, led by the National Council for Behavioral Health (National Council). The goal of this initiative was to develop and test a process for Indiana counties to implement TI-ROSC. This toolkit is a result of a nine-month information gathering and strategic planning process conducted by National Council subject matter experts with two communities chosen by the Indiana Family and Social Services Administration. The information and tools presented in this toolkit were recommended by providers and community partners and identified as the critical components necessary to implement TI-ROSC in Indiana counties.

USING THE TOOLKIT

The Toolkit provides information, resources and tools to guide implementation of TI-ROSC to best serve individuals with opioid use disorder and other substance use disorders. It is organized into two sections. Part I provides foundational concepts, data on the current state of opioid use in Indiana, information and examples to better understand effective responses to opioid use and other substance use disorders, trauma-informed approaches, recovery-oriented systems of care and the need for a comprehensive and coordinated care delivery system. Part II identifies and describes eight recommended change components to move systems toward trauma-informed and recovery-oriented approaches. Specific tools have been created or adapted to facilitate the implementation of the change components and are described in Part II. It is recommended that the change components be implemented in the order they

[1] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2016, November). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Retrieved from https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf

[2] Lawson, K. M., Back, S. E., Hartwell, K. J., Moran-Santa Maria, M., & Brady, K. T. (2013). A comparison of trauma profiles among individuals with prescription opioid, nicotine, or cocaine dependence. *The American journal on addictions*, *22*(2), 127-31.

are presented beginning with increasing urgency and buy-in through education. A County Change Team, described in Part II, should be developed early in the process to lead the TI-ROSC planning, implementation and sustainability efforts.

PART I: CONCEPTUAL FRAMEWORK

GLOSSARY OF TERMS

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential.

Recovery-oriented system of care (ROSC): A coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families and communities to achieve abstinence and improved health, wellness and quality of life for those with or at risk of alcohol and drug problems.[3]

Recovery support services: Supportive services typically delivered by trained case managers, recovery coaches and/or peers who help engage and support individuals in treatment and provide ongoing support after treatment. Specific supports include help navigating systems of care, removing barriers to recovery, staying engaged in the recovery process and providing a social context for individuals to engage in community living without substance use.[4]

Trauma: An event, series of events or set of circumstances experienced by an individual that are physically or emotionally harmful or life-threatening that have lasting adverse effects on their functioning and mental, physical, social, emotional or spiritual well-being.

Trauma-informed approach: A program, organization or system that recognizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures and practices and seeks to actively resist re-traumatization.[5]

Trauma-informed, recovery-oriented system of care (TI-ROSC): A coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families and communities to achieve abstinence and improved health, wellness and quality of life for those with or at risk of alcohol and drug problems. This system of care also recognizes the widespread impact of trauma, understands trauma's connection to addiction and understands potential

[3] Substance Abuse and Mental Health Services Administration. (n.d.) ROSC Resource Guide. Retrieved from https://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf

[4] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2016, November). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Retrieved from https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf

[5] Substance Abuse and Mental Health Services Administration. (2018, October). Trauma and Violence. Retrieved from https://www.samhsa.gov/trauma-violence

paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures and practices and seeks to actively resist re-traumatization.

THE OPIOID EPIDEMIC

NATIONAL IMPACT OF THE OPIOID EPIDEMIC

The U.S. is currently facing an unprecedented opioid epidemic that claims approximately 116 deaths every day.[6] More than 49,000 individuals in the U.S. died from an opioid overdose in 2017, accounting for 68 percent of all drug overdose deaths.[7] In 2017, 11.4 million individuals aged 12 and older misused opioids and 2.1 million had an opioid use disorder.[8] Of the 20.7 million individuals who were in need of substance use disorder treatment in 2017, only 2.5 million (12.2 percent) received specialty treatment.[9] The opioid epidemic's impact on families and communities is immense, with total economic costs in 2015 estimated at $504 billion.[10]

People of all genders, races, ethnicities, income levels, educational levels, geography and disability status have been touched by the opioid epidemic; however, certain groups are impacted at higher rates and more severely than others. Rates of drug overdoses have risen more quickly in rural areas than in urban areas. In 2015, the number of drug overdoses in rural areas surpassed those in urban areas (17.0 per 100,000 compared to 16.2 per 100,000).[11] Additionally, opioid use and its related harm are growing at faster rates for women than for men.[12] Between 1999 and 2010, opioid-related deaths increased by 400 percent among women, compared to 237 percent among men.[13] Between 2000 and 2009, the number of mothers using or dependent on opiates increased by approximately 500 percent and the

[6] U.S. Department of Health and Human Services (HHS). (2018). National Opioids Crisis. Retrieved from https://www.hhs.gov/opioids/

[7] Ahmad, F. B., Rossen, L. M., Spencer, M. R., Warner, M., Sutton P. (2018, September 12). Provisional drug overdose death counts. National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[8] Substance Abuse and Mental Health Services Administration (SAMHSA). (2018). Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 National Survey on Drug Use and Health (HHS Publication No. SMA 18-5068, NSDUH Series H-53).

[9] Ibid.

[10] The Council of Economic Advisers. Office of the White House. (2017, November). The Underestimated Cost of Opioid Crisis. Retrieved from https://www.whitehouse.gov/sites/whitehouse.gov/files/images/The%20Underestimated%20Cost%20of%20the%20Opioid%20Crisis.pdf

[11] Mack, K. A., Jones, C. M., & Ballesteros, M. F. (2017, October 20). Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. *Morbidity and Mortality Weekly Report, 66*(19), 1-12.

[12] HHS Office of Women's Health. (2017, July 19). Final Report: Opioid Use, Misuse, and Overdose in Women. Retrieved from https://www.womenshealth.gov/files/documents/final-report-opioid-508.pdf

[13] HHS Office of Women's Health. (2017, July 19). Final Report: Opioid Use, Misuse, and Overdose in Women. Retrieved from https://www.womenshealth.gov/files/documents/final-report-opioid-508.pdf

number of infants born with neonatal abstinence syndrome rose by 500 percent between 2000 and 2012.[14]

Several related factors have contributed to the opioid epidemic, including an increase in prescription opioid overdose deaths since 1999, a 400 percent increase in heroin overdoses since 2010 and a 300 percent increase in deaths related to synthetic opioids, such as fentanyl, since 2013. Alarmingly, the opioid epidemic's severity has contributed to a decrease in average life expectancy in the U.S. the last two years.[15]

IMPACT OF THE OPIOID EPIDEMIC IN INDIANA

Like every state in the U.S., Indiana has felt the impact of the opioid epidemic. Opioid overdoses accounted for 785 deaths in 2016, an increase of 170 percent since 2014[16] and the total deaths by overdose from any drug increased steadily from 1,152 in 2014 to 1,518 in 2016.[17] In 2016, 488 overdose deaths were related to opioid pain relievers and 296 deaths were related to heroin.[18] Hoosiers across races, ethnicities, ages and genders are impacted by the opioid epidemic. Individuals aged 25 to 54 had the highest number of opioid overdose deaths.[19] In 2016, a greater number of men died of opioid overdose than women (518 compared to 267).[20] More than 10 times as many white people died of opioid overdose compared to black people and 768 non-Hispanics died of opioid overdose compared to 15 Hispanics in 2016.[21]

In 2015, Indiana State Department of Health officials confirmed an outbreak of HIV infection linked to injection of oxymorphone in Scott County prompting the declaration of a public health emergency with 215 HIV infections ultimately attributed to the breakout.[22] A comprehensive public health response to the outbreak was launched by the Centers for Disease Control and Prevention (CDC), the Indiana State Department of Health, law enforcement, health care providers and community members which included HIV and hepatitis C care and treatment, substance use counseling and a public education campaign. In

[14] National Institute on Drug Abuse. (2015, September). Dramatic Increases in Maternal Opioid Use and Neonatal Abstinence Syndrome. Retrieved from https://www.drugabuse.gov/related-topics/trends-statistics/infographics/dramatic-increases-in-maternal-opioid-use-neonatal-abstinence-syndrome

[15] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2018, September). Facing Addiction in America: The Surgeon General's Spotlight on Opioids.

[16] Ibid.

[17] Indiana State Department of Health, Epidemiology Resource Center. (2018). Vital Records Report. Table 2. Drug Overdose Deaths by Selected Opioid Drug Categories by Sex, Age, and Race/Ethnicity by Death Year. Retrieved from https://www.in.gov/isdh/27393.htm

[18] Ibid.

[19] Ibid.

[20] Ibid.

[21] Ibid.

[22] Rapaport, L. (2018, October 5). Indiana HIV outbreak among drug users may have been preventable. Reuters Health. Retrieved from https://www.reuters.com/article/us-health-hiv-indiana/indiana-hiv-outbreak-among-drug-users-may-have-been-avoidable-idUSKCN1ME2N7

addition, a short-term authorization was granted by the governor to establish a syringe exchange as a harm reduction measure.[23]

Opioid-related incidents have also resulted in increased non-fatal emergency department visits and hospitalizations in Indiana. In 2016, statewide, there were 7,940 hospitalizations related to substance use with 2,426 resulting from opioid use. Among opioid-related hospitalizations, 648 were related to heroin use and 1,813 were non-heroin opioid-related.[24] During the same time period, there 19,939 drug-related emergency department visits.[25] Among the 6,934 opioid-related emergency department visits, 4,690 were heroin-related and 2,357 were non-heroin-related.[26] Rates of opioid-related hospitalizations and emergency department visits were unevenly distributed across counties, ranging from 1,814 emergency department visits in Marion County to zero in Posey County.

INDIANA'S RESPONSE TO THE OPIOID EPIDEMIC

To address the impact of the opioid epidemic in Indiana, the state developed the Indiana Integrated Response to the Opioid Epidemic. The state leveraged 21st Century Cures Act funds to focus on six strategic goals listed in Table 1. Across the state, efforts are being made to address the opioid epidemic through research, prevention, treatment and recovery initiatives. Efforts include the Indiana Medication Assisted Treatment Program (IMAP), aimed at decreasing barriers between medication-assisted therapy providers and individuals with opioid use disorder in Porter, Starke and Scott counties; Prevention for States (PFS), a CDC-funded evaluation of opioid-related policies in Indiana; Planned Outreach, Intervention, Naloxone, and Treatment (POINT), an emergency department-based intervention that connects opioid overdose survivors to medication-assisted treatment (MAT); and Project ECHO, utilizing technology to reduce disparities in care through case-based learning.[27]

[23] Conrad, C., Bradley, H. M., Broz, D., Buddha, S., Chapman, E. L., Galang, R. R., . . . Duwve, J. M. (2015, May 1). Community Outbreak of HIV Infection Linked to Injection Drug Use of Oxymorphone — Indiana, 2015. *Morbidity and Mortality Weekly Report, 64*(16), 443-444.

[24] Indiana State Department of Health, Division of Trauma and Injury Prevention, Data Analysis Team & Indiana Hospital Association. (2018). Vital Records Report. Table 3. Non-fatal Hospitalizations by County of Residence and Drug Category, Indiana Residents, 2016. Retrieved from https://www.in.gov/isdh/27393.htm

[25] Indiana State Department of Health, Epidemiology Resource Center. (2018). Vital Records Report. Table 4. Non-fatal Emergency Department Visits by County of Residence and Drug Category, Indiana Residents, 2016. Retrieved from https://www.in.gov/isdh/27393.htm

[26] Ibid.

[27] Indiana University Richard M. Fairbanks School of Public Health. (n.d.) Opioid Use & Health in Indiana. Retrieved from https://fsph.iupui.edu/doc/news-events/OpioidFactSheet-RV2.pdf

TABLE 1. SIX GOALS OF INDIANA'S INTEGRATED RESPONSE TO THE OPIOID EPIDEMIC[28]

Strategic Goals	
1	Expansion of residential/inpatient detoxification and treatment including increased capacity, training in medication-assisted therapy and evidence-based practices and provision of service linkages.
2	Deployment of mobile crisis teams focused on overdose reversal, referral to treatment, crisis management and short-term therapeutic solutions.
3	Development and Implementation of I-ECHO, a statewide training protocol for all health care professionals that will focus on opioid use disorder case management and specialized learning.
4	Development of a recovery coach initiative that will engage peers and professionals with individuals who are in emergency rooms for opioid overdose to ensure systematic engagement with all aspects of the spectrum of care.
5	Expansion of provider access to integrated prescription drug monitoring and electronic health records with a particular focus on mitigating costs for lower-income healthcare organizations.
6	Undertake statewide social marketing and health communications campaigns that intelligently are targeted to vulnerable population segments using culturally-competent language and strategies.

CONTINUUM OF CARE FOR OPIOID USE DISORDER

Effective services are available to prevent and treat opioid use disorder and support individuals in long-term recovery. Recent studies have shown that more than 50 percent of adults and 35 percent of adolescents who received treatment achieve sustained remission lasting at least one year.[29] A continuum of services are critical to addressing the complexity of factors causing opioid use disorder and its related impact. Table 2 shows the continuum of care that systems should offer to individuals with opioid use and other substance use disorders as recommended by the U.S. Surgeon General and the Substance Abuse and Mental Health Service Administration (SAMHSA).

[28] Indiana State Department of Health. (2017). Indiana's Integrated Response to the Opioid Epidemic, Abstract. Retrieved from https://www.in.gov/recovery/files/2017%20Indiana%20Integrated%20Response%20Opioid%20PNF.PDF
[29] Ibid.

TABLE 2. SUBSTANCE USE DISORDER TREATMENT CONTINUUM OF CARE[30]

Enhancing Health	Primary Prevention	Early Intervention	Treatment	Recovery support
Promoting optimum physical and mental health and wellbeing, free from substance use disorder, through health communications and access to health care services, income and economic security and workplace certainty.	Addressing individual and environmental risk factors for substance use through evidence-based programs, policies and strategies.	Screening and detecting substance use problems at an early stage and providing brief intervention, as needed, and other harm reduction activities.	Intervening through medication, counseling and other supportive services to eliminate symptoms and achieve and maintain sobriety, physical, spiritual and mental health and maximum functional ability. Levels of care include: • Outpatient services. • Intensive outpatient/ partial hospitalization services. • Residential/ inpatient services. • Medically-managed intensive inpatient services.	Removing barriers and providing supports to aid the long-term recovery process. Includes a range of social, educational, legal and other services that facilitate recovery, wellness and improved quality of life.

ENHANCING HEALTH

Health is largely determined by the social, economic and environmental conditions in which individuals live and work, often called the social determinants of health. Improving neighborhood conditions and economic opportunities and providing access to health care services enhances communities' overall health and wellness and helps prevent substance use disorder. Additionally, providing health education and improving health literacy helps individuals understand the factors that contribute to their health and the ways they can improve their overall well-being.

PRIMARY PREVENTION

There are a range of prevention activities that counties and organizations can conduct to promote primary prevention of substance use disorders. Individual and environmental strategies can be used to support healthy behavior and have been found by research to be effective.[31] Individual-level interventions could include interactional peer-led classes on healthy behaviors that focus on life and social skills, emphasize norms for and a social commitment to not using drugs and underscore the benefit of life skills. Environmental interventions are aimed at changing the conditions in which individuals live that lead to substance use. Public education, social marketing and media advocacy are

[30] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2016, November). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.
[31] Substance Abuse and Mental Health Services Administration. (2016, July). Prevention approaches. Retrieved from https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-approaches

examples of environmental interventions that increase awareness and knowledge of and address misconceptions and stigma related to substance use.[32]

Indiana has developed a campaign focused on increasing education and resources related to addressing the opioid epidemic, Know the O Facts, which provides information and resources specific to addressing stigma including using person-first language. Person-first language ensures that individuals are seen as people and not their substance use disorders or other chronic illnesses (see Table 3).

TABLE 3. EXAMPLES OF PERSON-FIRST LANGUAGE

Use This	Not This
Person with opioid use disorder	Addict
Disease	Drug habit
Person living in recovery	Ex-addict
People with mental health conditions	The mentally ill
Had a setback; returned to use	Relapse
Positive drug screen	Dirty drug screen

EARLY INTERVENTION

Early intervention strategies identify problematic substance use or mild substance use disorders to reduce risk behavior and prevent progression of substance use disorder. Early intervention strategies can be provided in a range of settings including primary care, mental health and school-based clinics. Early intervention strategies generally identify problematic substance use, provide education on risks and normal use and refer individuals to other services and treatment. Harm reduction strategies are also used to reduce risks but are often used with individuals who are actively using substances and may not be ready to stop substance use.

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT

Screening, Brief Intervention and Referral to Treatment, commonly known as "SBIRT" is an evidence-based early intervention used to identify and assist individuals with or at-risk for substance use-related issues. Table 4 describes the three steps in SBIRT processes. The National Council for Behavioral Health offers a wealth of resources related to SBIRT implementation and financing across a wide-range of settings including the Implementing Care for Alcohol and Other Drug Use in Medical Settings change guide for primary care. This guide identifies appropriate evidence-based screening tools and methods to successfully implement SBIRT.

[32] Ibid.

TABLE 4. MAJOR COMPONENTS OF SBIRT[33]

Component	Description
Screening	A health care professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any health care setting.
Brief Intervention	A health care professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.
Referral to Treatment	A health care professional provides a referral to brief therapy or additional treatment to individuals whose screen indicates a need of additional services.

HARM REDUCTION

Harm reduction includes a range of strategies that reduce risk of death and harm due to substance use. These programs are public health-oriented, evidence-based and have been shown to be cost-effective.[34] The principles of harm reduction include establishing quality of individual and community life and well-being; understanding substance use as a complex, multi-faceted phenomenon; using nonjudgmental, noncoercive methods to provide services; and ensuring individuals who use substances have a voice in the policies and programs that are designed to impact them.[35] Harm reduction efforts include the use of naloxone (Narcan) to prevent overdose deaths and syringe access and exchange, among others, and are an important component of a recovery-oriented system of care.

TREATMENT

The general goal of treatment is to assist individuals with substance use disorders to initiate the recovery process and provide them with the knowledge, skills and abilities to continue that process going forward to live healthy productive lives. Treatment can occur in a variety of inpatient and outpatient care settings, including specialty substance use disorder programs, primary care offices, hospitals and residential programs and includes a range of services including withdrawal management, MAT, recovery supports and behavioral therapies, among others.

Engaging individuals into treatment generally begins with an assessment and diagnosis by a trained professional to understand the severity of the individual's disorder. A treatment plan is then developed based on the assessment and diagnosis and can include a range of services and supports specific to the clients individualized needs. This process often involves consultation with a peer specialist or peer coach to identify the most appropriate treatment modalities for each person. In addition to recommendations for formal treatment services within the program, treatment plans will include referrals to other services within the community. Before a client is discharged from care, they are connected with additional recovery supports and resources in the community to continue the healing process.

[33] Substance Abuse and Mental Health Services Administration. (2017). SBIRT: Screening, Brief Intervention, and Referral to Treatment. Retrieved from https://www.samhsa.gov/sbirt

[34] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2016, November). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.

[35] Harm Reduction Coalition. (2018). Harm Reduction Principles. Retrieved from https://harmreduction.org/about-us/principles-of-harm-reduction/

MEDICATION-ASSISTED TREATMENT

While there are number of evidence-based treatments for substance use disorders generally, evidence suggests that the use of Food and Drug Administration (FDA)-approved medications for opioid use disorders such as methadone, buprenorphine and naltrexone (see Table 5) to assist behavioral therapy is highly effective.[36] Specifically, these medications in conjunction with behavior therapy and supports reduce the risk of infectious disease transmission as well as criminal behavior associated with drug use, increase the likelihood that a person will remain in treatment, which is associated with lower risk of overdose mortality, reduced risk of HIV and HCV transmission and greater likelihood of employment. Of the three FDA-approved medications for opioid use disorder treatment available, methadone and buprenorphine are governed by specific prescribing regulations determining the permitted setting it can be administered and the required credentialing and licensure providers must have to prescribe. Despite the efficacy of these medications, they are still underutilized.[37] Only 20 percent of adults with opioid use disorder receive the treatment they need each year. More than 95 percent of states and the District of Columbia have opioid use disorder or dependence rates that exceed treatment capacity.[38] Table 5 identifies the FDA-approved medications for opioid use disorder, frequency of administration, route and prescribing/dispensing information.

TABLE 5. MEDICATIONS/PHARMACOTHERAPY FOR OPIOID USE DISORDER[39]

Medication	How it Works	Frequency of Administration	Route of Administration	Who May Prescribe or Dispense in Indiana
Methadone	Full agonist: binds to and activates opioid receptors in the brain that were activated by the drug, but in a safer and more controlled manner. Reduces the symptoms of withdrawal and cravings.	Daily	Orally as liquid concentrate, tablet or oral solution of diskette or powder.	SAMHSA-certified and Drug Enforcement Administration (DEA)-regulated outpatient treatment programs (OTPs) dispense methadone for daily administration either on site or at home.
Buprenorphine	Partial opioid agonist: binds to and activates opioid receptors but with less intensity than full agonists.	Daily tablet or film (also alternative dosing regimens)	Oral tablet or film is dissolved under the tongue.	Physicians, physician assistants and nurse practitioners who have been trained to obtain DATA 2000 waivers can

[36] The American Society of Addiction Medicine. *Advancing Access to Addiction Medications*. http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final

[37] Larochelle MR, Bernson D, Land T, Stopka TJ, Wang N, Xuan Z, et al. Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality: A Cohort Study. Ann Intern Med. ;169:137–145. doi: 10.7326/M17-3107.

[38] Jones, C. M., Campopiano, M., Baldwin, G., & McCance-Katz, E. (2015). National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment. *American Journal of Public Health, 105*(8), e55-e63.

[39] Substance Abuse and Mental Health Services Administration (SAMHSA)-Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions. (2018). Adapted from Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide (SMA14-4892R) from Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide (SMA14-4892R).

Probuphine (buprenorphine implant)	Partial opioid agonist: binds to and activates opioid receptors but with less intensity than full agonists.	Every six months	Subdermal	prescribe to a capped number of patients.
Sublocade (buprenorphine injection)	Partial opioid agonist: binds to and activates opioid receptors but with less intensity than full agonists.	Monthly	Injection (for moderate to severe opioid use disorder)	
Naltrexone (injection)	Antagonist: chemical substance that binds to and blocks the activation of certain receptors on cells, preventing a biological response.	Monthly	Intramuscular injection into the gluteal muscle by a physician or other health care professional.	Any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, nurse practitioner) may prescribe and/or order administration by qualified staff.

There are several resources available to organizations planning to implement MAT. Providers Clinical Support System (PCSS) offers numerous training modules at no cost to providers. Trainings are designed to help physicians, nurse practitioners and physician assistants meet their training requirements to become buprenorphine-waivered providers. In addition to the training, PCSS offers providers peer-to-peer mentoring and a wealth of other resources. Additionally, the National Council provides a Medication-Assisted Treatment (MAT) Readiness Checklist to guide MAT planning and implementation efforts within organizations. MAT is a critical component of trauma-informed, recovery-oriented systems of care providing individuals with the range of effective services and treatments that are necessary for long-term recovery.

RECOVERY SUPPORT

Recovery support services engage and support individuals in treatment and provide a range of ongoing services and supports following treatment to help individuals maintain long-term recovery. Recovery support services are provided by substance use disorder treatment programs and community programs and are often delivered by trained case managers, recovery coaches and peers. Recovery support services can include a wide-range of supports that enhance health and help individuals overcome barriers to care and wellness. SAMHSA identifies four main dimensions that support recovery: health (managing one's disease, supporting physical and emotional wellness), home (having a stable and safe place to live), purpose (conducting meaningful life activities) and community (having relationships and

social networks).[40] Recovery supports help individuals fulfill these domains and can include employment support, housing assistance, transportation and peer support, among others.

TRAUMA

WHAT IS TRAUMA?

Research shows that individuals who suffer childhood and adolescent trauma are at a higher risk of substance misuse and substance use disorders. Additionally, having a substance use disorder or a family member with a substance use disorder can be traumatizing. Individuals who have experienced four or more adverse childhood experiences (ACEs) were two times more likely to smoke, seven times more likely to misuse alcohol and 10 times more likely to inject illicit drugs.[41] Stress caused by ACEs have been shown to act on the same stress circuits in the brain as addictive substances. This is one explanation for the increased risk of substance use disorders among individuals who have experienced trauma.[42] The complex relationship between trauma and substance use disorders necessitates comprehensive, trauma-informed, recovery-oriented systems of care to best serve individuals.

DEFINING TRAUMA

Trauma, in a medical context, often refers to severe physical injuries resulting from a sudden event. In the context of TI-ROSC, however, trauma encompasses emotional, psychological and physical events resulting in long-lasting harms to an individual's well-being.

Trauma is experienced in multiple forms and ways including physical, sexual and emotional abuse and neglect, interpersonal violence, impacts from natural disasters, serious illness, surviving or witnessing violence, historical trauma, bullying, military trauma and war, racism and forced displacement. Trauma is pervasive and long-lasting at the individual level and can affect families and entire communities. It can also be passed on through generations, resulting in historical or cumulative trauma.[43]

The CDC estimates that 60 percent of the general adult population has experienced trauma[44] and another study estimates 46 percent of youth aged 17 and younger experienced at least one traumatic

[40] Substance Abuse and Mental Health Services Administration. (2018, October). Recovery. Retrieved from https://www.samhsa.gov/recovery
[41] Centers for Disease Control and Prevention. (2010, December 17). Adverse Childhood Experiences Reported by Adults – Five States, 2009. MMWR. Morbidity and Mortality Weekly Reports. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5949a1.htm
[42] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2016, November). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Retrieved from https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf
[43] Stevens, S., Andrade, R., Korchmaros, J., & Sharron, K. (2015). Intergenerational Trauma Among Substance-Using Native American, Latina, and White Mothers Living in the Southwestern United States. *Journal of Social Work Practice in the Addictions, 15*(6), 6-24.
[44] Centers for Disease Control and Prevention. (2010, December 17). Adverse Childhood Experiences Reported by Adults – Five States, 2009. MMWR. Morbidity and Mortality Weekly Reports. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5949a1.htm

event in 2016.[45] While all populations are affected by trauma, certain groups experience trauma at higher rates than the general population. One study found that 83 percent of youth living in urban areas reported experiencing one or more traumatic events.[46] Youth who identify as lesbian, gay, bisexual, transgender, queer and/or questioning (LGBTQ) experience trauma at higher rates than youth who identify as heterosexual.[47] Populations that have suffered discrimination, racism, slavery, genocide, war, forced migration and other forms of oppression are more likely to suffer from cumulative trauma. An in-depth analysis of the current research on trauma can be found in a literature review compiled by Kaiser Permanente and the National Council for Behavioral Health.

In Indiana, between July 1, 2014, and June 30, 2015, there were 77 reported child fatalities due to abuse or neglect. Stress, a major risk factor, was present in 94 percent of the neglect cases and 74 percent of the abuse cases. Substance misuse was present in 46 percent of the neglect cases and 17 percent of the abuse cases. Additionally, domestic violence was a risk factor in 20 percent of the neglect cases and 19 percent of the abuse cases.[48] In 2016, approximately 23 percent of children in Indiana experienced one ACE and 24 percent experienced two or more.[49]

STIGMA AND DISCRIMINATION

Stigma and discrimination are two factors that negatively impact individuals with substance use disorders and individuals who experienced trauma. SAMHSA defines stigma as "a mark of disgrace or infamy, a stain or reproach, as on one's reputation."[50] Substance use disorders and mental illnesses are highly stigmatized due to misconceptions that having these disorders is the result of personal fault and attitudes that individuals have control over their conditions. Research supports that clinicians treat individuals with substance use disorders and mental illness differently than individuals with other types of chronic diseases, including misattributing physical symptoms of illness to mental disorders and referring individuals with substance use disorder and mental illness to appropriate physical health services at lower rates than individuals without behavioral health diagnoses.

Stigma leads to discrimination against individuals with substance use disorders, with trauma histories and those who are in recovery. As a result of experiencing stigma and discrimination, individuals with substance use disorders suffer poorer health and social outcomes.[51] Individualized and institutionalized forms of discrimination, including failed criminal justice approaches to addiction, have resulted in

[45] Sacks, V., & Murphey, D. (2018). The prevalence of adverse childhood experiences nationally, by state, and by race/ethnicity. Child Trends Publication #2018-03. Retrieved from https://www.childtrends.org/
[46] Collins, K., Connors, K., Donohue, A., Gardner, S., Goldblatt, E., Hayward, A., . . . Thompson, E. (2010). Understanding the impact of trauma and urban poverty on family systems: Risks, resilience, and interventions. Family Informed Trauma Treatment Center.
[47] National Child Traumatic Stress Network. (2015). LGBTQ Issues and Child Trauma. Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/safe_spaces_safe_places_flyer_2015.pdf
[48] Prevent Child Abuse Indiana. (2018). Indiana Statistics. Retrieved from http://pcain.org/research/indiana-laws/
[49] Child and Adolescent Health Measurement Initiative. Data Resource Center for Child and Adolescent Health. (2018). 2016 National Survey of Children's Health (NSCH) data query. Retrieved from www.childhealthdata.org
[50] Substance Abuse and Mental Health Services Administration. (2017). Words Matter: How Language Choice Can Reduce Stigma. Retrieved from https://www.samhsa.gov/capt/sites/default/files/resources/sud-stigma-tool.pdf
[51] Ibid.

barriers to education, housing and employment among individuals with substance use disorders and mental illness.[52]

Trauma-informed, recovery-oriented systems of care embrace practices and policies that look to eliminate stigma and discrimination. Practical tools and tips are available to help staff and providers overcome stigmatizing language and behaviors, including the use of person-first language; developing programs, policies and procedures that incorporate input from multiple stakeholders including people in recovery; and providing robust staff training on stigma and discrimination.[53]

TRAUMA-INFORMED APPROACH

Trauma-informed organizations and systems embed core principles related to understanding, recognizing and responding to the effects of trauma into practices and services.

While each trauma-informed setting may look different, all trauma-informed organizations and systems adhere to six key principles shown in Table 6. These principles are the underlying foundation that guide policy, program and practice development within trauma-informed settings.

TABLE 6. SIX PRINCIPLES OF A TRAUMA-INFORMED APPROACH

Principle	Definition	Examples in Practice
Safety	Ensuring physical and emotional safety among individuals and staff.	• Understand that safety as defined by individuals receiving services is a high priority of the organization. • Create calm waiting areas and exam spaces that are safe and welcoming. • Ensure privacy is respected in all interactions.
Trustworthiness and transparency	Operations and decisions that are conducted with transparency and the goal of building and maintaining trust with individuals, family members and staff.	• Provide clear information about services. • Ensure informed consent. • Schedule appointments consistently.
Peer support and mutual self-help	Peers or individuals with trauma histories are valued and their lived experience is applied to promote recovery and healing.	• Facilitate group and partner interactions for sharing recovery and healing from lived experiences. • Include peer supporters in health teams.
Collaboration and mutuality	Decisions are made in partnership with individuals and power is shared between individuals and provider.	• Give individuals a significant role in planning and evaluating services.

[52] National Academies of Science, Division of Behavioral and Social Sciences and Education. (2016, August). Ending Discrimination against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK384918/

[53] Substance Abuse and Mental Health Services Administration. (2017). Words Matter: How Language Choice Can Reduce Stigma. Retrieved from https://www.samhsa.gov/capt/sites/default/files/resources/sud-stigma-tool.pdf

Principle	Definition	Examples in Practice
Empowerment, voice and choice	Individuals retain choice and control during decision-making and individual empowerment. Skill building is prioritized.	• Create an atmosphere that allows individuals to feel validated and affirmed with each contact. • Provide clear and appropriate messages about a individuals' rights, responsibilities and service options.
Cultural, historical and gender issues	The organization deliberately moves past cultural stereotypes and biases and incorporates policies, protocols and processes that are responsive to the racial, ethnic, cultural and gender needs of individuals served.	• Ensure access to services that address the specific needs of individuals from diverse cultural backgrounds. • Display messages in multiple languages to ensure everyone feels welcome. • Ensure access to gender responsive services. • View every policy, practice, procedure and interaction through a cultural and linguistic competence lens.

RECOVERY

DEFINING RECOVERY

Recovery from substance use disorders has been defined different ways as the recovery movement in the U.S. grew and evolved over the last several decades. Recently, as the principles of recovery have become more widely adopted, more standardized definitions have been formulated. SAMHSA[54] states that:

> *Even individuals with severe and chronic substance use disorders can, with help, overcome their substance use disorder and regain health and social function. This is called remission. When those positive changes and values become part of a voluntarily adopted lifestyle, that is called "being in recovery." Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, pro-social feature.*

The widespread adoption of recovery marks a significant movement away from a deficits-based approach and toward a strengths-based model of understanding and treating substance use disorders.[55] Historically, abstinence-only was the focus and goal of substance use disorder treatment and programs, however, there were some innovators who have been incorporating a continuum of services that includes harm reduction. Recovery encompasses an individual's holistic needs including one's physical, mental and social wellness.

[54] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2016, November). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Retrieved from https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf

[55] Best, D., Edwards, M., Cano, I., Durrance, J., Lehman, & White, W. (2018, June). Strengths Planning for Building Recovery Capital. *Counselor Magazine,* 33-37.

RECOVERY-ORIENTED SYSTEMS OF CARE

Recovery-oriented systems of care (ROSC) are systems that provide the necessary services to support individuals in long-term recovery. SAMHSA's Partners for Recovery Initiative defines recovery-oriented systems of care as[56]:

ROSC are networks of services and supports through which individuals and families with alcohol and drug problems discover unique pathways and sustain journeys to health, wellness and recovery within vibrant and welcoming communities. ROSC require an ongoing process of systems improvement that incorporates the voices and experiences of recovering individuals and their families in the design and implementation of services. ROSC support the adoption of person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families and communities. ROSC make it possible to offer a comprehensive menu of services and supports that can be tailored to the needs of individuals and families. They encompass and coordinate the operations of multiple systems, providing flexible, outcomes-driven approaches to care.

ROSC are developed based on several values and include operational elements that support individuals in long-term recovery and are built on the values of person-centeredness, self-direction, strengths-based and community participation (see Table 7). ROSC operational elements define the core system components necessary to deliver services in accordance with the values (see Table 8).

TABLE 7. RECOVERY-ORIENTED SYSTEMS OF CARE VALUES[57]

Value	Description
Person-centered approach	Services and supports are built on the needs, preferences and strengths of individuals. Multiple pathways to recovery are recognized including treatment, mutual aid groups, faith-based recovery, cultural recovery, natural recovery, medication-assisted treatment and others.
Self-directed approach	Individuals have the greatest level of choice over their service and support options and responsibility for recovery.
Strengths-based approach	Individuals' assets, strengths, resources and resiliencies are identified and supported.
Participation of family members, caregivers, significant others, friends and community	The role that an individual's familial and social supports have in their recovery is acknowledged and these supports are incorporated in recovery planning and support when appropriate.

TRAUMA-INFORMED RECOVERY-ORIENTED SYSTEMS OF CARE

Applying a trauma-informed approach to a recovery-oriented system of care operationalizes two models that have overlapping shared values and principles to improve the health and wellness for individuals

[56] Substance Abuse and Mental Health Services Administration. (n.d.). Recovery-Oriented Systems of Care (ROSC) Resource Guide-Working Draft. Retrieved from https://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf

[57] Ibid.

with substance use disorders, including opioid use disorder. Table 8 identifies the core operational elements of TI-ROSC.

TABLE 8. TI-ROSC ELEMENTS[58]

TI-ROSC Element	Description
Collaborative decision-making	Individuals are ***empowered*** to ***collaborate*** with professionals, peers and other formal and informal service providers and have ***voice and choice*** in their own recovery to the greatest extent possible.
Individualized and comprehensive services and supports	A broad array of supports to meet the holistic needs of individuals are offered and ***safety*** of the individual is prioritized. Services are designed to support recovery across the lifespan, are ***gender-specific***, ***culturally relevant***, trauma-informed, family-focused and appropriate to an individual's state of recovery.
Community-based services and supports	A range of ***culturally relevant, gender-specific*** resources including community-based services, ***peer-support and mutual self-help***, faith-based organizations, schools, civic groups, recovery community organizations and professional and non-professional organizations are offered to individuals. Individuals are ***empowered*** to have ***voice and choice*** directing their own participation in community-based services and supports.
Continuity of services and supports	***Culturally relevant*** services and supports are provided that ensure ongoing and seamless connections within and among various organizations for as long as an individual needs them and individuals have ***voice and choice*** in determining their need.
Multiple stakeholder involvement	All segments of the community are involved in the system, including individuals, family members and ***peers***. The system promotes ***trust and transparency*** in its design and delivery of services and supports.
Recovery community/peer involvement	Members of the recovery community are included in the design of systems, services and supports. Individuals in recovery and their family members and other social supports are included among decision-makers and decisions are made ***collaboratively***. ***Peer-to-peer*** recovery support services are included in the array of services offered.
Outcomes-driven	***Trust and transparency*** drive quality improvement and evaluation processes. Outcomes are measured to inform system improvements. Individuals' physical and emotional ***safety*** are prioritized above all else.
Adequately and flexibly funded	Funding is maximized to allow flexibility to provide a menu of services options and to ensure the physical and emotional ***safety*** of individuals.

[58] Ibid.

PART II: ANNOTATED TOOLS FOR IMPLEMENTATION AND OPERATIONALIZING

The data, information, principles and values discussed in the first half of this toolkit provide the foundation for counties to conceptualize and begin planning their trauma-informed, recovery-oriented systems of care (TI-ROSC). The second half of this toolkit provides the necessary change components, resources and tools to operationalize the principles and values of TI-ROSC across counties in Indiana. It is recommended that the change components be implemented in the order they are presented beginning with increasing urgency and buy-in through education.

READINESS ASSESSMENT

Prior to implementing the change components described in the next section, reviewing and conducting a countywide readiness assessment is recommended. The readiness checklist tool is designed to assist counties with assessing their readiness and level of implementation as it relates to the system changes and changes in services needed to more effectively meet the needs of people with substance use disorders. It is grounded in the framework of the TI-ROSC approach, which provides a comprehensive array of prevention, intervention, treatment and recovery support services that are individualized, coordinated, culturally competent, trauma-informed and recovery-focused.

COMPONENTS OF CHANGE

To successfully implement TI-ROSC, we recommend implementing eight change components (see Table 9). Each change component described is linked to related tools and resources to guide implementation efforts. The development of the eight change components have been informed by the Eight-Step Process for Leading Change, a nationally-recognized change management and leadership process developed by Dr. John Kotter.[59] The eight change components comprehensively address TI-ROSC planning, implementation and sustainability.

TABLE 9. TRAUMA-INFORMED RECOVERY-ORIENTED SYSTEM OF CARE CHANGE COMPONENTS

	Change Component	Objective	Recommended Tools
1	**Increase urgency and buy-In through community education**	Increase awareness and knowledge among community members and stakeholders on a TI-ROSC.	• Community education PowerPoint presentation. • Crafting a Compelling Story Tool.
2	**Community assessment**	Elicit diverse stakeholder perspectives and opinions; map current system and processes; identify strengths, weaknesses, opportunities and threats (SWOT) to inform TI-ROSC planning efforts.	• TI-ROSC Community Needs Assessment. • TI-ROSC Community Needs Assessment Scoring Sheet. • TI-ROSC SWOT Tool.

[59] Kotter, Inc. (2018). Eight-Step Process for Leading Change. Retrieved from https://www.kotterinc.com/

	Change Component	Objective	Recommended Tools
3	**Creating a County Change Team**	Develop a team to lead planning and implementation activities.	• Key Stakeholders List
4	**Visioning**	Create a county-wide shared vision of a TI-ROSC.	• TI-ROSC Planning Tool Step 1: Visioning.
5	**Future system development**	Identify the necessary components of the county's TI-ROSC	• TI-ROSC Planning Tool Step 2: Necessary Components • Trauma-Informed Care Principles Assessment.
6	**Goal setting**	Identify and prioritize short and long-term goals for each system component	• TI-ROSC Planning Tool Step 3: Components Sorting.
7	**Action planning**	Create action steps to successfully reach each goal	• TI-ROSC Planning Tool Step 4: Action Planning
8	**Implementation and sustainability**	Implement action steps, assess implementation progress, continuously make quality improvements and continuously educate and communicate with community members and stakeholders for ongoing buy-in.	• TI-ROSC Strategic Plan Tracking Tool.

1. INCREASE URGENCY AND BUY-IN THROUGH COMMUNITY EDUCATION

An early and important step in the TI-ROSC planning process is to educate the community and stakeholders on trauma-informed principles and recovery-oriented systems of care, including evidence-based practices for treating opioid use disorder. Community misperceptions perpetuated by a history of persistent stigma has resulted in general misunderstandings and ambivalence regarding treatment and care for individuals with substance use disorders. Providing education to a diverse set of stakeholders, including health and behavioral health providers, community services organizations and partners, individuals receiving services and community members will facilitate buy-in and support for the project.

To assist counties with educating the community, an informative PowerPoint presentation has been created that provides an overview of the opioid epidemic and other substance use disorders, trauma, ACEs, the TI-ROSC principles and resources for further learning and implementation.

CRAFT A COMPELLING STORY

An effective way to educate community members and gain buy-in is to craft a compelling story. Stories are important tools that help the community and other stakeholders identify with individuals who have experienced trauma and are in recovery. Stories are compelling when they help the listener or reader identify with the person and motivate a change in attitudes, beliefs or behavior. The Crafting a Compelling Story tool helps providers and individuals in recovery tell person-centered stories about how

addiction has impacted them, the services and supports that helped and the hope of recovery. Crafting a compelling story will also be useful when creating a county change team, another early step in the TI-ROSC process.

2. COMMUNITY ASSESSMENT

Conducting a comprehensive community assessment helps counties understand the current environmental state, identify the community and stakeholders' perspectives and opinions related to services and care for individuals with substance use disorders and assess the strengths, weaknesses, opportunities and threats (SWOT) related to the TI-ROSC project. These assessments provide valuable data to inform the planning, goal setting and implementation of the project. To assist counties with conducting the community assessment, several tools have been created and are discussed here.

TI-ROSC COMMUNITY NEEDS ASSESSMENT

The TI-ROSC Community Needs Assessment is an environmental scan for your community as it relates to implementation of a trauma-informed, recovery-oriented system of care for individuals who have substance use disorders. It is designed to elicit feedback from a range of stakeholders on the components of a trauma-informed, recovery-oriented system of care. The questions are constructed to provoke critical thinking about how your system is designed and delivered and to bring underlying the system culture to the surface. Issues, such as stigma and discrimination, that have a profound impact on outcomes for individuals who have experienced trauma, use substances and are in recovery are also addressed by the TI-ROSC Community Needs Assessment.

The TI-ROSC Community Needs Assessment should be completed individually by all stakeholders, including persons seeking services, caregivers, staff and other community stakeholders. Responses across the system should be aggregated and discussed by the team to develop a work plan for moving forward to a trauma-informed, recovery-oriented system of care. The TI-ROSC Community Needs Assessment Scoring Sheet provides an easy method to analyze assessment responses using an excel sheet with the necessary formulas pre-populated.

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS ANALYSIS

Understanding the strengths, weaknesses, opportunities and threats (SWOT) of each component of the care system is an important step to inform planning, quality improvement and sustainability efforts. The TI-ROSC SWOT Tool provides counties and organizations with a detailed assessment instrument to guide a SWOT analysis across the continuum of care including: prevention and early intervention, engagement and treatment, recovery and reconnection and maintenance and sustainability.

3. CREATING A COUNTY CHANGE TEAM

To lead successful planning and implementation of TI-ROSC, a County Change Team should be created. Key stakeholders who are action-oriented and empowered to drive change within the county should comprise the team. A Key Stakeholders List has been developed to assist counties with identifying the best-suited team members within their counties. The County Change Team should have representation from a wide-range of key stakeholders including people in recovery, community behavioral health providers, MAT providers, peer support providers, first responders, primary care providers and social services providers, among others.

4. VISIONING

One of the most important steps for the county change team to develop is a shared TI-ROSC vision for the county. Vision statements should be short, specific, simple and ambitious. They should align to the values that you want people to exhibit as they perform their work. A vision statement should be a memorable and inspirational summary that describes your reason for doing this work, one that will help to motivate existing staff and stakeholders. The goal is to articulate a vision that is so clear that it fits on one page and takes less than a minute to share. To assist counties with visioning, the TI-ROSC Planning Tool Step 1: Visioning has been developed.

VISION STATEMENT EXAMPLES

"The community of Wayne County will unify to support the health and well-being of every resident."

"Dearborn County is an educated and unified community where individuals and families can safely and easily access reliable services and lasting support towards hope, recovery and

5. FUTURE SYSTEM DEVELOPMENT

Identifying the specific components of the TI-ROSC across the recovery continuum (enhancing health, primary prevention, early intervention, treatment and recovery support) is a critical step to begin to materialize your vision. Future system development includes identifying the services and supports, communication and messaging and continuous quality improvement efforts the system will need within each step of the continuum to provide comprehensive trauma-informed, recovery-oriented services and supports. The TI-ROSC Planning Tool Step 2: Necessary Components provides County Change Teams a worksheet to identify each of the components necessary to meet counties' unique needs. Additionally, the Trauma-Informed Care Principles Assessment Tool assists County Change Teams to identify steps that could be taken to better align system and organizational policies and practices with the six trauma-informed principles.

6. GOAL SETTING

Articulating and prioritizing short and long-term goals is a critical component to successful change implementation. The TI-ROSC Planning Tool Step 3: Components Sorting provides County Change Teams a rubric to identify "low-hanging" goals that can be accomplished in zero to 12 months and "stretch" goals that will take more than 12 months to accomplish across the recovery continuum.

7. ACTION PLANNING

Once short- and long-term goals are identified, County Change Teams should create specific objectives and action steps that will help teams reach their goals and implement their TI-ROSC vision. Action steps should be "SMART" – specific and strategic, measurable, attainable, relevant (results oriented) and time-framed. The TI-ROSC Planning Tool Step 4: Action Planning provides County Change Teams action plan grids to facilitate the identification of SMART objectives for each step in the recovery continuum and across service components.

8. IMPLEMENTATION AND SUSTAINABILITY

To successfully implement and sustain the county's TI-ROSC activities, ongoing strategic planning and quality improvement should take place. To assist County Change Teams with strategic planning, a TI-ROSC Strategic Plan Tracking Tool has been created. The tracking tool helps teams stay organized and timely in their implementation and assessment of project activities. It also tool tracks action items, deadlines, persons responsible, assessment and current status of project activities across the recovery continuum and care components.

CONCLUSION

Communities across Indiana will benefit from the development of trauma-informed, recovery-oriented systems of care that support individuals with substance use disorders and people in recovery. Providing comprehensive, effective, person-centered services and supports gives individuals the best opportunity to live fulfilling, healthy lives in long-term recovery. The information and tools included in this toolkit provide Indiana counties the foundational resources necessary to plan, develop, implement, monitor and sustain recovery-oriented, systems of care.

ADDITIONAL RESOURCES

Table 10 provides useful information, education and training materials, draft policies and implementation supports to guide the successful implementation of TI-ROSC.

TABLE 10. ADDITIONAL RESOURCES TO SUPPORT TI-ROSC PLANNING AND IMPLEMENTATION

Name/Weblink	Description	Source
Person-First Guidelines	Guidelines for the use of person-first language from a county behavioral health system.	Philadelphia Department of Behavioral Health and Intellectual Disability Services
Practice Guidelines for Recovery and Resilience Oriented Treatment	Practice guidelines for providers to deliver recovery and resilience-oriented treatment from a county behavioral health system.	Philadelphia Department of Behavioral Health and Intellectual disability Services
Facing Addiction in America	Information from the U.S. Surgeon General on substance use and substance use disorders, including opioid use disorder.	U.S. Department of Health and Human Services, Office of the Surgeon General
Decisions in Recovery: Treatment for Opioid Use Disorders	Handbook and web-based tool that offer information about medication-assisted treatment.	Substance Abuse and Mental Health Services Administration
Implementing Care for Alcohol and Other Drug Use in Medical Settings: An Extension of SBIRT	A step-by-step guide for primary care clinicians to implement SBIRT.	The National Council for Behavioral Health
State Targeted Response (STR) Technical Assistance (TA) Consortium	Technical assistance request portal and information to support efforts to prevent and address opioid use disorder.	State Targeted Response (STR) Technical Assistance (TA) Consortium
Addiction Technology Transfer Center Network	Resources including online courses to increase adoption and implementation of evidence-based addiction and recovery-oriented practices.	Addiction Technology Transfer Center Network
Medication-Assisted Treatment (MAT) Readiness Checklist	A free organizational assessment designed to assist in determining organizational readiness to implement MAT.	National Council for Behavioral Health
MATx – Mobile App	A free mobile application that supports clinicians who are providing MAT to treat opioid use disorder.	Substance Abuse and Mental Health Services Administration
Selected Papers of William L. White	A collection of papers authored by recovery expert and advocate, William L. White, on building recovery-oriented systems of care.	Selected Papers of William L. White
Providers Clinical Support System	Training, mentoring and other resources to assist providers with implementing MAT.	Providers Clinical Support System
Faces and Voices of Recovery	Resources for implementing recovery-oriented systems of care.	Faces and Voices of Recovery
Know the O Facts	A collection of information, training resources and tools related to opioid use disorder and addressing stigma.	State of Indiana