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The Recovery Community Organization: Toward A Working Definition and Description

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What is a recovery community organization?

A recovery community organization (RCO) is an independent, non-profit organization led and governed by representatives of local communities of recovery. These organizations organize recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, and/or provide peer-based recovery support services (P-BRSS). The broadly defined recovery community – people in long-term recovery, their families, friends and allies, including recovery-focused addiction and recovery professionals – includes organizations whose members reflect religious, spiritual and secular pathways of recovery. The sole mission of an RCO is to mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction. Public education, policy advocacy and peer-based recovery support services are the strategies through which this mission is achieved.

How many recovery community organizations are there in the United States?

There are a number of national organizations, some with state and local affiliates, whose primary focus is on the needs of individuals, families and communities seeking or in recovery from alcohol and other drug addiction. The National Council on Alcoholism and Drug Dependence (NCADD), founded over 60 years ago, can be described as the nation's first modern recovery community organization. Today, many of its affiliates have spawned or operate as recovery community organizations. There has been a recent growth in new grassroots recovery advocacy and support organizations linked nationally through the activities of Faces & Voices of Recovery (Faces & Voices). Some of these

organizations operate at the state level with local and/or city-wide chapters or affiliates, such as FAVOR-SC with four local affiliates; People Advocating Recovery (KY) with six chapters; and Alabama Voices for Recovery with three chapters. Also, a subset of RCOs has emerged from recovery-focused ministries. The National Alliance of Methadone Advocates (www.nama.org), Advocates for Recovery through Medicine (ARM) (www.methadonetoday.org/armhelp.htm), the National Alliance of Advocates for Buprenorphine Treatment (NAABT) (www.naabt.org) and the Opioid Dependence Resource Center http://www.methadone.net all provide assistance for those in medication-assisted recovery. Other national organizations, some with state and local affiliates, are focused on supporting recovery for particular ethnic groups. One example is White Bison (http://www.whitebison.org/), whose mission is focused on recovery advocacy and support in Native American communities. All told there are over 175 local and state recovery community organizations in the US.

How are recovery community organizations formed?

Recovery community organizations are usually birthed by persons in personal and/or family recovery in response to unmet needs in local communities. They often exist as voluntary advocacy and service organizations for some time before they have funding to support their activities on a more formal basis. Faces & Voices of Recovery provides the connecting tissue between these groups at a national level. A directory of these organizations is posted on the Faces and Voices website (www.facesandvoicesofrecovery.org). If there is not an RCO in your community, consider starting one. Papers describing the history of recovery advocacy and P-BRSS and resources for starting an RCO are also posted at the Faces & Voices website.

What are the Core Elements of a Recovery Community Organization?

In our work with RCOs around the country, we believe that there are three characteristics that distinguish RCOs from other organizations concerned with alcohol- and other drug-related problems.

1. Recovery Vision: The RCO, its leaders and its members have a singular goal: enhancing the quantity and quality of support available to people seeking and experiencing long-term recovery from alcohol and other drug addiction.

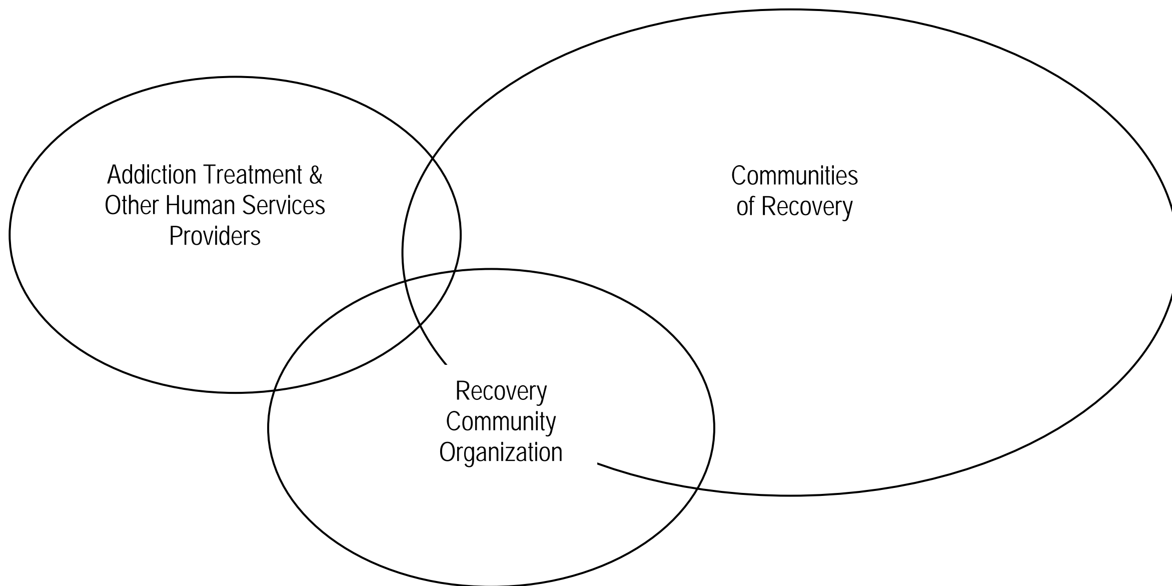
2. Authenticity of Voice: Authenticity of voice means that an RCO represents

one or more communities of recovery. There are some that aspire to represent the widest possible diversity of those communities (e.g., Faces and Voices, CCAR, PRO-ACT), but most represent some portion of the total. Authenticity comes from the connection to one or more communities of recovery and not the representation of all such communities. Organizations should not be excluded from the RCO definition if they represent a specific constituency unless that constituency is NOT a community of recovery and constitutes a very different organizational entity.

Ideally, an RCO achieves authenticity by representing diverse communities of recovery (or diverse voices of recovery within a specific construct) and assuring that its leaders accurately represent the voices of those communities. The RCO is led (via its board of directors, managers, staff, volunteers and membership) by a majority of people representing local communities of recovery. Those serving in these roles are comfortable self-identifying as persons in long-term recovery, family members, friends and allies of recovery and offering themselves and their personal stories as living proof of the transformative power of recovery. Healthy organizations strive to include people representing different styles and lengths of recovery as well as diversity by age, gender, ethnicity, sexual orientation, and political and religious affiliation. The voices of individuals and family members affected by alcohol and other drug addiction are prominent at all levels of the organization. Vibrant RCOs insure that the voices of people who have experienced all forms of recovery are heard and embraced and that the organization's public education, advocacy and recovery support services respond to the broadest spectrum of local recovery needs.

3. Independence: We believe that an RCO is most credible and effective as a stand alone entity. The leading RCOs are open to multiple levels of collaboration with a wide variety of other organizations, but they are not under the control of an organization that may have conflicting interests. For example, RCOs may work closely with, but are independent of addiction treatment providers. The RCO's real strength is drawn not from its links to other service organizations but from the authentic voice of the individuals in the recovery community who relate to and actively support it. An RCO serves as a bridge between diverse communities of recovery, the addiction treatment community, governmental agencies, the criminal justice system, the larger network of health and human services providers and systems and the broader recovery support resources of the extended community (e.g., recovery-conducive housing, education, employment, and leisure). The RCO can effectively recruit members of local communities of recovery to advocate on behalf of the needs of those seeking and in recovery and to give back to their communities through acts of voluntary and paid service to others seeking or in recovery. The RCO engages clinical treatment providers by offering those they

serve a viable source of recovery support before, during and following treatment and, in some cases, as an alternative to treatment. The figure below illustrates how we see the RCO nested within larger systems and serving as a bridge between local communities of recovery and local professional service providers.



What are the core strategies of RCOs?

There are 8 core strategies of RCOs (White & Taylor, 2006):

- *Building strong, grassroots organizations* that develop leaders, offer opportunities for recovering people to express their collective voice and provide a forum for community service.
- *Advocating for meaningful representation and voice* for people in long-term recovery and their family members on issues that affect their lives.
- *Assessing needs* related to the adequacy and quality of local treatment and recovery support services.
- *Educating the public, policymakers and service providers* about the prevalence and multiple pathways of addiction recovery.

- *Developing human and fiscal resources* by expanding philanthropic and public support for addiction treatment, recovery support services and recovery advocacy and cultivating volunteerism within local communities of recovery.
- *Advocating for policy changes* at the local, state and federal levels that promote recovery and remove barriers to recovery.
- *Celebrating recovery from addiction* through public events that offer living testimony of the transformative power of recovery.
- *Supporting research* that illuminates effective strategies and the processes of long-term recovery.

The most central of these activities are public education, policy advocacy and peer-based recovery support services.

Public Education and Policy Advocacy: Advocacy can take many forms, but most RCOs educate the public by seeking to "put a positive face and voice on recovery" using a vanguard of individuals and families willing to offer their lives and stories as testimony that long-term recovery is a reality. The focus of public education and outreach is on communicating the reality of long-term addiction recovery and the many pathways and styles of such recovery to the culture as a whole, policymakers, the media and local communities. This education is intended to replace pessimism with the hope and healing power of recovery combating the stigma associated with addiction. It provides mainstream society a highly visible solution to the staggering problems associated with alcohol and other drug addiction. Probably the best-known of these activities is the observance of National Alcohol and Drug Addiction Recovery Month each September.

Public policy advocacy is aimed at promoting policies that widen the doorways of recovery and assure resources to enhance the quality of long-term recovery, ending discriminatory polices. For example, Faces & Voices advocates helped restore funding for the federal government's Recovery Community Services Program (RCSP) and restore the rights of students with drug convictions to federal student financial aid; the McShin Foundation helped save Medicaid funding for addiction treatment in the state of Virginia, RI Cares helped overturn a ban on voting rights for felons; the Connecticut Community for Addiction Recovery (CCAR) influenced the state pardons process; the Addictions Coalition of Delaware helped remove barriers to work facing people with felony convictions; and Friends of Recovery VT secured state funding for nine Recovery Community Centers.

Peer-Based Recovery Support Services (P-BRSS): One of the most significant recent trends in the addictions field (and in related mental health, public health, and child welfare fields) is the emergence of peer-based and other recovery support services that are distinct from professionally-directed clinical services offered by addiction treatment organizations or other helping institutions. Peer-based recovery support services cover a wide range of activities not generally offered by treatment providers. Such services include but are not limited to peer support (e.g., recovery coaching), housing, transportation, vocational training, employment services, telephone support, support groups, system navigation, recovery resource dissemination, life skills training and sober social activities. A recent trend is to deliver these services through Recovery Community Centers. One model for a Recovery Community Center can be found on the CCAR website at http://ccar.us/recoverycntrs.htm along with links to that organization's four Recovery Community Centers.

The federal government's Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment's Recovery Community Services Program (RCSP) and Access To Recovery (ATR) grants have helped several states and over fifty community-based organizations build their capacity to deliver peer-based and other recovery support services. Traditional treatment providers, facilitating organizations, faith-based organizations and recovery community organizations have all been awarded funding under RCSP and ATR. In addition, a number of states and private foundations are providing funding for peer-based and other recovery support services and some insurers are reimbursing for these services.

Funding sources, both public and private; regulators and evaluators will need to explore several key issues related to the public education, policy advocacy, and peer-based recovery support service activities of organizations as they think about peer-based recovery support services. These issues encompass such questions as the following:

- Do long-term recovery outcomes for individuals and families differ when P-BRSS are delivered through different types of organizations?
- Are outcomes clearly superior when services are delivered by one type of organization over another? Do these outcomes vary for particular types of populations to be served and across ethnic/cultural contexts?

- Will a community's long-term recovery capital[1] be strengthened more depending on the type of organization delivering those services?
- How can continuity of care be best maintained across what are potentially multiple service organizations and multiple levels of care?
- How can the highest quality and highest number of P-BRSS be delivered with available funds?

One relatively new entity that is delivering P-BRSS is the recovery community organization (RCO). This essay postulates that RCOs are a legitimate and potentially preferred provider of P-BRSS.

How do recovery community organizations differ from addiction treatment providers and from recovery mutual aid societies?

RCOs take many forms but as a whole differ significantly from addiction treatment organizations and recovery mutual aid groups. As noted earlier, RCOs are independent, meaning that they are usually not part of organizations involved in activities beyond recovery-focused public education and policy advocacy and the delivery of peer-based recovery support services. They are led by individuals representative of the recovery community. They are committed to recovery-related social change (e.g., recovery-focused community education, advocating pro-recovery social policies) and they invest considerable resources in organizing recovery resources within their local communities. RCOs are not a program of personal recovery nor do they promote a particular pathway to recovery (e.g., RCO volunteers do not act as Twelve Step sponsors in their volunteer role). RCOs celebrate the multiple pathways of recovery and offer resources to help people access those frameworks of recovery.

For RCOs that offer services to individuals and their families, the focus tends to be on peer-based, non-clinical recovery support services. RCOs bridge the gap between a clinical treatment episode and long-term recovery through the provision of P-BRSS. RCO staff and volunteers do NOT provide professional assessment nor do they provide addiction counseling or related clinical services. Other distinctive characteristics of RCOs are their conscious effort to achieve cultural diversity, their emphasis on leadership development within the recovery community (e.g., building advocacy skills as part of taking personal responsibility for one's citizenship). RCOs emphasize people's recovery potential rather than

[1] By community recovery capital, we mean the total pool of resources that can be brought to bear to initiate and sustain recovery from severe and complex alcohol and other drug problems and to enhance the quality of life of individuals and families in recovery.

their historical problems and pathologies. They also promote the development of local core recovery values and ethical guidelines to govern the organizational and volunteer decision-making in advocacy and peer-support activities.

How are recovery community organizations funded?

RCOs receive funds from a wide variety of sources. They may receive federal funding through the Center for Substance Abuse Treatment's RCSP (which received more than 170 applications for six grants in its last funding cycle), Access to Recovery, Recovery Month and other federal programs such as those for people reentering communities after incarceration. In some states with a more recovery-oriented system of care (e.g., CT, VT, AZ, OR), RCOs receive grants or are able to bill for the delivery of P-BRSS through the state Medicaid program.

At the local level, hundreds of businesses and local units of governments have provided support to RCO events. Private foundations have also provided financial support for particular RCO-sponsored activities or special events. The Christopher D. Smithers Foundation funded the printing and North American distribution of a White Bison, Inc. book on the history of recovery among Native American tribes. The Robert Wood Johnson Foundation has supported Faces & Voices of Recovery and that organization's support of RCOs since its founding in 2001. State-level recovery community organizations like People Advocating Recovery (PAR) in Kentucky have enjoyed support from health care conversion foundations like the Greater Cincinnati Health Foundation. NAABT, Inc. has received funding from pharmaceutical companies in the form of "Unrestricted Educational Grants. CCAR receives annual funding from the Connecticut Department of Mental Health and Addiction Services (DMHAS) and recently funded a technology upgrade through a grant from the Hartford Foundation for Public Giving. This support has not met the fiscal needs of the growing numbers of recovery community organizations that are growing in size. Some RCOs are self-funded primarily from donations of those in recovery themselves and their circle of friends and associates. Many RCOs envision their long-term financial sustainability in terms of support from members of their local communities of recovery. This support is most often delivered through either paid memberships in the RCO, in response to individual giving campaigns or in event sponsorship.

Are there regulations or ethical guidelines governing recovery community organizations?

Most RCOs have a set of core values or an ethical code that guides individual and organizational decision-making. Some RCOs, like the Pennsylvania Recovery Organization – Achieving Community Together (PRO-ACT) has developed specific ethical guidelines for the delivery of P-BRSS (White, et al, 2007). In addition to these organization-driven guidelines, some states are developing credentialing standards for peer recovery support specialists that include a code of ethical conduct that an RCO will be required to adopt.

Have recovery community organizations been formally evaluated?

Most of the RCSP grantees and state-funded peer and other recovery support programs have undergone some level of project evaluation. Rigorous scientific studies that will be published in peer-review scientific journals are underway. Some RCOs have contracted with evaluators for specific projects. There is considerable scientific evidence for the effectiveness of the types of peer-based recovery support services that RCOs are providing. These P-BRSS include outreach and engagement, ancillary support during primary treatment, assertive linkage to communities of recovery, post-treatment monitoring and support and (when needed) early re-intervention (Kurtz & White, 2006). There is a growing body of scientific evidence suggesting that post-treatment monitoring (recovery checkups and "assertive approaches to continuing care) and support can elevate recovery outcomes for adults (McKay, 2001; McKay, 2005; Dennis, Scott & Funk, 2003; Scott, Dennis, & Foss, 2005) and adolescents (Godley, Godley, Dennis, et al, 2002, 2007) and that such services can be delivered in a telephone-based format (McKay, Lynch, Shepard, & Pettinati, 2005).

An example of the promising data coming out of P-BRSS pilot project utilizing a peer telephone recovery support process is that being provided by CCAR —a project funded in part by federal Access To Recovery dollars (Broffman, Fisher, Gilbert, & Valentine, 2006). In 2006, CCAR volunteers made 4,688 attempts to call 339 different recoverees and made contact 1,828 times (making contact means the caller actually spoke with the recoveree). Out of those 1,828 contacts the recoveree indicated they were still in recovery 1,697 times or 92.8% of the time. 38 times people said they had relapsed and on 13 of those occasions the volunteer was able to help the person back into recovery. Many recoverees have been enrolled for more than one full year. Of note is the increase in the number of unduplicated recoverees; in the first three months of 2007, CCAR had called more individual recoverees, 380, than in all of 2006. Based on this preliminary data and increased demand for such services, the Connecticut Department of Mental Health and Addiction Services posted a statewide RFQ (Request for Qualifications) for Telephone Peer Support Services in April, 2007.

What are the organizational contexts from which P-BRSS are being delivered?

P-BRSS are being delivered out of different organizational contexts (e.g., treatment organizations, RCOs, faith-based recovery ministries.) These organizations are providing a varying array of services delivered by individuals who are paid, volunteers, or volunteers whose expenses are paid by the sponsoring organization. We believe the growing number of RCOs delivering P-BRSS will become an increasingly prominent feature in the landscape of addiction treatment and recovery in America.

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References

Broffman, T., Fisher, R, Gilbert, W. & Valentine, P. (2006) A direct contact after discharge. Connecticut agencies test telephone recovery support conducted by peers. Addiction Professional, March-April, pp. 1-4 Accessed June 19, 2007 at http://www.addictionpro.com/ME2/dirmod.asp?sid=9B6FFC446FF7486981EA3C0C3CCE4943&nm=ArtIcles%2FNews&type=Publishing&mod=Publications%3A%3AArticle&mid=8F3A7027421841978F18BE895F87F791&tier=4&id=97C7675F4CA94695BE77F2397C589AE0

Dennis. M. L., Scott, C. K., & Funk, R. (2003). An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. *Evaluation and Program Planning, 26*(3), 339-352.

Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R., & Passetti, L. (2002).

Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment: Preliminary outcomes. *Journal of Substance Abuse Treatmen*t, *23*(1), 21-32.

Godley M.D., Godley S.H., Dennis M.L., Funk R.R., & Passetti. L.L. (2007). The effect of assertive continuing care on continuing care linkage, adherence and abstinence following residential treatment for adolescents with substance use disorders. *Addiction*. 102(1):81-93.

McKay, J. R. (2001). Effectiveness of continuing care interventions for substance abusers: Implications for the study of long-term treatment effects. *Evaluation Review, 25*(2)*,* 211-232.

McKay, J. R. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction*, *100*(11), 1594-1610.

McKay, J.R.; Lynch, K.G.; Shepard, D.S.; and Pettinati, H.M. (2005) The effectiveness of telephone-based continuing care for alcohol and cocaine dependence. *Archives of General Psychiatry* 62(2):199-207.

Scott, C. K., Dennis, M. L., & Foss, M. A. (2005). Utilizing recovery management checkups to shorten the cycle of relapse, treatment re-entry, and recovery. *Drug and Alcohol Dependence, 78*(3), 325-338.

White, W. & Kurtz, E. (2006). *Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches*. Pittsburgh, PA: Institute for Research, Education and Training in Addictions.

White, W., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits R. & Donohue, B. (2007). Ethical Guidelines for the Delivery of Peer-based Recovery Support Services. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W. & Taylor, P. (2006). A New Recovery Advocacy Movement. Posted at www.facesandvoicesofrecovery.org