PRO·A
Pennsylvania Recovery Organizations Alliance
900 S Arlington Ave, Suite 254A
Harrisburg, PA 17109-1014

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Recovery Issues & Improvements
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Testimony on Recovery Funding
William Stauffer LSW, CCS, CADC

Recommendations and Overview of PRO-A & Recovery Community Organizations

I want to thank the Senate Democratic Policy Committee for including me here today. To start, the *most underutilized resource we have to support addiction recovery* are the thousands of Pennsylvanians in recovery and our grassroots Recovery Community Organizations (RCO)s which are authentic, independent, non-profit organization led and governed by representatives of communities of recovery, who understand and live recovery from addiction every day. Programs like Easy Does It in Berks County, or the PRO-ACT Montgomery County Recovery Community Center. Recovery is contagious - lets fund, support, strengthen, and spread it!

Overview:

- Having run the stakeholder group who made recommendations on recovery house standards, we are concerned that the new recovery house regulations have created conditions in which the thousands of marginalized people who use this housing in early recovery will not be able to afford to live in them.
- As a result of our recent efforts, we are pleased that our Department of Drug and Alcohol has identified through the Recovery Rising that the recovery community has not been funded or included in meaningful ways historically. This encompasses all recovery support services, including how recovery houses are funded and implemented. The Recovery Rising process can improve policy if conducted in truly inclusive ways open to addressing the disparate funding and exclusion of our voices in matters that impact our community.
- While addiction is one of our costliest social challenges in resources and lives, we also know that 85% of the people who reach five years of addiction recovery remain in recovery for the rest of their lives. We should focus on long term recovery as our functional system metric for severe substance use disorders (SUD).
- Policy has focused on short-term treatment and harm reduction strategies, critical, lifesaving elements of an effective care system, yet we have seen minimal investment in community-based recovery efforts. If we expanded investment in long term recovery in ways that meet the needs of the recovery community, we could save more lives, strengthen families, and heal communities.
- Strong, effective policy and interventional strategies are best developed by, and in true collaboratively partnerships with the recovery community organizations that focus on strengthen recovery capital, including recovery housing and other recovery services in these communities and expand our recovery capacity through our statewide recovery community organization.

Recommendations:

1. We should independently examine the implementation of the recovery house regulatory standards and their impact on the working poor recovery community that depends on this form of housing.
2. Similar to how we support veteran centers and senior citizen centers, we should fund 12 recovery community organizations across Pennsylvania with technical assistance funded and provided through our statewide recovery community organization to strengthen this neglected but critical resource.
3. Statewide SUD peer training has been sole sourced by DDAP through a closed door, no bid process, shutting down the marketplace, setting up a gatekeeper model beyond stakeholder input. It has already increased workforce barriers for our whole SUD system and this sole sourced training process should be eliminated.
4. Programming for SUDs tends to become punitive, over bureaucratized, and ineffective over time due to the subtle impact of implicit bias that influences how are systems address treatment and recovery needs. The recovery movement in America has focused on reestablishing our roles in these same systems. Our rallying

cry, NOTHING ABOUT US WITHOUT means that no programming should be developed without the full and equitable participation of our recovery community. Elevating and funding RCOs to help develop policy, implement programming, and participate in evaluation would improve care and support for persons with SUDs in ways that reduce discrimination and increase the effectiveness of our entire care system.

Who am I

My name is William Stauffer, I have served in many capacities within our SUD treatment and service support system for well over 3 decades. I am a licensed social worker, certified clinical supervisor and certified alcohol and drug counselor, I teach at Misericordia University and train nationally, including for Faces & Voices of Recovery the national recovery community organization. I worked in and supervised a publicly funded outpatient treatment program for ten years; I ran a publicly funded longer term residential program for 14 years and have served as the Executive Director of PRO-A for 9 years. In 2018, I testified at the US Senate Hearing on Older Adults and the Opioid Epidemic in the Senate Committee on Aging at the invitation of ranking member Senator Bob Casey. In 2019 I assisted organizing and testified at a hearing on the lack of adolescent services in Pennsylvania for the House Human Services Committee and participated in a hearing on the impact of COVID-19 on our service system in 2020. I have written extensively on the recovery in America and how to strengthen our recovery efforts across the nation. In 2019, I was honored at the America Honors Recovery event in Arlington VA with the Vernon Johnson Award as the Recovery Advocate of the year award. I have experienced the loss of close family members to addiction, and I am also a person in long term recovery for over 35 years.

What is PRO-A - The Pennsylvania Recovery Community Organizations – Alliance (PRO-A)

We are the statewide RCO, a 501C3 started in 1998 with a mission to "mobilize, educate and advocate to eliminate the stigma and discrimination toward those affected by alcohol and other substance use conditions; to ensure hope, health and justice for individuals, families and those in recovery." We have worked collaboratively to develop recovery initiatives across five PA administrations. We have over 5,000 members and membership **has always been free**. We provide education, training, and technical assistance across the state of Pennsylvania.

- The federal government modeled the very approach that led to the development of RCOs by acknowledging and supporting that people in recovery are the experts on recovery and honoring "community up" solutions.
- 24 states have statewide RCOs similar to PRO-A, many supported financially through state resources.
- We were born out of the national New Recovery Advocacy Movement, predicated on the belief that no policy or service should be developed without the full participation of the authentic recovery community.
- These concepts were historically embraced across our care systems and heavily influential in the development of Recovery Oriented Systems of Care (ROSC) in PA. It established collaborative efforts across several departments of government and with recovery community stakeholders over several decades.
- Peer recovery support services provided by authentic recovery community organizations remain a fundamental element of a recovery-oriented system of care vision in Pennsylvania and beyond.
- We had historically been modestly funded through our state Single County Authority the Pennsylvania Department of Drug and Alcohol Programs but have not received any funding through DDAP since FY 2019.

Noted Work Conducted by PRO-A for the State of Pennsylvania

- Development of the Recovery Oriented Systems of Care - White Paper in 2008 through the Pennsylvania Drug and Alcohol Coalition established in collaboration with Pennsylvania Governor's Policy Office, Department of Public Welfare, Office of Mental Health & Substance Abuse Services and the Department of Health, Bureau of Drug and Alcohol Programs.
- Development of the Certified Recovery Specialists (CRS) credential with other RCOs in part with our own funding, one of the first peer credentials in the nation, designed and facilitated us to serve our needs.

- Oversight of the Certified Drug and Alcohol Recovery Housing (CDARH) Task Force for DDAP. This report assisted the hard work of this body in the passage of Act 59 of 2017.
- Authored a paper at the request of DDAP in 2018 to examine national trends to improve best practices for our recovery community. Thriving Communities in Recovery: Policy Report on National Trends, Best Practices, and Evaluation of How Pennsylvania Can Improve its Recovery Environment.
- Facilitated a series of focus groups in 2019 for our Department of Drug and Alcohol Programs on Peer Family Support Services (PFSS) to inform the development of family peer services.
- Completed a preliminary report to our Department of Drug and Alcohol Programs titled Strategic Peer Workforce Development focused on strengthening the SUD peer professional workforce that came out of our organizations grassroots efforts over the last two decades.
- We helped write a letter to Congress in February of 2021 with a other statewide RCOs to raise awareness of the lack of funding and the need to increase the block grants and to support statewide recovery community and other, regional recovery community organizations.

What is a Recovery Community Organization?

A recovery community organization (RCO) is an authentic, independent, non-profit organization led and governed by representatives of communities of recovery. These organizations organize recovery-focused policy activities, carry out recovery-focused community education and outreach programs, and/or provide recovery support services.

- There has never been an established, stable funding mechanism to support recovery community organizations in the state of Pennsylvania across all regions. Instead, funding is patchwork.
- People in recovery understand addiction and have lived experience of recovery. RCOs can support persons, families and communities struggling with addiction by fostering hope, purpose, and connection.
- Resources to fund technical assistance and anti-stigma efforts with state dollars are not being invested in our recovery organizations but instead are flowing out to national organizations or housed within academic institutions with no connection to or knowledge of our experience of recovery and facets of discrimination.

The History and Influence of Recovery Community Organizations

RCOs were funded by SAMHSA in the late 1990s. RCOs have changed the way America thinks of recovery. We introduced the notion of recovery focused care beyond traditional acute care treatment, developing peer support services and recovery messaging to help people move recovery out into the public's eye. We want a care model to support long term recovery to heal individuals, families, and whole communities.

Until 2018, PRO-A's collaborative work with our Department of Drug and Alcohol Programs (DDAP) had historically been central to its state plan (page 11):

> *"Recovery is the foundation of DDAP's work on behalf of individuals and families experiencing drug and alcohol problems. With recovery as a cornerstone of DDAP's work, it is essential that we support and promote the statewide recovery organization to ensure that we continually have representation of the faces and needs of the individuals and families that we exist to serve distinct from stakeholders in the direct service arena. It also provides a mechanism to engage and support individuals and groups across the Commonwealth concerned about the issues of addiction and recovery.*

Fragmented Recovery Community Funding

Funding for recovery community organizations has historically been quite limited. RCOs that have been able to develop have done so by cobbling together patchwork grants and service initiatives to support their missions. To strengthen recovery efforts, we need sustainable ways to develop and fund these vital community programs

- SAMHSA had long offered grants RCSP on the federal level to support RCOs to develop these models, which have greatly improved how we conceive of recovery and provide SUD care and support in America.
- There has been investment in peer services provided by Certified Recovery Specialist and Certified Family Recovery Specialists through health choices reinvestment dollars and the Center Of Excellence programs.
- Some Single County Authorities (SCA)s have chosen to support recovery community organizations. In their respective communities, we are seeing the benefits of this investment in building recovery capital.
- DDAP has offered several time limited peer service grants offered competitively across Pennsylvania for services to recovery support services, but these grants have largely gone to established human service organizations. They have not been focused on the strengthening of recovery efforts at the community level developed and provided by recovery community organizations steeped in recovery.
- Even as funding has increased, one BIPOC (Black and Indigenous people of color) run RCO that operated for 2 decades closed in the last year for lack of funding and another receives zero support public dollars.
- Grassroot RCOs are often funded through bake sale and spaghetti dinner type funding drives supported by their local community and not within our established care system because funding has not been established for them in a cohesive and sustainable way at the state or regional levels.
- Peer training for Certified Recovery Specialists were initially developed with regional RCOs by PRO-A, our statewide RCO. Last year, DDAP awarded noncompetitive funding to a private organization to take over all peer training in both the public and private sectors. Training for peer workers can now only be done through this new gatekeeper model funded with public dollars. Training requirements can now be changed by this private entity with no input from SUD stakeholder groups creating a system wide workforce barrier.
- The requirements for SUD peer training are perhaps now the most arduous in the nation. They are subject to being changed in ways that impact our entire SUD care system workforce due to this closed-door process eliminating our training marketplace and awarding the facilitation of all public and private training for SUD peer workers to this single entity outside of a system of oversight, checks and balances.

Our Policies and System Orientation Have the Wrong Focus

There is some national recognition that we have failed to focus on flourishing for persons with addiction. In a February 2019 Op-ed for the Journal Alcohol & Drug Dependence, senior editor Dr. Eric Strain noted that "*our failure to forcefully advocate that patients need to flourish is tacitly acknowledged through interventions such as low threshold opioid programs, provision of naloxone with no follow up services, and buprenorphine providers who only offer a prescription for the medication*." He suggests that we need to engage patients to support flourishing and provide meaning, a fundamental human need. This is a facet of a recovery-oriented system.

- Research and historic efforts to support wellness has focused on addiction, not on recovery. We need to shift our focus to recovery to heal our loved ones, families, and communities.
- In an Op-Ed for STAT news in early 2020, I noted that "*few Americans get anywhere near 90 days of care. Within the confines of existing insurance networks, short-term treatment of 28 days or less is all that most Americans are offered — if they can get any help at all. This ultimately reflects the soft bigotry of low expectations: an inadequate care system designed to deliver less than what people need because we still moralize addiction and do not value people who have substance use disorders."*
- *If we want to improve our outcomes, we need to change our measures to focus on recovery and not a single facet of addiction or a short-term outcome.*

What is the Five-Year Recovery Paradigm?

The five-year recovery paradigm was started by Dr. Robert DuPont, former Director of the Office of National Drug Control Policy and primary investigator of the first national study of the physician health programs (PHPs) which produced impressive long- term outcomes for individuals with severe SUDs. This has evolved into the conception of the "New Paradigm" for long-term recovery with goal of five-year recovery for all SUD

treatments including all types of programming and recovery support services with a clear shared goal of long-term recovery. We should focus our efforts across harm reduction strategies, SUD treatment and recovery support services on their ability to produce sustained recovery for persons with severe SUDs.

Focus on Long Term Recovery Outcomes

We should change our lens to focus on long term recovery to strengthen our recovery community.

- "The National Institute on Drug Abuse Principles of Drug Addiction Treatment defines 90 days across levels of care as the minimum threshold of care below which recovery outcomes begin to deteriorate. Of all those discharged from addiction treatment who will resume drug use in the following year, most will do so in the first 90 days following discharge." Article, Bill White Recovery, the first 90 days.
- An study on the relationship between the duration of abstinence and other aspects of recovery found:
  - Only about a third of people who are abstinent less than a year will remain abstinent.
  - For those who achieve a year of sobriety, less than half will relapse.
  - If you can make it to 5 years of sobriety, your chance of relapse is less than 15 percent.
- *What it includes: "The shift to a model of sustained recovery management includes changes in treatment practices related to the timing of service initiation, service access and engagement, assessment and service planning, service menu, service relationship, locus of service delivery, assertive linkage to indigenous recovery support resources, and the duration of posttreatment monitoring and support"* From article Recovery management: What if we really believed that addiction was a chronic disorder?

Funding Models – Peer Services vs Funding Recovery Community

We should establish sustainable funding mechanism that nestle recovery in *recovery community centers run by recovery community organizations by and for the recovery community*.

Funding Recovery Community Centers as a community resource:

- The end goal we should focus on is the strengthening of recovery capital to support long term recovery, which is an effective strategy to strengthen recovery. Recovery capital is the development of all the internal and external resource to support recovery at the individual, family, and community level.
- The best way to strengthen recovery capital is to invest in grassroot recovery community organizations that are focused on the development of these facets at all three levels, individual, family and community.
- We fund community centers and senior centers as community resources and not within the traditional fee for service model because they are community oriented and not a narrowly focused individual service.

The limitations of funding peer services provided as individual or group sessions at the individual level:

- Peer services can support the development of recovery capital at the individual level through existing fee for service models, but these tend to focus only on the individual and not family and community level support.
- The trap of fee for service funding structures is that some grassroot community organizations are often locked out of these provider networks and communities are not able to benefit from what they can offer.
- Even those RCOs who can navigate the fee for service structures end up getting stuck in a funding structure that results in the chasing of low reimbursement rates to stay open while narrowing their effective work to the individual, resulting in an erosion of their capacity to strengthen recovery capital at the community level.

Retooling substance use care to support long term recovery

Addiction is our most pressing public health crisis. The science is showing us that five years of sustained substance use recovery is the benchmark for 85% of people with substance use disorder (SUD) to remain in recovery for life. So why are we not designing our care systems around this reality?

The National Institute on Drug Abuse (NIDA) identifies that the minimum dose of effective treatment is 90 days, yet far too few people get even that. Negative public perception about people with SUDs underpins much of our system problems – we ration care, regarding persons with SUDs as undeserving. As a result, fewer achieve lasting recovery than could. As SUDs impact one in three families, it is time we recognize these are "our" people and not "those" people and deserve our help. It makes sense and it saves resources.

We have seen that the opioid crisis alone caused a 2.8% reduction in our Gross Domestic Product. Alcohol use disorders still surpass opioid use disorders in annual fatalities. We are talking about a lot of resources spent shoveling up after untreated or undertreated SUDs. Despite these hard facts, we have set arbitrary limits on service, long wait times to access care, insurance denials for care as a norm, and a byzantine process for persons needing help to navigate treatment. People are often served at lower levels and shorter durations of care needed. Ironically, the person often feels like they failed, rather than the system failing to help them.

When a person gets a diagnosis of cancer, our medical system orients care to support multiple interventions, procedures, supports and checkups over the long term. If one approach does not work, we move to another. It is a chronic care model. Such a system is flexible, properly resourced and offers multiple pathways to health. The system coordinates care in a supportive manner through the disease process to get them to the day that they can celebrate five years in remission. This model is the model we need to orient to for severe SUD recovery.

When a person achieves five years in full remission from a SUD, the likelihood of remaining in recovery for the rest of their lives is around 85%. Achieving this standard of care across our service system requires expanding peer services and reorienting care to a long-term service model. It involves treatment assisted by medication, peer support services, family support and case management to help people get back into care quickly in the event of a lapse. People could obtain multiple services based on individual need, typically reducing in intensity over time. In the event of resumption of active use, people can access care in real time with no barriers.

A recovery oriented five-point plan to strengthen and heal our communities:

1. A service system that supports long-term recovery: Establishing and funding SUD treatment and long-term recovery support services that address the needs of the person, including co-occurring conditions/ issues, generally with decreasing intensity - over a minimum of five years.

2. A system that meets the needs of our young people: Develop Recovery High Schools, Collegiate Recovery Programs, and Alternative Peer Groups (APGs). Provide local family education, professional referral, and support programs to assist each young person with a SUD to sustain and support recovery for a minimum of 5 years.

3. Build the 21st Century workforce to serve the next generation: Develop stable funding streams, reasonable compensation, administrative protocols, and peer recruitment and retention efforts.

4. Although there are many social, employment, legal, educational, and other important issues with the person with a SUD, there are a couple of exceptionally important areas. Employment, education, and self-sufficiency are fundamental to healthy recovery and functional communities. We envision a network of employers that provide work opportunities for persons in recovery. We must expand college and trade educational opportunities while reducing and eliminating barriers to employment, like those posed by criminal records, for persons in recovery. There must be simple processes for persons to clear their records from past criminal charges as they attain stable recovery and are ready to become fully productive citizens.

5. Recovery housing opportunities: People in recovery need stable, supportive, and affordable transitional and long-term housing. We must develop a system of quality recovery houses. This system needs to include adolescent and special population housing, infrastructure development, and training for house operators to support recovery from a SUD. The housing system needs to work collaboratively to support long-term treatment and recovery as part of a system of care with a five-year recovery goal.