

**Pre-Application Technical Assistance Reports for the
Access to Recovery Grant Program**

Report on Technical Assistance to Maine

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Consultation between Dee S. Owens and the State of Maine Written Report

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Introduction (Purpose of Technical Assistance)

Kimberly Johnson, Director of the Office of Substance Abuse, the Single State Authority (SSA) for the State of Maine, requested assistance from SAMHSA's Center for Substance Abuse Treatment (CSAT) concerning methods by which Maine, with its rural/frontier setting, can offer the choice of providers required for the ATR voucher program. Under Task Order with CSAT, Dee Owens was provided as a consultant to assist Maine. Rural areas pose special issues for service provision, including but not limited to lack of adequate transportation, sparse availability of providers, and a small population base. Some areas of Maine have only six people per square mile, contributing to difficulty in hiring and retaining qualified staff. To meet the need for services in rural areas requires creativity and knowledge of rural culture. Teamwork and consortia are often used to meet client needs.

Methodology

A telephone call was held on May 19, 2004, between Kimberly Johnson (Director of the Office of Substance Abuse), Lynn Duby (Executive Director of a provider organization in Maine and former director of the SSA), and Dee S. Owens, consultant. About an hour was devoted to the conference via telephone.

The discussion summarized in this report is paraphrased and not verbatim.

Content of TA Discussion

Maine: The RFA for the Access to Recovery (ATR) grant program requires that clients be able to choose from among two or more qualified providers, with at least one to which the client has no religious objection. Maine's question is one common to rural States: How can we provide choice when we are often grateful to be able to provide any services whatsoever in frontier areas?

The State currently contracts directly with local agencies, using cost sharing and applying Medicaid funding for client services. Two agencies have voucher-type programs, and the State will look at those agencies to inform the process and decision-making for the ATR voucher program. At least initially, it is envisioned that religious institutions in rural areas will be able, at best, to provide recovery support services. Clinical treatment for

substance abuse and dependence must be provided by certified, and therefore qualified, personnel and providers in the State.

Issue #1: Travel to providers

Maine: The State noted that travel is a great concern and that the purchase of vans for transportation may be warranted.

Consultant: Experience in Oklahoma and Indiana demonstrates that vans can be an effective tool in rural areas. Setting up a van service can involve these challenges:

- Finding a worker who holds a CDL (chauffeur driver's license) to drive the van. Sometimes a person in recovery is willing to offer these services at low cost, and recovery support services (transportation to 12-step meetings at night, for example) can be facilitated by use of the van.
- Acquiring adequate insurance coverage.

Issue #2: Scarcity of providers

Maine: A second difficulty is providing services where there are few, if any, providers. Maine is considering options that include the use of private practitioners with certain licenses, such as an LCSW.

Consultant: Different models were discussed. It was decided that the SSA would have great difficulty trying to work with and monitor each practitioner chosen by clients for services. Instead, private counselors could be listed with a certified local provider, a lead agency, which would be responsible for supervision and other requirements in the RFA as clients presented with vouchers and chose any particular counselor. This model would allow expansion of choice without greatly increasing the State bureaucracy and infrastructure. Also, through the lead agency, this model would facilitate the required outreach to new providers. Both the local lead agency and the new provider(s) could then conduct outreach to as-yet-unserved clients.

Other suggestions concerning models included:

- ***Using a lead-agency model for administration.*** The RFA does not allow direct contracting with providers, but grantee administrative costs up to 15 percent are allowed under the ATR grant to the States. Clients will present with vouchers at agencies or providers of their choice. The lead agency could also be responsible for assessment, which the client would receive upon presentation of the voucher. The lead agency would need to have procedures in place to assure there are no conflicts of interest between its assessment and treatment components. After assessment, the client can choose a provider.

- ***Developing a consortium of substance abuse service providers.*** Indiana has a consortium of substance-abuse service providers that contract with the State agency to cover clients in rural areas. Other providers are able to form consortia and to contract for services with the SSA, but most prefer to work together in the existing consortium. Maine is seriously considering this model, as then the consortium would assist the State to provide many of the RFA-required services, such as monitoring of voucher utilization and identifying faith-based organizations for recovery support services. The client-chosen providers could report GPRA data to the consortium. The consortium model could be modified to include: (1) the creation of regions, where local lead agencies would be responsible for recruitment and administration in a particular area, and (2) the use of client choice rather than direct contracting.

Maine already has a budding consortium of four agencies that have banded together to explore the difficulties inherent in working within sparsely populated areas that have few existing services. Assisted by Lynn Duby, the former SSA director, this consortium has been working as a partner with the State agency to formulate the best possible plan to offer services in this largely rural State.

Issue #3: Resources for recovery support in remote areas

Maine: The State was interested in exploring what types of groups could effectively provide recovery support in rural areas.

Consultant: The teleconference participants agreed that faith-based and community-based organizations would be good resources for recovery support in remote areas. These groups are accustomed to helping with food, clothing, and shelter in rural areas, and they are often the only organizations besides schools with the capability to help. Members of these organizations generally know the persons whom they help. These groups offer other advantages, such as:

- Local places of worship could start and house 12-step meetings, including those of Alcoholics Anonymous, Narcotics Anonymous, and Al-Anon, as well as other needed groups. Outreach could inform this process while bringing new resources into the recovery network.
- Including faith-based and community-based organizations in the planning and support for recovery may reduce stigma through education and involvement. In small rural communities with few services and businesses of any sort, most residents have always “pitched in” when there are emergencies and have taken care of their neighbors. However, up until now, most residents have kept out of others’ problems with regard to addiction, in great part because they don’t know what to do. Community action around recovery might help to restore the rural sense of community.

The consultant discussed the role that community coalitions could play in bringing together and fostering recovery support efforts by faith- and community-based organizations. Prevention providers in rural areas have long been trained to form community coalitions, and treatment providers can turn to those in prevention for assistance. In Oklahoma, for example, 18 prevention resource satellites worked as arms of the SSA to provide locally driven and articulated services with schools, primary care providers, businesses, and other local groups. In much the same way, treatment providers could work with local groups to recruit and to “ensure that individuals receive appropriate services in safe settings from appropriate individuals,” as required by good practice and the RFA.

Issue #4: Communication infrastructure

Maine: Data collecting and reporting for the ATR voucher program seems to require that computers be available to treatment and recovery support providers. In Maine, local provider infrastructure is such that client access via the web is unrealistic; some providers do not have computers! Maine, like Oklahoma, has areas where there are few computer-related services and no technological infrastructure. [Note: In the Oklahoma panhandle, *USA Today* did not have delivery, since there was nowhere to download and print the paper. Similarly, newspaper vending machines were few and far between, since servicing them was expensive and impractical.]

Consultant: In the ATR voucher program, it may be necessary to acquire appropriate equipment or services to track use of vouchers, GPRA data, and the client outcome information from the seven domains. Since many rural providers have only paper and pencil systems, it would make sense to properly equip lead agencies or consortia with items that can help expand provider choice and facilitate the proper and timely reporting of outcomes. Because of this need for equipment, administrative costs may well be higher in rural States.

Currently, the use of smart cards or other electronic means is highly unlikely in remote areas. With adequate equipment and training for providers, the expansion in choice of providers could be extended beyond the grant period and into the future.

Issue #5: Workforce development for local providers

Maine: Workforce development in rural areas is difficult, because existing providers do not have adequate staff to allow the release of counselors or administrators to attend skill-building and knowledge training. Although they must take continuing education credits to keep not only current but also certified, counselors in rural areas are often unable to miss workdays, even for no-cost workshops. For example, the National Rural Institute on Alcohol and Drug Abuse offers in-depth and inexpensive training, and both the Centers for Substance Abuse Treatment and Prevention provide scholarships. But, because another staff member is not available to cover the counselor’s clients, some of these scholarships go unused.

Consultant: In rural areas, one answer may be to import telecommunications technology that can provide classroom training in a rural school setting. This generally requires a partnership with a college or university that has the appropriate capabilities to provide satellite feeds and equipment. While this association may not exist as yet, it makes sense for SSAs and consortia in rural areas to begin to build such relationships and to question how they can secure training opportunities for low cost. It may be possible to partner with other local agencies that also need these capabilities, which could lead to expanded training for agency staff. This technological solution would also be a way to facilitate video conferencing with others in the State, including the SSA.

Consultant's Background

Dee S. Owens is the former Deputy Commissioner for Substance Abuse Services at the Department of Mental Health and Substance Abuse Services in Oklahoma, the Single State Authority in a rural State, with frontier areas in the Panhandle. She currently is Director of the Alcohol-Drug Information Center at Indiana University in Bloomington, Indiana, where she has also directed the State association for treatment counselors, a rural regional office for the Governor's Commission for a Drug-Free Indiana, and the alcohol-education programming for a consortium of rural school districts. She was Chair of the Rural Task Force of the Midwest Regional Center for Drug-Free Schools and Communities and, for 15 years, has taught the prevention track at the National Rural Institute on Alcohol and Drug Abuse. Ms. Owens served on the National Advisory Council of SAMHSA for 4 years, serving more than 2 years as Co-Chair with the Administrator. She also served on the SAMHSA Rural Stakeholders Panel in 2003. Ms. Owens has worked in the field for more than 20 years.