

The Role of Recovery Support Services in Recovery-Oriented Systems of Care



White Paper



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Introduction

Addiction has long been recognized as a chronic disease. However, most treatment for addiction uses acute care interventions rather than a disease management approach. For many people seeking recovery, this has created a revolving door of multiple acute treatment episodes. Under the leadership of the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), the substance use disorders treatment field is shifting from an acute care model of treatment to a chronic care approach, known as recovery-oriented systems of care.

Creating recovery-oriented systems of care requires a transformation of the entire service system as it shifts to becoming responsive to meet the needs of individuals and families seeking services. To be effective, recovery-oriented systems must infuse the language, culture, and spirit of recovery throughout their systems of care. They have to develop values and principles that are shaped by individuals and families in recovery. These values and principles provide the foundation for systems that provide:

- Accessible services that engage and retain people seeking recovery;
- A continuum of services rather than crisis-oriented care;
- Care that is age- and gender-appropriate and culturally competent; and
- Where possible, care in the person's community and home using natural supports.¹

This movement to recovery-oriented systems of care is being informed by a number of key dynamics that are affecting the substance use disorders field simultaneously, including:

- SAMHSA's commitment to ensuring a person-centered approach to recovery that offers clear choices to individuals;
- Increased involvement of grassroots faith- and community-based organizations that afford people multiple pathways to recovery;
- Current research findings supporting the need for comprehensive, individualized services;
- Changing norms and expectations of services as defined by the Institute of Medicine's Quality Chasm Series reports;
- Transformation in the mental health field with its focus on consumer-driven recovery-oriented services;
- An emerging and energized recovery community;
- Key leadership on the State level (e.g., Connecticut and Arizona each have created recovery-oriented systems for behavioral health services); and
- Most importantly, SAMHSA's commitment to providing a life in the community for everyone.

¹ Supports that occur and are provided by the relationships in the community—work/school, social and family.

Recovery support services—services provided to people and families during the initiation, ongoing, and post-acute stages of their recovery—are an integral component of recovery-oriented systems of care. A variety of programs and providers provide these services in many venues.

II. Purpose

The purpose of this White Paper is twofold: (1) to describe our understanding of the present state of recovery support services; and (2) to lay a framework for future activities and products that will support the continuing development of recovery support services.

III. Background

A. Institute of Medicine

The Institute of Medicine (IOM) issued two seminal reports—*Crossing the Quality Chasm* (2001) and *Improving the Quality of Health Care for Mental and Substance-Use Conditions* (2006)—that inform the foundational qualities of recovery-oriented systems of care. IOM proposed six goals to improving the health care system (2001). Health care should be:

- Safe—avoiding injuries to patients;
- Effective—providing services based on science;
- Patient-centered—providing respectful and responsive care;
- Timely—reducing waiting and delays for service;
- Efficient—avoiding waste; and
- Equitable—providing equal care to all people without regard to gender, ethnicity, geography, socioeconomic status, or any other factor.

IOM concluded that quality health care should employ a patient-centered approach that includes participation of patients and their families in the decision-making and in all aspects of treatment and recovery planning and management. IOM also maintains that patients' self-management of their own recovery is central to improving the quality of care. In addition, the 2006 IOM report on mental and substance-use conditions recognizes the importance of peer support services and calls for reimbursement for peer support services and other recovery support services.

B. Research Supporting Recovery Support Services

Addiction treatment and recovery support services have repeatedly been shown to be effective with many people achieving recovery. As with any chronic disease, however, discrete treatment episodes, supported by continuing recovery support services, are often needed to help people achieve and maintain recovery. Treatment for addictive disorders is not typically a “one-shot” type of intervention. Research indicates that cost savings are associated with a chronic care model when compared to an acute care model (Zarkin, Bray, Mitra, Cisler, & Kivlahan, 2005).

A number of studies have been conducted on specific aspects of recovery support services. Several studies indicate that for people with low recovery capital² and high disease severity, social supports provided by sober living communities are critically important to long-term recovery (Jason, Davis, Ferrari, & Bishop, 2001; Jason, Davis, & Ferrari, 2007). Other studies on recovery support services involving family members and other allies found that providing social supports helps maintain recovery (Gruber & Fleetwood, 2004; Brown & Lewis, 1998). Studies have also shown that providing comprehensive services assists recovery (Pringle et al., 2002) and that strong social supports also improve recovery outcomes (Humphreys, Moos, & Finney, 1995). Research on peer-recovery support, in addition to the many studies that have been conducted on mutual aid groups, provides evidence for the effectiveness of services in supporting recovery (Humphreys et al., 2004). Another study randomly assigned 150 individuals to either an Oxford House or usual-care conditions after substance abuse treatment. At 24-month follow-up, those in the Oxford House condition had significantly lower substance use, significantly higher monthly income, and significantly lower incarceration rates than those in the usual-care condition (Jason, Olson, Ferrari, & Lo Sasso, 2006). Additional studies support the benefit of recovery coaches, mutual aid societies, and social and community supports in achieving long-term recovery (Scott, Dennis, & Foss, 2005; Laudet, Savage, & Mahmood, 2002).

A study by McKay (2005) found that recovery check-ups and active linkage to recovery supports following treatment are important in maintaining recovery. These services can be low cost, such as telephone-based support and checkups, and still be effective. Research by Fiorentine and Hillhouse (2000) found that those who participated in both treatment and recovery support groups had better long-term recovery outcomes than people who used either service alone.

C. SAMHSA's Programs

SAMHSA/CSAT has initiated several grant programs that foster the creation of a chronic care approach for persons with substance use disorders, which can be integral to the development of recovery-oriented systems of care. SAMHSA's Access to Recovery and the Recovery Community Services Program are the most illustrative examples. These programs support SAMHSA's goals of accountability, capacity, and effectiveness—as well as the six aims expounded by the Institute of Medicine—by fostering person-centered care, providing choice, expanding capacity, and improving linkages to primary care and community- and faith-based organizations.

1. Access to Recovery

Access to Recovery, a competitive discretionary grant program funded by SAMHSA/CSAT, seeks to expand capacity, support client choice, and increase the array of community- and faith-based providers for clinical treatment and recovery support services. These grants are available to States, Territories, the District of Columbia, Tribes, and Tribal Organizations (all

² Recovery capital means the quantity and quality of internal and external resources an individual brings to the initiation and maintenance of recovery (Granfield & Cloud, 1999).

referred to in this paper as “States”). A Presidential initiative, Access to Recovery is a voucher system that gives clients a choice of eligible treatment providers from which to obtain needed recovery services. The first Access to Recovery grants were awarded in 2004 to 14 States and one Indian Health Board for a 3-year period. Grantees maintain a diverse network of community- and faith-based organizations that offer treatment and recovery support services. Second-round grants were issued in 2007.

Access to Recovery offers flexibility in designing and implementing programs, consistent with proven models of care, and ensures that clients have a genuine, free, and independent choice among eligible providers. The voucher program is designed to support a mixture of clinical treatment and recovery support services and to provide cost-effective, successful outcomes for the largest number of people. Access to Recovery provides an array of clinical and recovery support services for people who are diagnosed with substance dependence or substance abuse, and services are individualized to meet each person’s needs.

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An important component of the Access to Recovery program is partnering with grassroots providers, including community- and faith-based organizations. These organizations are often based in poor and isolated communities where local residents may have few opportunities or resources for other sources of support or help. These groups are often uniquely positioned as trusted institutions in their respective communities and have the cultural understanding necessary to provide long-term recovery support to local residents.

2. Recovery Community Services Program

CSAT initiated the Recovery Community Support Program in 1998 to help the recovery community organize members to participate in public policy discussions and to develop campaigns to combat stigma. The 1998 cohort of grantees consistently voiced the great need for community-based recovery support services to help prevent relapse and promote long-term recovery. In 2003, the name was changed to the Recovery Community Services Program (RCSP), and CSAT began providing funding for grantees to develop and provide innovative, peer-based recovery support services in community settings. These services extend the continuum of recovery by offering strengths-based services that emphasize social support as a factor in initiating and maintaining lifestyle change.

The primary target population for the RCSP is people with a history of alcohol or drug problems who are in or seeking recovery, along with their family members and significant others. People in recovery design and, as peer service providers, deliver peer recovery support services.³ Successful peer recovery support programs offer clients a network for building strong and mutually supportive relationships with formal systems in their communities (i.e., treatment programs, housing, transportation, justice, education). Peer services are designed and delivered primarily by individuals in recovery to meet the targeted community’s recovery support needs, as the community defines them.

³“Peer” means people who share the experience of addiction and recovery, either directly or as family members/significant others.

Therefore, although supportive of formal treatment, peer recovery support services are not treatment in the commonly understood clinical sense of the term.

Peer recovery support services are expected to extend and enhance the treatment continuum in at least two ways. These services help prevent relapse and promote long-term recovery, thereby reducing the strain on the overburdened treatment system. Moreover, when individuals do experience relapse, recovery support services can help minimize the negative effects through early intervention and, where appropriate, timely referral to treatment.

IV. Recovery and Recovery Oriented Systems of Care

A. Definition of Recovery

In September 2005, CSAT’s Partners for Recovery Initiative convened a diverse group of 100 stakeholders—including systems professionals, treatment providers, researchers and evaluators, recovery support services providers, mutual aid groups, and recovery advocates—for a National Summit on Recovery. The goals of the Summit were (1) to develop ideas to transform services, systems, and policies in a movement toward developing recovery-oriented systems of care; (2) to articulate guiding principles of recovery that can be used across programs and services; and (3) to generate ideas to advance recovery-oriented care across different systems and for diverse populations.

One of the tasks assigned to the stakeholders was to develop a working definition of recovery. Their deliberations resulted in the following definition: “Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life” (CSAT, 2007).

B. Principles of Recovery

The stakeholders at the Summit established an overarching framework for recovery articulated in the following guiding principles (CSAT, 2007):

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery involves a personal recognition of the need for change and transformation.
- Recovery is holistic, involving the body, mind, relationships, and spirit.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.
- Recovery emerges from hope and gratitude.
- Recovery is a process of healing and self-redefinition.
- Recovery involves addressing discrimination and transcending shame and stigma.

- Recovery is supported by peers and allies.
- Recovery is (re)joining and (re)building a life in the community.
- Recovery is a reality.

The stakeholders further agreed that the recovery process is not linear and may include varying levels of progression through the phases of recovery—pre-recovery preparation, initiation of recovery, continuing recovery, and relapse. Stakeholders were clear that recovery is a personal journey and the path to recovery is uniquely individualized. There are no wrong paths to recovery. Recovery may be achieved through any number of ways, including natural recovery, mutual support groups, peer recovery services, clinical treatment, faith-based approaches, or a combination of these and other methods. The critical variable is that the individual chooses the manner of his or her recovery and the services most appropriate to managing his or her recovery.

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There was consensus that the recovery process is a holistic approach to lifestyle changes that may include a spiritual component defined by Ringwald (2002) as “... an ongoing internal process of change that results in a transformation of the recovering person’s attitudes, values, beliefs, and practices.”

C. Elements of Recovery-Oriented Systems of Care

Recovery-Oriented Systems of Care (ROSCs) support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness, and recovery from alcohol and drug problems. ROSCs offer a comprehensive menu of services and supports that can be combined and readily adjusted to meet the individual’s needs and chosen pathway to recovery. ROSCs encompass and coordinate the operations of multiple systems, providing responsive, outcomes-driven approaches to care. ROSCs require an ongoing process of systems improvement that incorporates the experiences of those in recovery and their family members.

Recovery Management is a chronic care approach to the provision of client-directed management of services and supports for persons with chronic disorders at the provider level that reflects many of the elements of ROSCs. Unlike ROSCs, which are designed to address the full spectrum of needs of individuals with substance use problems and disorders, including screening, brief intervention, brief treatment, and early intervention, Recovery Management is a clinical approach taken from a chronic disease management approach applied in general medical settings.

In recovery-oriented systems of care, the expectation is that contact with the client will continue after the acute stage of treatment is completed and that recovery support services are extended to family members and to people who may not have remained in treatment. Recovery management may include checkups in the form of follow-up phone calls, face-to-face meetings, or emails, as well as assertive linkage to recovery communities.

The stakeholders at the 2005 Summit identified the elements of recovery-oriented systems of care as follows:

- Person-centered;
- Family and other ally involvement;
- Individualized and comprehensive services across the lifespan;
- Systems anchored in the community;
- Continuity of care (pretreatment, treatment, continuing care, and recovery support);
- Partnership-consultant relationship, focusing more on collaboration and less on hierarchy;
- Strengths-based (emphasis on individual strengths, assets, and resilience);
- Culturally responsive;
- Responsive to personal belief systems;
- Commitment to peer recovery support services;
- Inclusion of the voices of recovering individuals and their families;
- Integrated services;
- Systemwide education and training;
- Ongoing monitoring and outreach;
- Outcomes-driven;
- Based on research; and
- Adequately and flexibly financed (CSAT, 2007, p. 12-13).

Another difference between acute care systems and recovery-oriented systems is that recovery-oriented systems of care utilize a recovery plan instead of a treatment plan. Recovery plans consider a person's recovery capital. In keeping with the person-centered focus of recovery-oriented care, the recovery plan is driven by the client, not the treatment professional (White & Kurtz, 2006).

V. Recovery Support Services

A. Recovery Support Services Defined

Recovery support services (RSSs) are nonclinical services that assist individuals and families to recover from alcohol or drug problems. They include social support, linkage to and coordination among allied service providers, and a full range of human services that facilitate recovery and wellness contributing to an improved quality of life. These services can be flexibly staged and may be provided prior to, during, and after treatment. RSSs may be provided in conjunction with treatment, and as separate and distinct services, to individuals and families

who desire and need them. Professionals, faith-based and community-based groups, and other RSS providers are key components of ROSCs.

Recovery support services are typically provided by volunteers or paid staff members who are familiar with their community's support for people seeking to live free of alcohol and drugs. Often recovery support services are provided by peers—people in recovery or family members. Some services require reimbursement, while others, such as mutual support groups, may be available in the community free of charge. As described in the Access to Recovery grant program, recovery support services may include the following:

- Employment services and job training;
- Case management and individual services coordination, providing linkages with other services (e.g., legal services, Temporary Assistance for Needy Families, social services, food stamps);
- Outreach;
- Relapse prevention;
- Housing assistance and services;
- Child care;
- Transportation to and from treatment, recovery support activities, employment, etc.;
- Family/marriage education;
- Peer-to-peer services, mentoring, and coaching;
- Self-help and support groups (e.g., 12-step groups, SMART Recovery®, Women for Sobriety);
- Life skills;
- Spiritual and faith-based support;
- Education;
- Parent education and child development support services; and
- Substance abuse education.

B. Types of Recovery Support Services Providers

Recovery support services can be delivered in a number of settings such as freestanding recovery community organizations, as part of treatment agencies, and as services offered by faith-based organizations. Many of these entities are grassroots organizations with annual budgets of less than \$500,000. Recovery support services are also delivered by organizations affiliated with other systems, such as criminal justice, HIV/AIDS services, and child welfare. A number of RCSP grantees are housed—and have peers providing services for recently released offenders—in jails, HIV/AIDS programs, and child welfare agencies. Also, recovery support services can be provided by a variety of personnel ranging from peers and family members who serve

in a voluntary capacity, specialized staff trained to provide recovery support services, faith leaders and trained congregants, and credentialed professionals.

1. Peer Recovery Support Services

Peer recovery support services are designed and provided primarily by peers who have gained practical experience in both the process of recovery and how to sustain it. Within RCSP projects, these individuals are designated as peer leaders. Many peer leaders donate their time to the peer recovery support project out of a desire to give back to their communities by helping others who are seeking to recover or sustain their recovery. In addition, peers derive significant benefit from helping others, which is known as the “helper principle” (Riessman, 1965, 1990).

Peer recovery support services provide social support to individuals at all stages on the continuum of change that constitutes the recovery process. Services may be provided at different stages of recovery and may:

- Precede formal treatment, strengthening a peer’s motivation for change;
- Accompany treatment, providing a community connection during treatment;
- Follow treatment, supporting relapse prevention; and
- Be delivered apart from treatment to someone who cannot enter the formal treatment system or chooses not to do so.

Peer recovery support services expand the capacity of formal treatment systems, e.g. medication assisted therapy, residential, therapeutic community and outpatient, by promoting the initiation of recovery, reducing relapse, and intervening early when relapse occurs. Peer leaders in some RCSP projects also provide social support to the recovering person’s family members.

Peer recovery support services are exemplified by the RCSP projects, funded by CSAT, and based on the concept that a crucial factor in helping people move along the recovery continuum is social support. Four kinds of social support identified in the literature (Salzer, 2002a, 2002b) constitute the core of RCSP services:

- **Emotional support**—demonstrations of empathy, caring, and concern in such activities as peer mentoring and recovery coaching, as well as recovery support groups;
- **Informational support**—provision of health and wellness information, educational assistance, and help in acquiring new skills, ranging from life skills to employment readiness and citizenship restoration (e.g., voting rights, driver’s license).
- **Instrumental support**—concrete assistance in task accomplishment, especially with stressful or unpleasant tasks (e.g., filling out applications, obtaining public benefits) or providing supports such as child care, transportation to support group meetings, and clothing closets.
- **Affiliation support**—opportunity to establish positive social connections with others in recovery so as to learn social and recreational skills in an alcohol- and drug-free environment.

2. Faith-Based Services

Many faith-based organizations provide services within the context of a religious framework of beliefs and rituals. These services may or may not be peer-driven and can be used as an adjunct to treatment or as a path to recovery, depending on the needs of the person and family seeking services. Faith-based organizations, many of which have a mission outside of the addiction treatment field, may already be providing services that are consistent with recovery support services. They often work with families, provide youth services, and are oriented toward providing social supports such as social activities and community services, which inherently support recovery. Faith-based organizations could be enlisted to provide more focused recovery support services, such as pretreatment support for the individual and family, sustenance and support of treatment adherence, and continuing recovery support.

Faith-based organizations may serve a vital function in recovery-oriented systems of care, particularly in underserved areas and those areas with a large number of ethnic and racial minorities. Trusted by their members, they are often the center of community life, and most have a strong commitment to serving their faith community. Engaging faith-based organizations in a recovery-oriented system of care can help expand the types of recovery services offered to people and families seeking such support.

SAMHSA's reauthorization in 2000 included statutory language regarding charitable choice in substance abuse programs. In 2003, the statutes were promulgated as regulations governing SAMHSA's Block Grant and discretionary grant programs. The statutes prohibit the expenditure of SAMHSA funds on programs that include sectarian worship, instruction, or proselytizing. By designing the Access to Recovery program as a voucher-based program, however, faith-based organizations could include inherently religious activity in their programs when service recipients participate voluntarily. In 2002, presidential Executive Order 13279 directed Federal agencies to treat religious and secular organizations equally when awarding Federal funds. However, SAMHSA is still governed by statutes based on its authorizing legislation.

3. Services in Agencies with Recovery Support Staff

Recovery support services can also be delivered by personnel who are trained for specific job functions and who meet the institutional requirements for recovery support services positions within treatment agencies or other delivery systems. These staff members may themselves be in recovery or may be family members of persons in recovery, and they may perform a variety of duties, all under the supervision of a clinical staff person. As part of recovery-oriented systems of care, recovery support staff members assist in the implementation of aftercare and assertive continuing care. They can also serve as recovery coaches or case managers. Some States have or are in the process of developing credentialing programs for such recovery support staff.

VI. Models of Recovery-Oriented Systems of Care in Two States

More than a dozen States and municipalities have moved to adopt recovery-oriented systems of care, and a variety of models can serve as guides for other States, counties, and cities that are beginning this process. Two States, both with more than 5 years of experience in this process, were selected as case studies for this paper. These States model different approaches to implementing recovery-oriented systems of care, which may offer guidance and lessons learned to other States and governmental units. Connecticut, an Access to Recovery grant recipient, is considered by many to be the leader in the transformation to a recovery-oriented system of care and offers insights into the process used to make extensive changes in its practice and delivery systems. Arizona is not an Access to Recovery grantee but also exemplifies a State that has been in the forefront of change to a recovery-oriented system of care.

A. Connecticut

The Connecticut Department of Mental Health and Addiction Services serves 90,000 people annually and has an operating budget of \$600 million. It began a systematic effort to turn its delivery system (which includes both mental health and substance use disorders) into a recovery-oriented system of care starting in 1999. This transformation encompassed the following steps:

- Develop core values and principles.
- Establish a conceptual and policy framework to guide its efforts.
- Make significant workforce changes that involve establishing new competencies and skills.
- Change programs and the services structure to enhance certain types of program models (e.g., peer-run programs, programs operated by the recovery community).
- Re-align fiscal resources and review administrative policies to ensure that recovery concepts and program models are being supported.

A number of meetings were convened to gather input from individuals in recovery and the recovery community. DMHAS worked with Advocates Unlimited, Inc. and Connecticut Community for Addiction Recovery, Inc.—two consumer recovery groups in the State—to develop the principles and core values that served as the foundation on which the State built its recovery-oriented system of care. The process took about 2 years to complete. The core values comprise four domains:

- Direction of the system, which encompasses all phases of care—from acute care to community services to ongoing continuing care—and involves persons in recovery, their families, significant others, and allies;
- Participation, which ensures that there is no wrong door to treatment (i.e., people can enter at any appropriate level of care when needed, not just at a time of crisis), and that an individual's choice must be respected in matters related to treatment;

- Programming, which must be flexible and tailored to the individual; and
- Funding and operations, which reimburse providers for services provided, outcomes met, and persons served.

These activities led to a landmark change in policies in September 2002, with the signing of the Commissioner’s Policy Statement No. 83: “Promoting a Recovery-Oriented Service System.” This policy statement set the direction and overarching goal for this transformation. Connecticut believes that recovery is a personal process that belongs to the individual and that the system’s role is to establish and foster conditions that support the recovery process.

The transformation of DMHAS’s system of care is an ongoing process that requires continuing emphasis on building partnerships with all stakeholders; identifying best practices; promoting cultural competencies; realigning the system to recovery-oriented performance outcomes, with changes at the system, provider, and individual levels. DMHAS structured its Access to Recovery grant to give consumers control over their recovery and allow them to select from a wide array of services, from traditional clinical treatment to recovery support services, such as housing, transportation, and vocational services. DMHAS has engaged faith-based organizations and peer recovery support organizations as key service providers within its system.

As part of the implementation process, DMHAS developed Practice Guidelines for Recovery-Oriented Behavioral Health Care. This document identifies eight domains of a recovery-oriented system of care, and within each presents concrete and practical action steps or guidelines. The domains are:

- **Primacy of participation.** People in recovery and their loved ones are involved in all aspects and phases of care delivery.
- **Promoting access and engagement.** Recovery-oriented practitioners promote access to care by facilitating swift and uncomplicated entry and by removing barriers to care.
- **Ensuring continuity of care.** Treatment, rehabilitation, and support are offered through a carefully created system that ensures continuity of the person’s most significant healing relationships and supports over time and across episodes of care and agencies.
- **Employing strengths-based assessment.** Using a strengths-based approach, providers balance critical needs that must be met with the resources and strengths that people possess.
- **Offering individualized recovery planning.** All services are individualized, and a multidisciplinary recovery plan is developed with the person receiving the services and any others he or she identifies. The recovery plan includes the person’s hopes, assets, strengths, interests, and goals, and reflects a holistic understanding of behavioral health concerns, medical concerns, and the desire to build a meaningful life in the community.

- **Functioning as a recovery guide.** The premise for this guideline is: “We are not cases, and you are not our managers.” This guideline exemplifies the need for providers to present their skills and expertise as tools individuals can use in their own recovery.
- **Community mapping, development, and inclusion.** Providers need to have an adequate knowledge of the individual’s local community and to map these resources to identify existing and often untapped or overlooked resources.
- **Identifying and addressing barriers to recovery.** The barriers in the community that create and perpetuate chronicity and dependency need to be identified, and strategies to address these barriers should be provided.

B. Arizona

Beginning in 2000, Arizona changed its delivery system from an office-based model to a system that is based in the community. Now focused on the individual and the family, Arizona’s system is strengths-based and culturally competent. Factors that prompted this shift included:

- A Federal Medicaid waiver that offered the State an opportunity to define and reimburse services in a new way;
- Passage of a State ballot initiative that significantly increased the number of people eligible to receive Medicaid services and the need to maximize Medicaid funds; and
- Settlement of a class action lawsuit that required the State to substantially improve the behavioral health care system for children.

A major component of Arizona’s system is peer support services. Arizona created a new provider category, Community Service Agencies, which comprises community- and faith-based organizations. At first, these services were for people with serious mental illness, but in 2003, they were expanded to include alcohol and drug treatment services.

Peer support services workers and volunteers serve as mentors and recovery coaches in alcohol and drug treatment agencies, providing support for people in treatment and enhancing treatment outcomes. The State developed a training program for peers and, as of 2006, had trained and employed about 70 peer support specialists throughout Arizona.

An important element in the growth of peer support services was a new guide to reimbursement rates issued in 2001, which required provision of all treatment and support services, including family and peer services. The State has developed training programs and minimum requirements (a high school equivalency diploma and training) for peer support services staff.

Arizona’s Department of Health began to certify community service agencies in 2001. These nontraditional community- and faith-based providers have expanded the availability of recovery support services. Currently, there are 12 community service agencies in Arizona. Although not licensed by the State, the community service agencies are certified by the Arizona Department of Health Services’ Division of Behavioral Health Services to provide “natural supports”

that use practical and informal approaches to recovery, include screening for depression and alcoholism, employment training, and educational services for consumers and family members. The community service agencies are funded through block grant funds for non-Medicaid eligible clients or through Medicaid for those who are eligible.

To underscore the difference between a recovery-oriented system of care and a more traditional service provision system, the first person a client sees upon entering the recovery-oriented system is usually a peer rather than a clinician. This approach has helped foster treatment engagement. The assessment is recovery-focused and is used to develop a recovery plan. Building on strengths and the supports in the client's life, attention is paid to locating housing and employment. Although new services were mandated, the State found that providers were uncomfortable and unfamiliar with peer-recovery support services and asked for technical assistance from SAMHSA to develop a model. This served as the basis for a practice protocol for peer support services.

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VII. Barriers and Challenges

Systems undergoing change—especially those as complex as systems delivering services for substance use disorders—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. For example, the professional status of addictions counselors is a relatively recent occurrence compared to many other disciplines, and changes to the system can create new concerns about the status of addictions counselors in the system. 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 delivery system, certainly presents some challenges.

A. Barriers

As described by White and Kurtz (2006), the conceptual and institutional barriers that impede the shift to a recovery-oriented system of care include:

- Difficulty in moving from deficit- or problem-focused thinking to a strengths-based focus and accepting the chronic model of care;
- Addiction professionals' pride and concerns about status and power, coupled with suspicion about the abilities of indigenous healers as peers;
- Lack of protocols and financing for recovery support services;
- Absence of ethical codes that guide peer recovery services; and
- Weak infrastructure of addiction treatment organizations and staff turnover.

In addition to the barriers among providers and professionals in the field, most faith-based and peer recovery support services are grassroots organizations that lack the infrastructure

needed to comply with Federal, State, or local reporting requirements. They often do not have appropriate accounting systems in place to track and justify grant or reimbursement payments. In addition, grassroots organizations need help in setting up an appropriate infrastructure—governance boards; financial, employee, and volunteer policies; ethical guidelines; and volunteer recruitment and training—as well as developing a sustainability plan. This lack of experience, as well as concerns about the respective roles of traditional providers and peer-recovery organizations in recovery-oriented systems of care, are concerns that need to be addressed. Overcoming these barriers requires a concerted leadership effort and the engagement of all stakeholders. Faith-based groups often are reluctant to participate in government programs as they are concerned about the constraints or conditions that come with government funding.

B. Challenges

The overall challenge to moving to recovery-oriented systems of care is maintaining quality assurance standards while preserving the uniqueness of the peer-recovery and faith-based services and integrating recovery support services into a more structured and regulated system. Utilizing peer-recovery services programs and faith-based organizations to provide services is a critical component of recovery-oriented systems of care, and preserving their status as non-professional grassroots entities is a key factor in maintaining a recovery focus. However, States and other governmental entities also need to ensure that organizations with good management practices are providing quality, competent services to clients and their families without overburdening these nontraditional providers with cumbersome regulations and standards.

In many cases, grassroots organizations need help with establishing appropriate fiscal policies, recordkeeping, and reporting tasks because these groups are very small and often rely on volunteer labor. States also have to ensure that faith-based organizations adhere to the requirements enumerated in the Executive Order on Charitable Choice, including protecting the religious freedom and choice of those seeking services, not using Federal funds for inherently religious activities, and separating recovery services from religious proselytizing. In addition, nontraditional providers need to develop codes of ethics that both are applicable to their status and protect consumers receiving services.

An additional challenge arises from the differences in cultures between faith-based and community-based grassroots organizations on the one hand, and the professional treatment system on the other. Differences may arise from concerns about encroaching on professional services, lack of understanding about recovery support services, resistance to change, and basic philosophical differences about paths to recovery. These differences also stem from concerns about quality assurance issues and how recovery support services fit into the overall system.

Developing a rate structure that sustains recovery support services is another challenge that States face as they move toward a recovery-oriented system of care. A number of States, particularly those with Access to Recovery grants, have developed rate structures for recovery support services. Among the services covered are housing, educational and employment

services, spiritual coaching, child care, mentoring, family support, life skills training, and vocational training. As States implement recovery support services, they need to review their organizational, regulatory, and funding mechanisms for needed changes.

Other challenges faced in adopting a recovery-oriented system of care, 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 any pressure, due to budget constraints or other reasons, to replace clinical services with recovery support services, as both are needed;
- Reviewing and modifying regulations and laws that are inconsistent with recovery-oriented systems of care; and
- Obtaining reliable evaluation data to support the efficacy of recovery support services.

VIII. Solutions and Opportunities

Through their experiences in developing recovery-oriented systems of care or in implementing the Access to Recovery grants, States have found many opportunities to respond to the challenges brought on by these system changes. Information from the SAMHSA Recovery Support Services meeting—“Lessons Learned and Future Directions,” held in January 2007—and a report on recovery support services, prepared by the Legal Action Center and presented at this meeting, provide some insights into how States have met the challenges and resolved some of these issues.

A. Overall Approach

In the reports from the States and in documents presented at meetings on recovery support services, an overriding concern about implementation was precisely how to enhance and increase access to services through use of recovery support services. Solutions included the following:

- Have stakeholders work together to identify ways to ensure the quality of recovery support services while allowing them to grow and diversify.
- Use a consensus building process, and bring together all the stakeholders from the outset.
- Keep the oversight of peer- and faith-based organizations flexible enough to adapt to new challenges and lessons learned.
- Provide adequate training to address new standards and regulations.
- Recognize that this is a multiyear process.
- Utilize existing partnerships to assist in the development and implementation of a recovery-oriented system of care.

B. Addressing Quality Assurance

A least 13 States have developed standards and oversight procedures for recovery support services (Legal Action Center, 2007). States have addressed quality assurance for recovery support services with a variety of responses, and examples of their approaches are provided below. In addition, the RCSP grantees developed a set of quality indicators, which may be useful in the development of standards for peer recovery support services programs.

1. State Responses to Quality Assurance

- **Connecticut** uses a number of approaches to ensure quality by having recovery support services providers obtain certification for each of the services they provide. The State has established practice guidelines for recovery support services that allow the provider to evaluate its capacity to provide services and comply with program requirements. Connecticut performs site visits as part of its monitoring oversight and provides suggestions for improvement. In addition, the State conducts cost analysis of recovery support services and analyzes their comparative effectiveness.
- **New Mexico** utilizes best practice standards for recovery support services. ValueOptions New Mexico is responsible for credentialing key personnel and volunteers who supervise delivery of recovery support services in the State. Those who provide pastoral recovery support services receive training in alcohol and drug addiction recovery and spiritual support methods.
- **Alaska** has initiated a Competencies and Credentialing Project to develop core competencies for all behavioral health, including recovery support services. The State is in the process of identifying alternative credentialing processes to operationalize the competencies.
- **Arizona** has created a new staff category, Peer Support Specialists. These staff members serve as mentors and recovery coaches in treatment programs. Although they originally focused on serving individuals with serious mental illness, 70 peer support specialists have been trained in the past few years to provide substance use recovery services. Training is a critical component of the State's system to ensure that peer support specialists are qualified for their positions.
- **Florida** requires that organizations providing recovery support services be certified or obtain credentialed status through the Single State Authority, which has partnered with the Florida Faith-Based Association to assist with the process. The credentialing process includes onsite reviews using a checklist developed for this purpose. Following review, programs receive either approval or a corrective action plan.
- **North Carolina** has tasked the University of North Carolina at Chapel Hill School of Social Work to develop and manage a certification program for peer support specialists working in both mental health and addictions. The program began in July 2007. Although some people providing recovery support services were grandfathered into the certification program in July 2006, everyone will be required to complete the training program and become certified within 2 years.

2. Common Indicators of Quality in Peer Recovery Support Services

Organizations

At their Annual Technical Assistance Conference in August 2005, the RCSP projects identified 12 common indicators of quality to use as guidelines for the peer recovery services grantees. These quality indicators reflect the insights of the 28 RCSP projects represented at the meeting. Not every RCSP grant project, or even any single project, can demonstrate all of the quality indicators. However, these indicators may be useful to others in the development of program standards or oversight mechanisms. The quality indicators are as follows:

1. Peer recovery support services are clearly defined in ways that differentiate them both from professional treatment services and from sponsorship in 12-Step or other mutual aid groups.
2. The programs and peer recovery support services are authentically peer (participatory, peer-led, and peer-driven) in design and operation.
3. The peer recovery support program has well-delineated processes for engaging and retaining a pool of peer leaders who reflect the diversity of the community and of people seeking recovery support.
4. The peer recovery support program has an intentional focus on leadership development for the peer leaders.
5. The peer recovery support program operates within an ethical framework that reflects peer and recovery values.
6. The peer recovery support program incorporates principles of self-care, which are modeled by staff and peer leaders, and has a well-considered process for handling any relapse of peer leaders.
7. The peer program and peer recovery support services are nonstigmatizing, inclusive, and strengths-based.
8. The peer recovery support program honors the cultural practices of all participants and incorporates cultural strengths into the recovery process.
9. The peer recovery support program connects peers with other community resources, irrespective of types of services offered.
10. The peer recovery support program has well-established, mutually supportive relationships with key stakeholders.
11. The peer recovery support program has a plan to sustain itself.
12. The peer recovery support program has well-documented governance, fiscal, and risk management practices to support its efforts.

C. Financing Opportunities and Solutions

Another area of concern for States has been in the area of financing recovery support services. States are faced with declining budgets for treatment services as the demand for recovery services increases. Transforming a complex delivery system means committing scarce resources to addressing administrative, regulatory, and political issues.

For many States, money for recovery support services must be cobbled together from many different sources. A number of funding streams can be used to provide recovery services, including block grant funds, Medicaid, general funds; Temporary Assistance for Needy Families (child care), welfare reform (transportation to and from work), and vocational rehabilitation. A coordinator is needed to tap into these funding streams and to develop memoranda of understanding with other systems such as child welfare or criminal justice.

Block grant funds can be used for any planning, delivery, or evaluation of treatment and prevention services, as long as they further the States' provision of services; and recovery support services do qualify. However, most States must deal with regulations that may allow only licensed providers to be reimbursed for services. Given that most recovery support services programs do not meet most licensing standards, the regulatory changes must be dealt with first. Several States, such as Connecticut and Arizona, use block grant funds as well as Medicaid funds for recovery support services. Connecticut uses a combination of block grant, discretionary, and State general funds for recovery support services; Wisconsin is an example of a State using general funds.

**White
Paper**

IX. Next Steps

Many States are finding innovative ways to address quality assurance, financing, and regulatory issues as they move toward becoming recovery-oriented systems of care. Their experiences, which have resulted in a variety of model approaches and lessons learned, can offer guidance to others. Research is still needed regarding evidence-based practices in recovery support services that can help States build effective and efficacious recovery-oriented systems of care. Providing technical assistance can help States not only to develop recovery support services appropriate to their needs, but also to share lessons learned and to disseminate best practices at the same time.

A. Technical Assistance, Training, and Infrastructure Support

Some suggestions for technical assistance, training, and infrastructure support—compiled from the January 2007 meeting on recovery support services (held in Fort Lauderdale), the National Summit on Recovery in 2005, and the Legal Action Center paper (2007)—are listed below.

- Convene Single State Agencies at regional and national meetings to discuss the development of recovery-oriented systems of care. These meetings can be opportunities to share information on the challenges and benefits in developing such systems.

- Prepare an inventory of States' current programs and practices to determine gaps and strengths.
- Develop evidence-based cost bands for recovery support services.
- Create opportunities for dialogue at the State level for key stakeholders, such as providers of treatment and recovery support services.
- Invest in activities to build capacity and infrastructure.
- Expand and strengthen collaborations with other systems and nontraditional providers, such as the criminal justice system, child welfare, and mutual support organizations.
- Provide technical assistance and information to the Single State Agencies on ways to develop recovery-oriented systems of care and recovery support services.
- Provide technical assistance and develop tools to help nontraditional service providers build their organizational infrastructure.
- Provide a compendium on best practices for recovery support services.
- Bring together key stakeholders to explore quality control and oversight issues as well as to set standards.
- Examine the feasibility of a national accreditation process for recovery support services providers.
- Explore the feasibility of a certification process for recovery support services workers.
- Develop a methodology to match a client's needs to recovery support services.

SAMHSA's Partners for Recovery Initiative is already addressing the first suggestion by holding a series of regional recovery meetings to assist State teams in planning and implementing ROSCs. Three meetings were held in 2007 in Portland, Oregon; Dallas, Texas; Chicago, Illinois; and Newport, Rhode Island. The final meeting, scheduled for January 2008, will be held in Charleston, South Carolina.

B. Research Issues

A research white paper prepared for SAMHSA/CSAT's Partners for Recovery Initiative (Kautz, 2007) looked at the current research as it relates to recovery support services and elements of recovery-oriented systems of care. The findings are as follows:

- Extensive research exists on the many pathways to recovery, and studies show that recovery is supported through the help of peers, allies, and families.
- Numerous studies support many of the principles and system elements of recovery-oriented systems of care. However, limited research has been done on the cultural dimensions of recovery, the concept of person-centered focus, and the inclusion of voices and experiences of recovering individuals and families.
- Even less research exists on the holistic nature of recovery and on adequate and flexible financing.

- More research needs to be conducted to determine evidenced-based practices in recovery support services.
- Elements of social supports and social connectedness that are critical to maintaining long-term recovery have not been determined.

People in recovery need to participate actively in both developing the research agenda and formulating the research questions that need to be addressed. Their participation is essential to blending research and practice as well as to building recovery-oriented systems of care that truly meet the needs of those seeking recovery.

X. Conclusion

A recovery-oriented system of care focuses on the individual and family; provides persons in recovery with choices that are consistent with their values, needs, and culture; honors the multiple pathways to recovery; and allows for a life in the community for everyone. Great strides have been made in less than a decade as many States have moved to recovery-oriented systems of care. As implementing such systems becomes the norm, there is great promise that more people will be able to maintain and sustain long-term recovery with improved health, wellness, and quality of life.

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