Recovery-Oriented System of Care:

A Recovery Community Perspective

WHITE PAPER

Pennsylvania Drug and Alcohol Coalition
established in collaboration with:

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& Substance Abuse Services

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FORWARD

The Recovery Oriented Systems of Care (ROSC) Subcommittee was formed as part of the Drug and Alcohol Coalition with the specific charge to develop this White Paper. The overarching goal of the subcommittee is to improve the system of care offered in Pennsylvania by expanding to a chronic care model of care. This attached White Paper was developed in order to inform the larger Coalition and future efforts in Pennsylvania on this historic endeavor to expand services using a Recovery Oriented System of Care model. This paper then fits into a larger process to inform and influence service development through the Department of Health, the Department of Public Welfare and beyond.

During the period of time that this paper was developed, our state and nation have undergone tremendous and unprecedented economic upheaval. Limited resources and financial constraints have drastically impacted our state's ability to meet the needs of those affected by alcohol and other drug problems. We believe that every person has the right to the appropriate level of care for the appropriate amount of time. It is important to note that our subcommittee agreed early on and unanimously that to effectively change a system in such a manner, additional resources would need to be identified and developed to make it work as envisioned.

We know wholeheartedly that drug and alcohol addiction is a chronic disease, and yet our systems are set up to address the needs of persons seeking help in a limited manner. Over the last several years, there has been a growing recognition across the nation that acute care systems for addiction do not adequately meet the needs of our communities in need. To be effective, we know that the development of a ROSC system will need to preserve our existing service continuum while adding additional resources to meet the needs of our communities in a thoughtful and well planned manner.

It is important to remember that peer-based recovery support services should not be utilized in place of clinical care. Providing appropriate services to those in need of help for the appropriate duration of time saves lives and resources in all areas of our society. We believe that Recovery Oriented Systems of Care is a transformative process well worth pursuing but should not be undertaken in a half measured manner. Using existing acute care resources in an attempt to meet the needs of a chronic care model would result in the degradation of the entire treatment and service system available to all Pennsylvanians.

Recovery-Oriented System of Care:

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Executive Summary

The Pennsylvania Governor's Policy Office, Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services (OMHSAS), and Pennsylvania Department of Health, Bureau of Drug and Alcohol Programs (BDAP) have been working in collaboration with multiple state and county agencies, treatment providers, and recovery community organizations across the state to conceptualize, develop, and implement a Recovery-Oriented System of Care (ROSC) in Pennsylvania that embraces and promotes recovery from alcohol and other drugs (AOD). This group, known as the Drug and Alcohol Coalition, recognizes that to effectively execute the implementation of a recovery-oriented system of care, a dramatic shift will be required in the field. Moving from the current acute care model to a chronic care approach requires the entire system to embrace a recovery management approach to support those affected by AOD problems and to expand the present continuum of care (White, 2004). The Coalition also ascertained that as this paradigm shift occurs, it is paramount that Pennsylvania utilize the recovery community in all aspects of systems transformation to ensure authenticity of services, thus assuring that the needs of individuals and families in recovery are addressed at every level of the system in order to expand opportunities for long-term recovery. This can best be achieved through the development of a ROSC.

It is important to note that while the systemic implementation of a ROSC is new to Pennsylvania, the concept itself is not. Movement to a recovery management approach as a means to successfully support individuals and their families in their recovery from AOD problems has been well researched nationally and has been implemented in various venues across the country with promising success. At the Drug and Alcohol Coalition Retreat held in June 2008, subcommittees were formed to develop guidelines and best practices to be used in the development of a ROSC in Pennsylvania. Each subcommittee was charged with tasks specific to their areas of concern such as Finance, Workforce, Accessibility, Criminal Justice, and Recovery Based Issues (RBI). The RBI Committee was charged with the creation of the White Paper to determine the issues that are critical to the development of a ROSC from the perspective of individuals and families in recovery.

The work done by the RBI Committee spanned over an 18-month period. The committee spent countless hours reviewing the literature published by the Center for Substance Abuse Treatment; William White; The Institute for Research, Education & Training in Addictions; Thomas A. Kirk, et al; Linda Kaplan; and others (see Reference page) in order to get a comprehensive understanding of a ROSC and how established concepts, terminologies, and implementation strategies could best be adapted for our use. In addition, the recovery community of Pennsylvania was called upon to attend meetings, provide input, and participate in surveys designed by the RBI Committee to assess the general understanding of a ROSC and Recovery Support Services and to assess areas of need when considering the establishment of such a system within the state. This input proved to be extremely valuable to the writing of this paper and can also be used to guide current and future projects. (See Needs Assessment, Appendix VI , for specific survey information).

The RBI Committee recognizes that this White Paper is one of many tools that will be used in the ROSC transformation process in PA. It is our hope that this document, as well as the work

done by the PA D & A Coalition, will serve as the foundation for statewide system transformation that will better meet the needs of Pennsylvanians affected by this disease.

Conceptual Framework

The shift to a ROSC requires Pennsylvania to utilize not only therapeutic and clinical interventions as described by the PCPC (e.g. formal treatment services), but to also utilize non-clinical community-based resources that support recovery, early identification, engagement and sustention of the recovery process for individuals and families. This can, in part, be accomplished through the use of recovery support services. Through these services, individuals, families, and communities can gain access to recovery-focused services and support that will increase successful treatment completion rates, promote early re-engagement for those who have relapsed, and provide pathways to recovery for individuals not in need of clinical treatment services. Such a system would provide ongoing recovery-based services throughout the lifespan. Based on this information, the RBI Committee chose the following vision for our work:

> *To improve the capacity to access and sustain long-term recovery for individuals in PA who are affected by addiction to alcohol and other drugs by transforming the existing system into a Recovery-Oriented System of Care.*

Guiding Principles of Recovery

As in any system, there are Guiding Principles that are the ideals or code of conduct that defines the system's core values and priorities. Guiding Principles filter through every aspect of a system clearly identifying the moral values embedded within the system. Guiding Principles are the fundamental beliefs that guide the operation of a system throughout its life in all circumstances, irrespective of changes in its goals, strategies, type of work, or the top management. Therefore, once established, a ROSC should remain intact and authentic to the original vision, values and principles regardless of changes that occur in the implementation/execution of this system.

Those values that form the Guiding Principles of a ROSC include the following beliefs about recovery:

There are many pathways to recovery. Individuals are unique with specific needs, strengths, goals, attitudes, behaviors and expectations for recovery. Pathways to recovery are highly personal, and generally involve a redefinition of identity in the face of crisis or a process of progressive change. Furthermore, pathways are often social, grounded in cultural beliefs or traditions and involve informal community resources, which provide support for recovery. The pathway to recovery may include one or more episodes of psychosocial and/or pharmacological treatment. For some, recovery involves neither treatment nor involvement with mutual aid groups. Recovery is a lifelong process of change that permits an individual to make healthy choices and improve the quality of his or her life.

Recovery is self-directed and empowering. While the pathway to recovery may involve one or more periods of time when activities are directed or guided to a substantial degree by others, recovery is fundamentally a self-directed process. The person in recovery is the "agent of recovery" and has the authority to exercise choices and make decisions based on his or her recovery goals that have an impact on the process. The process of recovery leads individuals toward the highest level of autonomy of which they are capable. Through self-empowerment, individuals become optimistic about life goals.

Recovery involves a personal recognition of the need for change and transformation. Individuals must accept that a problem exists and be willing to take steps to address it; these steps usually involve seeking help for alcohol and other drug dependence. The process of change can involve physical, emotional, intellectual and spiritual aspects of the person's life.

Recovery is holistic. Recovery is a process through which one gradually achieves greater balance of mind, body and spirit in relation to other aspects of one's life, including family, work and community.

Recovery has cultural dimensions. Each person's recovery process is unique and impacted by cultural beliefs and traditions. A person's cultural experience often shapes the recovery path that is right for him or her.

Recovery exists on a continuum of improved health and wellness. Recovery is not a linear process. It is based on continual growth and improved functioning. It may involve relapse and other setbacks, which are a natural part of the continuum but not inevitable outcomes. Wellness is the result of improved care and balance of mind, body and spirit. It is a product of the recovery process.

Recovery emerges from hope and gratitude. Individuals in or seeking recovery often gain hope from those who share their search for or experience of recovery. They see that people can and do overcome the obstacles that confront them and they cultivate gratitude for the opportunities that each day of recovery offers.

Recovery involves a process of healing and redefinition for self and family. Recovery is a holistic healing process in which one develops a positive and meaningful sense of identity.

Recovery involves addressing discrimination and transcending shame and stigma. Recovery is a process by which individuals, families and communities confront and strive to overcome discrimination, shame and stigma by advocating for self and others.

Recovery is supported by peers and allies. A common denominator in the recovery process is the presence and involvement of people who contribute hope and support and suggest strategies and resources for change. Peers, as well as family members and other allies, form vital support networks for people in recovery. Providing service to others and experiencing mutual healing help create a community of support among those in recovery.

Recovery involves (re)joining and (re)building a life in the community. Recovery involves a process of building or rebuilding what a person has lost or never had due to his or her condition and its consequences. Recovery is building or rebuilding healthy family, social, spiritual and personal relationships. Those in recovery often achieve improvements in the quality of their lives, such as obtaining education, employment and housing. They also increasingly become involved in constructive roles in the community through helping others, productive acts and other contributions.

Recovery is a reality. It can, will, and does happen.

Guiding Principles are the blueprint that sets the course by which a system navigates (CSAT, 2007). Protecting and honoring the Guiding Principles of a ROSC are integral to its ongoing success and growth. Although they may be altered as necessary over time, in essence the Guiding Principles should always remain true to the original vision.

Elements of a Recovery-Oriented System of Care

The elements of a system, much like the Guiding Principles, are rooted in the very core of the system's values. They are the individual components that make up the whole. The elements of a system are those smaller parts that are similar to the larger system in that they can be described as common in value, behaviors and identity. Therefore, the elements of a ROSC broken down into their individual parts have recovery as their fundamental ingredient.

Person-centered – A ROSC is person-centered. Individuals will have a menu of choices that fit their needs throughout the recovery process.

Participation inclusive of individuals and families in recovery – An essential characteristic of a ROSC is the importance it places on the participation of people in recovery in all aspects and phases of the care delivery process, including financial support for individual and family involvement.

Family and other ally involvement – A ROSC acknowledges the important role that families and other allies can play. Family and other allies will be incorporated, with the permission of the individual, in the recovery planning and support process. They can constitute a source of support to assist individuals in entering and maintaining recovery. Additionally, systems address the prevention and early intervention, treatment, recovery and other support needs of families and other allies.

Inclusion of the voices and experiences of recovering individuals and their families – The voices and experiences of people in recovery and their family members contribute to the design and implementation of ROSC. People in recovery and their family members are included among decision-makers and system-level monitoring. Recovering individuals and family members are prominently and authentically represented on advisory councils, boards, task forces and committees at the federal, state and local levels.

Promoting access and engagement – Each person who seeks services should be afforded every opportunity to access appropriate addiction treatment and recovery support. A ROSC promotes access to care by facilitating swift and uncomplicated entry and by removing barriers to receiving services (i.e. no wrong door). Engagement involves making contact with the person (as opposed to their disease), building trust over time, attending to the person's stated goals and needs and, directly or indirectly, providing a range of services in addition to clinical care. This involves linkages.

Linkages – For many individuals, recovery sustainability is not achieved through short episodes of treatment currently authorized by funding entities or through sporadic participation in self-help programs. There is often a misconception that individuals can remain in recovery without additional services and support. Linkage to recovery support services can serve to expand the capacity of formal treatment systems by promoting the initiation of recovery, reducing relapse, and intervening early when relapse occurs (Kaplan, 2008). Participation in these services will enhance long-term recovery outcomes, regardless of involvement in formal treatment. It is also critical for individuals and families to be connected to ancillary forms of support to address additional needs that directly affect the recovery process (housing, employment, medical care, etc.). By collaborating with a wide range of service and resource providers, individuals will gain access to a wider array of resources critical to the recovery process.

Individualized and comprehensive services across the lifespan – A ROSC offers a menu of comprehensive services which are individualized, stage-appropriate, and flexible across the lifespan. Systems will adapt to the needs of individuals, rather than requiring individuals to adapt to them. They are designed to support recovery across the lifespan. The approach to alcohol and other drug-related issues will change from an acute-based model to one that manages chronic diseases over a lifetime.

Systems anchored in the community – A ROSC is nested in the community for the purpose of enhancing the availability and support capacities of families, intimate social networks, community-based institutions and other communities in recovery. These systems should establish and maintain effective formal and informal linkages throughout the state to connect individuals and families to clinical, community-based and recovery support services.

Ensuring continuity of care – A ROSC offers a continuum of care, including pre-treatment, treatment, continuing care and recovery support. Individuals should have a full range of stage-appropriate services from which to choose at any point in the recovery process.

Partnership-consultant relationships – A recovery-oriented system of care is patterned after a partnership-consultant model that focuses on collaboration, and less on hierarchy. Systems will be designed so that individuals feel empowered to direct their own recovery with safety being a paramount concern.

Strength-based – A ROSC emphasizes strengths, assets and resiliencies.

Culturally responsive – A ROSC is culturally sensitive, competent, responsive and aware of recovery language. There is recognition that beliefs and customs are diverse and can impact the outcomes of recovery efforts.

Responsiveness to personal belief systems – A ROSC respects the spiritual, religious and/or secular beliefs of those they serve and provide linkages to an array of recovery options that are consistent with these beliefs.

Commitment to peer recovery support services – A ROSC provides opportunities for ongoing participation of peers in the planning, implementation, and delivery of services throughout the full continuum of care.

Integrated services – A ROSC coordinates and/or integrates efforts across service systems to achieve an integrated process that responds effectively to the individual's unique strengths, desires and needs.

System-wide education and training – A ROSC ensures that concepts of recovery and wellness are foundational elements. Training, at every level, will reinforce the tenets of recovery-oriented systems of care.

Ongoing monitoring and outreach – A ROSC provides ongoing monitoring and feedback with assertive outreach efforts to promote participation, motivation and reengagement in order to continually improve the system.

Outcomes driven – A ROSC is guided by recovery-based processes and outcome measures. These measures will be developed in collaboration with individuals in recovery. Outcome measures will reflect the long-term global effects of the recovery process on the individual, family and community, not just remission of biomedical symptoms. Outcomes will be measurable and include benchmarks of quality of life changes.

Research-based – A ROSC is informed by research. Additional research on individuals in recovery, recovery venues and the processes and phases of recovery, including cultural and spiritual aspects, is essential. Research will be supplemented by the experiences of people in recovery.

Adequately and flexibly financed – A ROSC must be adequately financed to permit access to a full continuum of services, ranging from detoxification and treatment to continuing care and recovery support. The service delivery system will be flexible enough to provide the establishment of an array of programming around long-term recovery support to augment those already provided within our drug and alcohol service system.

End stigma and discrimination – A ROSC works toward the eradication of stigma and discrimination. Stigma and discrimination toward individuals and families seeking treatment and recovery will be eliminated and no longer serve as barriers in obtaining necessary services or progressing in their recovery.

Promote the highest level of autonomy – A ROSC promotes the highest degree of functioning and quality of life for all individuals in our system. The system recognizes that individuals may need to learn new skills to survive in the larger society. Success at an expanding array of life tasks and the assumption of new or enhanced roles in the community as they are defined by the person in recovery over time, both derive from and contribute to sustained recovery. The system provides emotional and financial resources, social support and skill building opportunities for individuals to achieve their individual goals (CSAT, 2005).

The elements of any system are the heart and soul that goes into its creation. The elements are what maintain the integrity of the system. As in any system, precious parts can be lost over time if those monitoring the system are not vigilant and focused on the true purpose of the system. Therefore, it is essential that the elements are reviewed frequently, especially during system transformation and change and that special care is taken to always maintain their authenticity.

Language

A ROSC requires a transformation not only in our thinking, but also in our language. This can be quite a challenging process. In an effort to establish a consistent frame of reference, the RBI Committee found it appropriate to describe the language and definitions for those reading this document who may not be familiar with the terminology used. For the purposes of the White Paper, we have identified and defined terms, concepts and principles critical to the recovery process and ROSC transformation. A *Glossary of Terms* has also been created (See Appendix II) to more fully explain the concepts utilized throughout the White Paper. Some of the most critical concepts to be defined are: Recovery, ROSC, Recovery Community and Peer-based Recovery Support Services (P-BRSS).

Defining Recovery

One of the most challenging tasks is defining the term Recovery. Recovery is a highly individualized process – one that goes beyond abstinence alone to include a full re-engagement – based on resilience, health, and hope – with one's family, friends, and community. Although no consensus has been reached on one universal definition of Recovery, the RBI Committee has established the following definition for our work in Pennsylvania.

> *Recovery from alcohol and other drug dependency is a highly individualized journey that requires abstinence from all mood altering substances. This journey is a voluntarily maintained lifestyle that includes the pursuit of spiritual, emotional, mental and physical well-being which may be supported through the use of medication that is appropriately prescribed and taken.*

Keep in mind that this is one of many definitions of recovery. We encourage you to expand your understanding of recovery through additional reading and research.

Defining Recovery-Oriented System of Care

A recovery-oriented system supports person-centered and self-directed approaches to care that build on strengths and resilience. Individuals, families, and communities take responsibility for

their sustained health, wellness, and recovery from alcohol and other drug related issues through the various life phases of recovery. This system refers to a macro-level organization of the larger cultural and community environment in which long-term recovery is nested and offers a complete network of formal and informal resources that support long-term recovery of individuals and families.

Goals of a ROSC:

- To support preventive strategies related to alcohol and other drug-related problems & disorders;
- To intervene early with individuals with alcohol and other drug problems;
- To support sustained recovery for those affected by addiction;
- To improve individual, family and community outcomes;
- To create opportunities for collaboration among formal and informal systems, planning and policy development

A ROSC offers a comprehensive menu of services and supports that can be easily accessed, coordinated and enhanced to meet the needs of individuals and families in the community, regardless of the pathway used to find recovery. This system is inclusive of and coordinates with multiple service systems to provide responsive and outcomes-driven approaches to care. As this system changes and grows, ongoing improvements are made that incorporate the experiences of the recovery community, families and other recovery allies.

The framework offered through a ROSC can be viewed as a tool to be used by state departments, communities, treatment and recovery support providers to improve and modify present service structures to better serve those affected by addiction. Throughout the development, refinement and implementation processes, the input of individuals and families in recovery (and others affected by AOD problems) must be sought and incorporated within the ROSC framework. This input is critical to establishing realistic goals and priorities that will broaden the continuum of care in Pennsylvania while expanding opportunities for recovery.

Defining the Recovery Community

The Recovery Community is a term used to convey the sense of shared identity and mutual support of those persons who are part of the social world of recovering people. The recovery community includes individuals in recovery, their family and friends, and a larger circle of "friends of recovery" that include both professionals working in the addictions field as well as recovery supporters within the wider community.

Defining a Recovery Community Organization (RCO)

Recovery Community Organizations (RCO) are grassroots community-based organizations, primarily non-profit, that are involved in public education, policy advocacy and the delivery of peer-based recovery support services. RCOs differ significantly from addiction treatment organizations and self-help groups as they put a face on recovery and promote a central organized vehicle to mobilize resources, reduce stigma, and provide recovery support services. These organizations are led by individuals representative of the recovery community. These organizations are committed to recovery-related social change (e.g., recovery-focused

community education, advocating pro-recovery social policies) and they make considerable contributions to organizing recovery resources within their local communities. RCOs celebrate multiple pathways of recovery and offer services and support to help people access and sustain long-term recovery in the community.

RCOs bridge the gap between clinical treatment and long-term recovery through the provision of peer-based recovery support services. RCO staff and volunteers do ***not*** provide clinical assessments nor do they provide addiction counseling or other clinical services. Other distinctive characteristics of RCOs are their conscious effort to achieve cultural diversity and their emphasis on leadership development within the recovery community (e.g., building advocacy skills as part of taking personal responsibility for one's citizenship). The focus of RCOs is on a person's recovery and their strengths rather than the disease.

Peer-Based Recovery Support Services

Peer-based recovery support services (P-BRSS) are non-clinical services provided by peers in the recovery community that assist individuals and families to recover from AOD problems. These services do not replace, but rather augment and compliment the focus of treatment, outreach, engagement and other strategies and interventions to assist people in recovery to gain the skills and resources needed to initiate, maintain and sustain long-term recovery.

P-BRSS include:

> ***Peer-Identified Services:*** programming, services or events that are identified as a need, problem or opportunity by members of a recovery community.
>
> ***Peer-Initiated Services:*** programming, services or events that are initiated by members of the recovery community for members of the recovery community, but may be provided by others.
>
> ***Peer-Delivered Services:*** programming, services and events that are delivered by peers to peers.

P-BRSS aim to remove personal and environmental obstacles to recovery through the provision of child care, transportation, housing, skill building, employment, etc. These services enhance identification of and participation in the recovery community through connecting people to treatment, 12-step and other mutual support groups and recovery support services including faith-based initiatives. P-BRSS strive to increase the person's "recovery capital" by assisting people in addressing their basic needs, gaining employment, going back to school, forming healthy social relationships, and encouraging leadership development. These services are anchored in the community and offered in many different settings: recovery centers, halfway houses, recovery houses, transitional living programs, missions, ministries, shelters, and informal settings. Some services require reimbursement, while others, such as mutual support groups, may be available in the community free of charge depending on the location and available resources.

P-BRSS are provided by non-profit organizations; grassroots organizations (such as RCOs); faith-based organizations (churches, missions, and other religious-based organizations); as part of a treatment provider system by a Certified Recovery Specialist (CRS) and other community-based organizations. Organizations typically utilize peer volunteers or paid staff members from the recovery community who are familiar with their community's resources to support the needs of people seeking to live free of AOD. The experiential knowledge and expertise in the areas of addiction and recovery make these individuals uniquely qualified to aid others new to the recovery process. These services are a vital component of a ROSC and to the success of individuals and families in recovery.

Four Models of Social Support

Research has shown that recovery is often facilitated by social support (McLellan et al., 1998). P-BRSS are based on the concept that a crucial factor in helping people move along the recovery continuum is social support. These services are designed to initiate, sustain and enhance the recovery process (White, 2007). A federally-funded program, known as the Recovery Community Support Program (RSCP), has identified four types of social support useful in organizing community-based peer-to-peer services. Four models of social support include:

Informational Support **-** characterized by assistance with knowledge, information, and skills (training, education);

Instrumental Support **-** characterized by concrete assistance in helping others get things done (e.g. transportation to support groups, clothing, job application assistance, supplement services, food assistance, child care, etc.);

Emotional Support **-** characterized by demonstrations of empathy, care and concern and is often demonstrated through mentoring, coaching, support groups and peer-to-peer recovery support services;

Affiliational Support **-** characterized by the feeling gained by being connected to others, and having a social group and/or community.

The more robust the types of social support available to address a multitude of recovery concerns, the more likely that a person seeking help will walk away with useful information, new insights and skills, and a feeling of confidence as they assist with the tasks ahead.

The value of P-BRSS cannot be overemphasized. These services promote long-term recovery; minimize occurrences and impact of relapse; minimize negative effects during early intervention/recovery; offer identification for those new to the recovery process; provide non-threatening and non-hierarchical approaches services; reduce costs to systems, communities, individuals and families; provide a bridge into the recovery community; promote responsible citizenship and volunteerism; and inspire hope for a new way of life.

Types of Peer-Based Recovery Support Services

P-BRSS include but are not limited to:

- Mentoring programs (Peer Support Mentoring Program, Mentor+, Inside-Outside Program, Youth Mentoring, Re-entry Services)
- Training and education (life skills, job skills, health/wellness, GED prep classes, etc.)
- Community-level recovery education (Children & Youth Agencies, Probation/Parole, District Attorney, etc.)
- Outreach (pre, during and post treatment)
- Parent education and child development services (Family Programs)
- Recovery-focused youth programs
- Information lines
- Telephone recovery support (recovery check-ups)
- Recovery planning
- Support groups
- Resource brokering - Basic needs (food, clothing, employment, personal care items, utilities, etc.), services and support
- Housing - sober housing, recovery houses, transitional living and shelters (with the goal being independent living)
- Transportation (peer service to and from some treatment settings, recovery groups, bus tokens etc.)
- Recovery case management and service coordination
- Peer to peer services provided by Certified Recovery Specialists (CRS), recovery coaches, peer providers, peer mentors, etc.
- Liaison (bridging, brokering/negotiating, partnering, resource mobilization) between individual, family, organizations and community
- Vocational and employment services/supports
- Faith-based services/supports (wide range of recovery and community support)
- Referral support (employment, food, shelter, clinical and medical services)
- Relapse prevention
- Recovery advocacy (individuals, families and communities)
- Recreation/social events (rallies, walk-a-thons, picnics, dances, breakfast/dinner events, sports leagues, companionship, etc.)
- Internet support

Peer-based recovery support services should not be confused with, or used to replace traditional treatment and other professional services. They are designed to augment such services and have their own place in the service continuum. The importance of such services cannot be emphasized enough. To truly create a ROSC, peer-based recovery support services are essential.

While some services may be similarly provided by the professional and the peer support service provider (for example, advocacy or transportation might be provided by a case manager or the peer volunteer), the difference may be apparent in the intensity of need experienced by the individual receiving the service, the level of expertise required in delivering the intervention or service to a particular individual, or the setting in which the service is rendered. Again, it is important to note that P-BRSS are meant to enhance an individual's recovery efforts. This enhancement can occur as an adjunct to professional intervention or where appropriate, in place of such interventions/services. These services offer opportunities to enhance linkages between the existing treatment agencies and local indigenous recovery support systems (White, 2004).

Recovery-Focused Trainings/Resources

P-BRSS differ from traditional treatment and professional services. Treatment services are typically more formal and clinical in nature and professional services can range anywhere from medical to psychological therapy to legal counsel, etc. Peer-based support services are less formal, not clinical and are specifically designed to be delivered by peers. These services focus on recovery, not intervention or cessation, and issues affecting the person in or seeking recovery. This distinction speaks to the need for specialized training designed both for the persons delivering the services and for professionals who will refer clients for these services.

(See Appendix II for Training Resources)

Barriers and Challenges to Implementing a Recovery-Oriented System of Care

Systems undergoing change—especially those as complex as systems delivering services for alcohol and other drug problems—face barriers and challenges to altering the "status quo". These barriers and challenges include issues related to infrastructure, regulation, and financing as well as conceptual and attitudinal shifts that must be made. Resistance to change is to be expected as people and institutions worry about their roles, positions, and possible change in status. In addition, attitudes and stigma about people in recovery can undermine the process. Creating a recovery-oriented system of care, which involves changes at all levels of the substance use disorders service delivery system, certainly presents some challenges; however, we believe through identification, communication, collaboration and cooperation, we can overcome these barriers to create a system that effectively promotes and supports recovery.

As we shift into a ROSC in Pennsylvania, we realize challenges and barriers exist. Some of these include:

- Conflicting priorities that hinder the shift from an acute model of care to a chronic model of care
- Absence of a universal understanding of recovery

- Overarching societal stigma toward those affected by the disease of addiction
- Disregard for scientific evidence that addiction is a disease
- Lack of acknowledgement of the benefits of a ROSC
- Fragmented system
- Implementation of a ROSC impeded by existing financial constraints
- Absence of dedicated funding streams for recovery support services
- Difficulty in engaging and retaining adequately trained staff
- Limited understanding of the components necessary for ROSC transformation
- Our inability to meet present needs with available resources

There are successful models within the state of Pennsylvania that have effectively and efficiently integrated ROSC principles, practices and services into their existing system; however, a statewide infrastructure is not in place to support replication and local adaptation in all areas of the state. Our committee believes it is critical to develop such an infrastructure that supports and promotes statewide replications. In addition, we recognize that there may be recovery organizations already providing such services and support that remain unknown to us. It is our hope that these organizations will come forth and join us in the statewide transformation process. Their participation will help to establish a complete and unified approach to statewide infrastructure development.

The overall challenge in moving to a ROSC is maintaining quality standards while preserving the uniqueness of P-BRSS and integrating these services into a more structured system. Utilizing RCOs and faith-based organizations to provide services are critical components of a ROSC. Preserving their status as non-professional grassroots entities is a key factor in maintaining a recovery focus.

Developing a financial structure that supports and sustains recovery support services is another challenge that PA may face as we move toward a ROSC. Without secure financial support, an effective ROSC will not be possible.

Other challenges faced in system transformation cited by a number of states include:

- Maintaining ongoing communication between licensed clinical treatment providers and nontraditional recovery support services providers
- Maintaining the “peer-ness” of peer recovery support services and resisting the pressure to “professionalize” these services, while ensuring quality services and successful outcomes
- Resisting pressure to replace clinical services with recovery support services due to limited resources and budgetary constraints
- Adequate role function and supervision of peers to avoid overlap and role ambiguity
- Implementing a statewide program within a commonwealth structure
- Obtaining reliable evaluation and outcome data to support the efficacy of recovery support services

- Adapting a model to deal with demographic uniqueness of the state

In order to overcome these barriers and challenges, a combined and orchestrated effort will be required to accomplish the implementation of a ROSC. Departments and agencies will have to work together in the spirit of cooperation, putting aside mistrust and "turf" issues that so often are present in such endeavors. However, if all parties approach this with the foreknowledge that this endeavor is not meant to usurp anyone's autonomy, or eliminate existing services, the process will become less threatening.

- Ensure adequate funding and resources are available to promote and sustain recovery across the life span (including financial support for prevention, treatment and recovery support).
- Ensure that recovery support services are available before, during and after formal treatment and when formal treatment is not warranted.
- Review organizational, regulatory, and funding mechanisms for needed changes to support a ROSC.
- Utilize existing RCOs to provide technical assistance to newly formed grassroots organizations.
- Create opportunities for career development and growth that recognizes and validates personal experience.
- Assure a collection of reliable evaluation data is maintained across the system.

Recommendations for Implementation of a ROSC

A ROSC is as complex and dynamic as the recovery process itself. This system must be designed to support individuals seeking to overcome their AOD problems across their lifespan. One of the critical values of a ROSC is the recognition that each person is the agent of his or her own recovery and all services can be organized to support recovery. Person-centered services offer choice, respect each person's potential for growth, focus on one's strengths, and support the overall health and wellness of an individual living with the disease.

Systems Change

In order to move to a ROSC, philosophical and systems change would need to be rooted in state and county government policy and procedure. To do so it will be necessary to develop a statewide infrastructure that facilitates and supports the implementation of recovery-focused values, principles and services. This will promote the highest degree of independent functioning and quality of life for all individuals affected by AOD problems.

Systems change will require the utilization of promising practices related to locus of service delivery and shaping of the post-treatment recovery environment. Such practices may consist of linkages to the recovery community, in-home and neighborhood-based services, recovery-focused social clubs, recovery support centers, recovery houses, and community outreach by individuals and families in recovery. A comprehensive menu of services and supports will need

to be developed that can be easily accessed and readily adjusted to meet the individual's needs and chosen pathway to recovery. Individuals should have access to a full continuum of care regardless of the system they enter or the community in which they live. Treatment and recovery support services must be integrated into a single, seamless continuum of care that is driven by an individual's needs.

BDAP, OMHSAS, Governor's Policy Office and all other affiliated agencies will need to establish coordination with multiple systems and services to provide responsive, outcomes-driven approaches to care. Request for Proposals (RFPs) can be utilized to solicit recovery-oriented services and recovery support from credible and established organizations to work in tandem with existing treatment providers, or independently as the case may be.

In order to support this statewide system change, a Management Information System (MIS) must be created to capture a wide array of information regarding service delivery and outcomes. MIS can be utilized to gather outcomes data for review, upgrade, ongoing monitoring, and evaluation of services and service delivery. By conducting a statewide inventory of recovery-focused services and supports, it will be possible to develop a directory of recovery support services.

It would also be important to establish a statewide Recovery Resource Center that could serve as a clearinghouse for resources on addiction, recovery and P-BRSS. This Center could also serve as a central location for training, technical assistance and other forms of support to individuals, groups and organizations as they as move through the system transformation process.

Organizational Change

In addition to statewide changes, transformation will need to occur at the organizational level as well. All recovery organizations, treatment providers, and other community-based organizations will need to assess their capacity to provide recovery-oriented services and supports, as well as their ability to respond to an individual's culture, beliefs and pathway to recovery. All policies, job descriptions and organizational structures should be revised to include recovery-oriented language, job functions, and services. Existing training providers should be utilized to educate staff on recovery, recovery support services, and ROSC (See Appendix III for Training Resources and Providers).

Within this system of care, each treatment provider will need to implement a recovery-focused philosophy along with clinical interventions to assure that services to individuals, families and communities affected by addiction are directed toward the ultimate goal: long-term recovery in the community. This would include program development, staff recruitment, orientation and training (knowledge, skills and attitudes), modeling core recovery values, case consultation, monitoring, performance evaluation and program evaluation. Currently utilized assessment tools will have to be expanded to gather more comprehensive information to promote long-term recovery. It is strongly recommended that treatment providers establish partnerships with P-BRSS providers in order to complement clinical treatment services and support an integrated, seamless continuum of care. In forging these partnerships, it is important to recognize and respect the special contributions made by faith-based communities, RCOs and recovery support providers to the treatment and recovery processes.

Inclusion of Individuals and Families

Individual and family participation is crucial to the successful implementation of a ROSC. They should be utilized as facilitators in training and educating professionals, legislators, and the community on addiction, treatment and recovery support services. A balanced, cross representation of recovering individuals and family members should be utilized at all levels of decision making in the system. Individuals and family members are valuable resources to be utilized in conducting ongoing forums/presentations; public speaking engagements; conference workshops (including ancillary fields); meeting with legislators, policy makers, local government; and for information dissemination (brochures, participants, web sites, etc.).

To assure effective implementation of an ROSC, BDAP and OMHSAS must establish an advisory structure consisting of a diverse representation to include individuals in recovery, family members, and representatives from education, housing, treatment and prevention, criminal justice, children and youth, mental health and others that serve individuals and families affected by addiction. This advisory structure should be involved in the development of policies regarding prevention, intervention, treatment and recovery support services. It can be called upon to monitor an ongoing quality improvement process to ensure inclusion on every level, as well as to host regional needs assessments throughout the state to gain vital input on services and support needed to sustain long-term recovery. Additionally, the advisory structure could develop and administer surveys to gather statewide stakeholder input critical to the development, implementation, and ongoing evaluation of the ROSC.

Funding Strategies to Support Recovery-Oriented Systems of Care

It is necessary to "think outside the box" and remain open to new possibilities when establishing funding to adequately support a ROSC. State Departments and administrators will need to be resourceful and innovative in providing funding within a system that is already strained to deliver the current regimen of services. Emphasis should be placed on collaboration among alternative funding streams from state, regional and local agencies that provide additional services to clients with alcohol and other drug addiction (e.g., criminal justice system, child welfare, education, juvenile justice, etc.).

***Reinvestment Dollars* -** Utilize reinvestment dollars through the Health Choices system to support recovery support services (e.g. Recovery Housing, Recovery Checkups, and CRSs).

External, Federal and Other Grants – Pursue funds to reframe existing funding allocations & services, include Medicaid reimbursement for CRSs.

Funding Partnerships – Establish partnerships with criminal justice, child welfare, mental health and related fields, private non-profits, academic communities, and others in order to develop new funding options of individuals in need of services.

As new funding opportunities arise, we should remain open-minded and receptive to working in collaboration with others to secure funding needed for systems transformation. A strategic plan

should be implemented for statewide system transformation, even if new dollars for this process have not been identified.

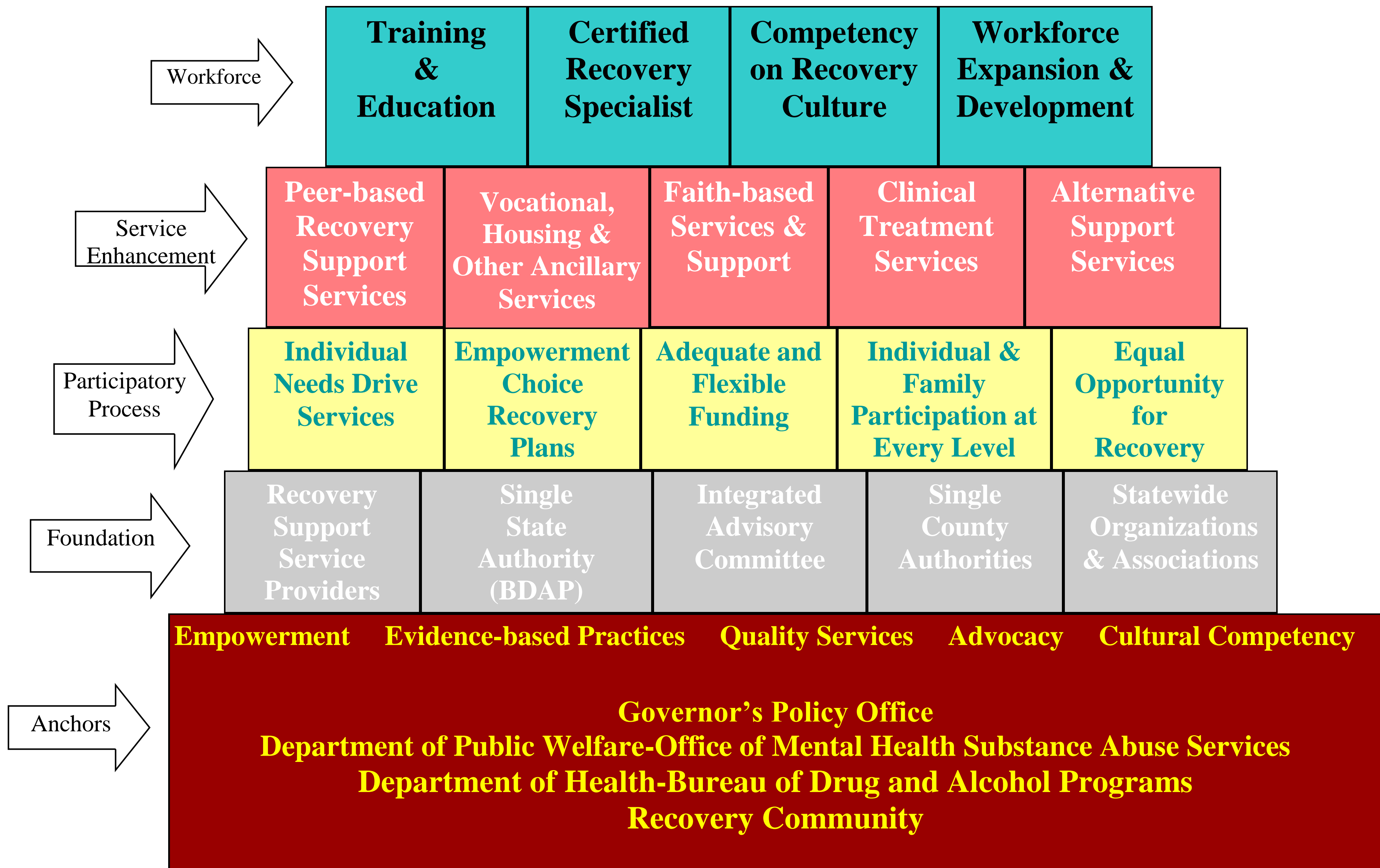
Summary and Final Thoughts

Systems change requires conceptual clarity, organizational commitment, and strong leadership. To effectively implement systems change in Pennsylvania, a strong infrastructure will be needed to support this process including staff planning and management resources, training and education. Definition and delineation of roles and responsibilities will be necessary to prevent confusion; however, the number one priority for this change to be truly successful will be to send a clear and consistent message across the state educating all parties concerned as to what a ROSC is and what their roles are going to be. It is not necessary to have a perfect plan to begin the change process, but it will be essential for there to be strong, consistent and resilient leadership promoting the process. Change agents throughout our state can greatly assist in the implementation process; ones that promote transparency among partners and that emanate credibility and authenticity. Continual communication is essential to secure a commitment from others and to assure optimum progress in the system transformation process. All parties involved with this change will need to enter into it with a firm commitment to see it through. A concerted and prolonged effort will be required in order for a ROSC to reach fruition in Pennsylvania.

Achieving both a recovery-oriented system of care and the implementation of a recovery management philosophy requires substantial changes in treatment philosophies, funding strategies, regulatory policies and monitoring protocols, clinical and support service menus, service relationships, roles and responsibilities, the training and supervision of staff and volunteers, and intra- and inter-organizational relationships. The findings of the literature as well as the RBI committee support addiction treatment system redesign efforts focused on: infrastructure enhancement; early intervention and improvements in service access and therapeutic engagement; improved systems of individual, family, and community assessment; broadening institutional and professional resources involved in service delivery; a shift in the service relationship to a partnership model; elevating the scope, quality, and duration of service delivery; assertively linking individuals and families to communities of recovery; providing post-treatment monitoring, support, and early re-intervention services to all clients/families for up to five years following completion of primary treatment; and the systematic collection of long-term, post-treatment recovery outcome data for all clients/families admitted to addiction treatment programs.

It is time we proactively managed the prolonged course of addiction and recovery rather than focusing on episodic biopsychosocial stabilization.

Systems Change in Pennsylvania



References

Center for Substance Abuse Treatment. National Summit on Recovery: Conference Report. DHHS Publication No. (SMA) 07-4276. Rockville, MD: Substance Abuse and Mental Health Services Administration 2007.

Center for Substance Abuse Treatment, What are Peer Recovery Support Services? HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

Kaplan, L., *The Role of Recovery Support Services in Recovery-Oriented Systems of Care.* DHHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2008.

Kirk, T., Evans A., and Dailey, W. (2005). Implementing a Statewide Recovery--Oriented System of Care: From Concept to Reality.

Recovery-Oriented Systems of Care – Perspectives from Cities and States. Recovery Symposium, Phila, 2008). Retrieved from:
http://www.ireta.org/ireta_main/philly/IRETARecoverySymposium2008.ppt

Taitt, S., Stein, J., & Whitter, M. (2008). *Recovery in the Community: An Emerging Framework- A Recovery-Oriented Systems Approach*. Presentation at the SAAS National Conference & NIATx Summit, Orlando, Florida on June 22-25, 2008.

White, W. (2002). An Addiction Recovery Glossary: The Languages of American Communities of Recovery. Retrieved from: www.bhrm.org/advocacy/add-rec-glossary.pdf.

White, W. (2009). *Recovery Management and Recovery-oriented Systems of Care*. Counselor: 10:1 February 2009.

White, W. (2004b). The history and future of peer-based addiction recovery support services. Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC.

White, W. (2006). *Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity.* (Monograph) Philadelphia, PA: Philadelphia Department of Behavioral Health.

White, W. & Kurtz, E. (2006b). *Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches*. Pittsburgh, PA: IRETA/NeATTC

APPENDIX I: Acronyms/Abbreviations

This list of Acronyms that may be used as PA moves toward a Recovery-Oriented System of Care.

Acronym	Meanings
AA	Alcoholic Anonymous (Support Groups)
AC	Acute Model
AL-ANON	A 12-Step support group for families
AOD	Alcohol and Other Drugs
ASAM	American Society of Addictions Medicine (Criteria)
ASI	Addiction Severity Index
ATTC	Addiction Technology Transfer Center
ATOD	Alcohol, Tobacco and Other Drugs
BDAP	Bureau of Drug and Alcohol Programs
CAC	Certified Addictions Counselor
CC	Case Coordination
COD	Co-Occurring Disorders
CRS	Certified Recovery Specialist
CSAT	Center for Substance Abuse Treatment (Dept. of SAMHSA)
D&A	Drug and Alcohol
DASPOP	Drug and Alcohol Service Providers Organization of Pennsylvania
DOH	(Pennsylvania) Department of Health
DPW	(Pennsylvania) Department of Public Welfare
EDI	Easy Does It, Inc.
ETOH	Alcohol
HC	HealthChoices
HMO	Health Maintenance Organization
ICM	Intensive Case Management
IOP	Intensive Outpatient
IRETA	Institute on Research, Education and Training in Addictions
IVDU	Intravenous Drug User
LAAM	Levo-Alpha-Acetyl-Methadol
LSW	Licensed Social Worker
LTC	Long Term Care
MA	Medical Assistance
MC	Message Carriers of PA, Inc. - RCO in western PA
MCO	Managed Care Organization
MH/MR	Mental Health/Mental Retardation
MH	Mental Health

Acronym	Meanings
MR	Mental Retardation
MOU	Memorandum of Understanding
MSW	Master of Social Work
NA	Narcotics Anonymous
NA	Narcotics Anonymous
NAMI	National Alliance for the Mentally Ill
NAR-ANON	A 12-Step support group for families
NCADD	National Council on Alcoholism and Drug Dependence
NIAA	National Institute on Alcohol
OCYF	Office of Children, Youth and Families
OMAP	Office of Medical Assistance Programs
OMHSAS	DPW State Office of Mental Health and Substance Abuse Services
OP	Outpatient
PACDAA	PA Association of County D&A Administrators
PAW	Post Acute Withdrawl
P-BRSS	Peer Based Recovery Support Services
PCB	PA Certification Board
PCPA	Pennsylvania Community Providers Association
PCPC	PA Client Placement Criteria
POM	Performance Outcome Measures
PRO-A	PA Recovery Organizations Alliance - statewide RCO
PRO-ACT	PA Recovery Organization-Achieving Community Together - RCO in southeastern, PA
PSA	Public Service Announcement
RASE	The RASE Project, Inc. - RCO in central PA
RCSP	Recovery Community Support Program
RM	Recovery Management
RC	Recovery Checkup
RCO	Recovery Community Organization
ROSC	Recovery Oriented System of Care
RP	Recovery Plan
RSS	Recovery Support Services
SAMHSA	Substance Abuse and Mental Health Services Administration
SAP	Student Assistance Program
SCA	Single County Authority
SSA	Single State Authority (BDAP)
TP	Treatment Plan

APPENDIX II: Glossary of Terms

Abstinence – Refraining from the use of alcohol and other drugs.

Addiction – A chronic, disease characterized by compulsive (loss of control) drug-seeking and drug-taking behavior despite adverse health, social, or legal consequences to continued use.

Addiction Ministry – Refers to the outreach, treatment and recovery support services offered through the auspices of local churches as part of their ministry to their community. The rise in addiction ministries, particularly within African American communities, constitutes one of the most significant developments in the modern history of recovery support structures.

Advocacy – See "Recovery Advocacy"

Alcoholism – A disease characterized by excessive and habitual drinking of alcoholic beverages that causes physical, psychological, and social harm.

Anonymity – A concept in 12-Step programs that provides protection for its members from being identified as an individual with an addiction (including alcoholism).

Assessment – The process of interviewing an individual to obtain the sociological background, psychological makeup, educational and work history, family and marriage difficulties and medical issues to better assess an individual's needs.

Behavioral Health Disorder – A term used to describe adjustment problems, behavioral issues, mental health and alcohol and other drug related disorders.

Boundaries – Limits that protect the space between the professional's power and the client's vulnerability.

Buprenorphine – A prescription medication for people addicted to heroin or other opiates that acts by relieving the symptoms of opiate withdrawal such as agitation, nausea and insomnia. This medication is also used for pain management.

Chemical Dependency – A general term used to describe a physical and/or psychological reliance on alcohol and other drugs.

Chronic Diseases – Disorders that cannot be cured with existing medical technologies and whose symptoms wax and wane over an extended period of time. These disorders often spring from multiple, interacting etiological roots; vary in their onset from sudden to gradual; and are highly variable in their course (pattern and severity) and outcome. The prolonged course of these disorders places a sustained strain on the adaptation resources of the individual and his or her family and friends. Chronic addictive disorders call for a process of sustained recovery management

Certified Recovery Specialist (CRS) – One who possesses the necessary knowledge, skills and abilities to safely and effectively provide peer based recovery support to individuals in recovery from chemical dependency.

Confidentiality – The non-disclosure of certain information except to another authorized person.

Continuity of Contact – A phrase used to underscore the importance of sustained, consistent support over the course of recovery. Such support can come from living within a community of shared experience and hope. The phrase also refers to the reliable and enduring relationship between the recovery coach (recovery support specialist) and the individual being provided recovery management services. Such sustained continuity is in marked contrast to the transience of relationships experienced by those who have moved through multiple levels of care or undergone multiple treatment relationships

Craving – A strong, nearly irresistible desire to use alcohol and other drugs.

Cyber Support – See "Virtual Recovery"

Denial – The failure of a person to acknowledge the reality of his/her addiction and circumstances apparent to other people.

Disease Model of Addiction – This model identifies addiction as a primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations.

Disease Management – The management of severe behavioral health disorders in ways that enhance clinical outcomes and reduce social costs. Its focus is on developing technologies of symptom suppression and reducing the number, intensity and duration of needed service interventions.

Enable – Any intervention that, with the intention of helping the individual, inadvertently results in the continuation of their addiction and destructive behaviors. Enabling is often unintentional but can result in additional harm and/or destruction.

Empowerment – The process of increasing an individual's or group's capacity to make their own choices and to transform those choices into desired actions and outcomes.

Ethics – A standard of behavior by which certified professionals must abide.

Evidence-Based Practices (EBP) – Clinical and service practices that have scientific support for their efficacy (work under ideal conditions) and effectiveness (work under real conditions). Advocacy of evidence-based practice is a commitment to use those approaches that have the best scientific support, and, in areas where research is lacking, a commitment to measure and use outcomes to promote those practices that have the greatest impact on the quality of life of individuals, families and communities.

Faith-Based Recovery – Addressing alcohol and other drug problems within the framework of religious experiences, beliefs, and rituals and within the mutual support of a faith community. Faith-based recovery frameworks may serve in conjunction with traditional recovery support programs or serve as alternatives to such programs.

Family-Centered Care – Refers to a treatment philosophy in which the family, rather than the individual, is the primary "client." Such philosophies are usually implemented by offering family

members clinical services that focus on their problems and needs and offering a continuum of pre-treatment, treatment, and recovery support services.

Family Disease – Refers to ways in which all members of the family are affected by the disease of addiction.

Halfway Houses – A state licensed and regulated community-based residential treatment facility that is professionally staffed and managed in a supportive chemical-free environment. Programming emphasizes independent growth and responsible community living that serve to integrate persons in care with local communities in recovery and in developing self-sufficiency through counseling services, vocational, employment development and other services. A number of these programs are enhanced with staff medical and psychiatric personnel to assist people with co-existing bio-psychosocial needs.

Home Group – The term given to a 12-Step self-help meeting that is most regularly attended by an individual. It is the inner circle in which one's recovery is forged and in which most milestones of recovery are celebrated. A home group is that meeting where a person makes the most significant personal commitment.

Higher Power – In the 12-Step tradition, the personification of a positive power "greater than ourselves" that can facilitate recovery and restore sanity to the individual.

Intervention – The process of precipitating a change-eliciting crisis in the life of a person experiencing a substance use disorder by conveying the consequences of his or her behavior on family, friends and co-workers.

Medication-Assisted Recovery – The use of specific medications designed to assist in recovery.

Mentor – To serve as a trusted counselor or teacher, or as a guide in the recovery process.

Methadone – A synthetic narcotic, similar to morphine but effective orally, used in the relief of pain and as a heroin substitute in the treatment of heroin addiction.

Missions/Ministries/Shelters – Facilities that strive to meet the needs of homeless individuals providing food, shelter, medical care, spiritual support, counseling, and other mutual support programs.

Mutual Aid Group – See Self-Help

No Wrong Door – A trained and integrated system available to all individuals where they can go to any social service agency to find the information and referral they are seeking.

Pathways to Recovery – The many different ways people use to successfully achieve recovery.

Powerlessness – The acknowledgement of one's inability to control the frequency and quantity of his/her alcohol and/or other drug use as well as other circumstances beyond one's control.

Recovery – A highly individualized journey that requires abstinence from all mood and mind-altering substances that may be supported through the use of medication that is appropriately

prescribed and taken. This journey is a voluntarily maintained lifestyle that includes the pursuit of spiritual, emotional, mental and physical well-being that is often supported by others.

Recovery Advocacy – The process of educating and exerting influence toward the development of pro-recovery social policies, programs and actions.

Recovery Capital – The quantity and quality of both internal and external resources that a person can bring to bear on the initiation and maintenance of recovery

Recovery Centers – A recovery oriented sanctuary anchored in the heart of the community that promotes maximum participation. Recovery Centers are places where recovery support services are designed, tailored and delivered by individuals from local recovery communities. Recovery Centers also utilize volunteers from the recovery community.

Recovery Coach – A person who helps remove personal and environmental obstacles to recovery, links the newly recovering person to the recovery community, and serves as a personal guide and mentor in the process of personal and family recovery. Such supports are generated through mobilizing volunteer resources within the recovery community, or provided by the recovery coach where such natural support networks are lacking.

Recovery Community – A term used to convey the sense of shared identity and mutual support of those persons who are part of the social world of recovering people. The recovery community includes individuals in recovery, their family and friends, and a larger circle of "friends of recovery" that include both professionals working in the addictions field as well as recovery supporters within the wider community.

Recovery Community Organizations (RCOs) – Independent, grassroots, collaborating organizations led and governed by representatives of local communities of recovery. Public education, community mobilizing, policy advocacy and peer-based recovery support services are some of the strategies used by these organizations to promote and support recovery.

Recovery Culture – A unique social network of recovering individuals that has its own recovery based history, language, rituals, symbols, literature, institutions and values.

Recovery Environment – A term indicating that recovery flourishes in communities that build the physical, psychological, social, and spiritual sanctuaries where healing can occur.

Recovery Houses/Transitional Living Programs/Oxford Houses – An unregulated, unlicensed residence or facility that does not provide treatment but may offer a safe, drug-free environment for newly recovering individuals who are not yet ready to live independently in the community. While these programs are not presently licensed and monitored in the state of Pennsylvania, other forms of monitoring and oversight may exist.

Recovery Management – A philosophy of organizing addiction treatment, prevention, and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery.

Recovery Movement – Collective efforts of grassroots organizations of recovering people and their families whose goals provide a message of hope about the long-term recovery from addiction, and to advocate for public policies and programs that help initiate and sustain recovery.

Recovery-Oriented System of Care (ROSC) – A system that supports person-centered and self-directed approaches to care that build on strengths and resilience. Individuals, families, and communities take responsibility for their sustained health, wellness, and recovery from alcohol and other drug related issues through the various life phases of recovery.

Recovery Outcomes – The degree of individualized benefits achieved as a result of recovery including everything from the cessation of use of alcohol and other drugs, to the total transformation of personal identity, character and lifestyle.

Recovery Plan – An individualized plan that focuses on personal recovery management.

Recovery Process – The ongoing development of healthy behaviors and attitudes that support a more productive lifestyle.

Recovery Support Groups – See "Self-Help Groups"

Recovery Support Services – Practical, non-clinical services designed and delivered by individuals and families in recovery to meet the needs of others. These community-based services serve to strengthen and enhance those offered through the addiction treatment system to help prevent relapse and promote long-term recovery.

Relapse – The process of returning to active alcohol and/or other drug use after a period of abstinence. Relapse may be part of the recovery process.

Self- Disclosure – The intentional telling of personal information about oneself that would not be readily known by others, including one's thoughts, feelings, past experiences and future plans.

Self-Help Groups – Groups of individuals who share their experience, strength and hope about recovery from addiction to help each other through the recovery process.

Social Service Agencies – Formalized professionalized organizations that provide ancillary support services.

Speakers Bureau – See "Story Telling"

Sponsorship – The practice within a 12-Step program of one recovering person guiding another through the Steps and Traditions of a the 12-Step program.

Story Telling – The process by which recovering people share their experience with others as acts of self-healing and service. Story telling is used as a stigma reducing service.

Substance Use Disorders – Those disorders in which repeated use of alcohol and/or other drugs results in significant adverse consequences.

Treatment – A continuum of clinical activities provided by licensed facilities designed to minimize or arrest the harmful effects of alcohol and other drug disorders. Through this process the individual's physical, psychological, and social level of functioning should improve.

Treatment Plan – Outlines the mutually acceptable goals to be accomplished in treatment based on a comprehensive assessment of the client. The Treatment Plan provides the roadmap for the treatment process by identifying long and short term goals, action steps necessary to achieve them and the type and frequency of treatment.

Tolerance – The need for increased amounts of a drug to achieve intoxication or a desired effect.

Twelve-Step (12-Step) – A program designed to assist in the recovery from addiction or compulsive behavior, especially a spiritually-oriented program based on the principles of acknowledging one's personal insufficiency and accepting help from a higher power.

Using – Actively consuming alcohol and/or other drugs.

Virtual Recovery – The achievement or maintenance of recovery through Internet support groups with limited or no participation in face-to-face support meetings.

Withdrawal – The characteristic signs and symptoms that appear when a drug that causes physical dependence is regularly used and is suddenly discontinued or decreased in dosage.

APPENDIX III: TRAINING RESOURCES

The following is a list of various training providers that offer recovery-focused trainings.

National Trainings

- Faces and Voices of Recovery
- The Johnson Institute
- CASA/Join Together
- IRETA – Northeastern Technology Transfer Center (NeATTC)
- SAMHSA-Center for Substance Abuse Treatment (CSAT)

Statewide Training

- Bureau of Drug and Alcohol Programs (BDAP)
- PA Certification Board
- PRO-A Recovery Institute (RI) Training Program
- PRO-A Annual Recovery Conference

Regional Trainings

- PRO-ACT
- RASE Project
- Message Carriers

Other Recovery-focused Resources

- Website Resources
- Periodicals and Publications
- Hotlines
- Helplines/Recovery Support Lines
- Contact
- PRO-A Helpline
- PRO-ACT Helpline
- Family Access Line
- Hotlines/Helplines by12-Step Programs

APPENDIX VI: RESULTS OF FOCUS GROUP SURVEYS

The Needs Assessment Process

People seeking recovery often face a variety of barriers that challenge their ability to find and sustain their recovery. These include issues such as finding appropriate housing, employment, child care, transportation, medical care, etc. Many of these issues are often addressed through recovery support services but many individuals and families are not aware that these services exist.

The Recovery-based Issues Committee conducted focus groups in the central, southeast and western regions of Pennsylvania to gather critical information from the recovery community on the need for recovery support services throughout the state. Needs assessment surveys were designed and administered to individuals and families in recovery from the different regions. Questions were designed to gather information regarding specific areas of need as well as preferred recovery support services.

Results from the focus group surveys are included in the following pages.