Increasing Recovery Consciousness

PEER RECOVERY CENTER OF EXCELLENCE

Grounding Systems in Recovery

2024 March

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At the time of this publication, Miriam E. Delphin-Rittmon, Ph.D., is Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services (DHHS) and the Administrator of the Substance Abuse and Mental Health Services Administration (SAMSHA). The opinions expressed herein are the views of the authors and do not reflect the official position of the DHHS or SAMHSA. No official support or endorsement of DHHS, SAMHSA or the opinions described in this product is intended or should be inferred. The work of the Peer Recovery Center of Excellence is supported 100% by SAMHSA grant funding.

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Summary

Recovery from addiction happens in the community through interactions with people with lived experience. Single state agencies are the main, and often only, source of funding for recovery support services in many states. The SAMHSA Peer Recovery Center of Excellence offers strategies for state agencies to build recovery-rich communities, using lived experience as the frame.

What is the problem?

State and county agencies distribute funds designated for recovery support services. In a time on increasing need, those resources need to be used strategically and effectively.

What is the case to be made?

Using funds more strategically to build communities that are saturated with recovery-centered resources can achieve better recovery outcomes. To do so, organizations that are recovery-centered—that is, that center lived experience in policy and practice—need to be prioritized for funding.

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Frequently Used Acronyms

MH
Mental Health

Peer CoE
SAMHSA Peer Recovery Center of Excellence

PRSS
peer recovery support services

ROSC
recovery-oriented system of care

RREM
recovery-ready ecosystem model

RSS
recovery support services

SAMSHA
Substance Abuse and Mental Health Services Administration

SUD
substance use disorder(s)

Glossary of Terms

Autonomous space
A physical or virtual area in which individuals or groups operate with a high degree of independence and self-governance. Decisions, rules, activities are determined collectively by the people within it rather than by external authorities.

Burnout
Burnout is a state of emotional, physical, and mental exhaustion caused by excessive and prolonged stress. It occurs when you feel overwhelmed, emotionally drained, and unable to meet constant demands. As the stress continues, you begin to lose the interest and motivation that led you to take on a certain role in the first place.

Compassion fatigue
a term that describes the physical, emotional, and psychological impact of helping others — often through experiences of stress or trauma.

Peer-governed
An organization or system that is directed by individuals who are persons in recovery; they collaboratively participate in decision making, drawing on their shared understanding of recovery to guide policy and practice.

Peer-led
An organization or system that has persons in recovery in the majority of the leadership roles.

Peer recovery support specialist
An individual with first-hand lived experience of substance use and/or mental health challenges that has received training to provide guidance, mentorship, and assistance to others. Peer specialists use their own experience to offer practical, emotional, and social support, helping others to achieve recovery goals and improve their overall wellbeing.

Principles of recovery
In its working definition of recovery, SAMHSA identified 10 guiding principles of recovery: hope, respect, strengths/responsibility, addresses trauma, culture, relational, peer support, holistic, many pathways, and person-driven (SAMHSA, 2012).

Recovery
A process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential (SAMHSA, 2012).

Recovery capital
The sum of the strengths and supports – both internal and external – that are available to a person to help them initiate and sustain long-term recovery from addiction.

Recovery support services
Comprehensive resources and assistance that individuals with substance use and mental health challenges can use to assist them achieving and maintaining wellness.

Recovery-oriented system of care (ROSC)
A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems (SAMHSA, 2010).

Glossary of Terms

Recovery-ready ecosystem (RRE)

Interconnected entities within a geographic area that support recovery or that can act as a barrier to the successful navigation of the recovery process. The *Recovery Ready Ecosystems Model* (Ashford et. al, 2020) identifies core elements at micro, mezzo, and macro systems levels.

Recovery outcomes

Indicators of progress toward self-defined recovery goals; positive changes and improvements that are achieved because of participation in programs and services. Common recovery outcomes include improved health, better social connectedness, and enhanced quality of life.

Recovery Consciousness and Integration Continuum (RCIC)

The framework outlined in this publication. It describes a range of awareness, perspectives, and practices that organizations might have related to recovery, incorporating elements from several different research-based models.

Shared decision making

A process in which clinicians and patients work together to make decisions and select tests, treatments and care plans based on clinical evidence that balances risks and expected outcomes with patient preferences and values.

Wellness Recovery Action Plan (WRAP)™

The WRAP™ process supports individuals in identifying the tools that keep them well and creating action plans to put them into practice in their everyday life. It also helps them incorporate key recovery concepts and wellness tools into their plans and life (WRAP, n.d).

Introduction

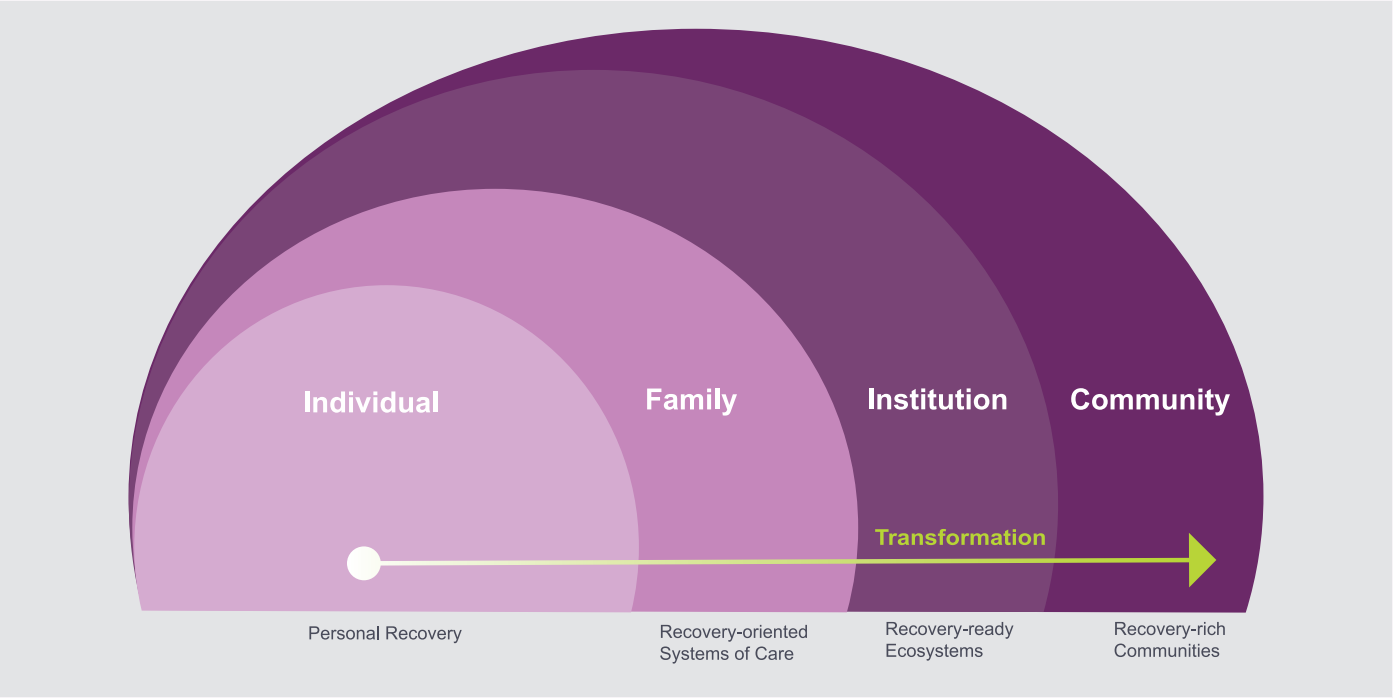


Figure 1. Transformation: Thinking Beyond the Individual

As the sciences of addiction and recovery continue to evolve, they confirm the belief that recovery from addiction happens in community through interactions with persons with lived experience. The emerging science prompts systems to "think beyond" what currently exists, to better connect individual recovery (personal transformation) to recovery-oriented systems of care (institutional transformation) to recovery-rich communities (community transformation). State agencies play an important role in all those levels of transformation, fostering system and community characteristics that create an environment that is maximally supportive of recovery.

In the expansion of peer recovery support services (PRSS), some efforts have missed the forest for the trees: It isn't (just) about integrating peers into systems—although that is a necessary step toward recovery-oriented systems of care (and beyond that, recovery-rich communities). Implicit within the peer model is a different way of working with and relating to individuals and communities. It is about centering the lived experiences of addiction *and recovery, or lived* experiences of mental health challenges *and recovery, and using those lenses to see and reframe everything that a program, organization, institution, or system does. When we understand that, it becomes easier to discern which programs are truly offering recovery support services (RSS) and others* that aspire to deliver RSS but have change their practices to be consistent with the principles of recovery. True recovery support isn't just about *what organizations do; it is about how they do it.*

Public health, health and human services, and single government agencies are the main, and often only, source of funding for recovery support services in many states, given their role as the funding administrator for the Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funding. Through funding decisions, these agencies shape state policy regarding the definition and structure of recovery support services, including PRSS. The strategic use of block grant funding is one way that many states have worked to change their behavioral health system. In many states, this includes funding that supports the integration of peer specialists into a variety of settings.

The problem is that those block grant funds designated for recovery support services are often distributed to organizations government agencies already fund, regardless of their recovery orientation. This is not an effective, efficient, nor strategic use of funds. The solution is to use funds to build communities that are saturated with recovery-centered resources, to achieve better recovery outcomes. To do so, organizations that are recovery-centered--that is, that center lived experience in policy and practice--need to be prioritized for funding.

To fully achieve recovery-rich communities, it is essential to continue to advocate for practices that are supported by the science of recovery. Research indicates that government agencies can do four key things to actively support transformation:

1. Identify, adopt, and support implementation of evidence-based and best practices in recovery support services.
2. Research, evaluate, and ensure fidelity and quality of new and existing recovery support services.
3. Educate and raise public awareness about effective recovery support services.
4. Support development of infrastructure, systems, and mechanisms for implementation and sustainability (Van Dyke & Naoom, 2016).

Government agencies can do this on their own or they can use an intermediary organization, such as statewide recovery community organizations, statewide peer networks, or other peer-led statewide recovery support organizations.

This publication offers strategies for government agencies to build recovery-rich communities, using lived experience as the frame. The brief includes solutions that can be implemented over the short and long-term to maximize existing resources. The goal is to rapidly improve access to recovery support services at a time of rising demand and promote strategies that will have long-term, enduring impact.

This work is also in alignment with *Optimizing Recovery Funding, Volume 2: Strategies for State Funding of Recovery Support Services (Peer Recovery Center of Excellence, 2023), which provides an overview of current state activities, identifies gaps and needs, and makes recommendations for strengthening RSS. Specifically, this brief and toolkit follow the recommendation for increased technical assistance, mutual learning, and training to state decision makers, and another recommendation citing the need for the development of a more uniform taxonomy of RSS.*

Supporting Recovery

The range of programs and services that can support recovery from substance use and mental health challenges has been described in many ways with the two most prominent models being recovery-oriented systems of care (ROSC) and recovery ready ecosystems (RREM).

A ROSC is defined as a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve improved health, wellness, and quality of life for those with or at risk for mental health and substance use problems. It includes clinical services and recovery support services at each point along a continuum of care (SAMHSA, 2010).

> The challenge for a recovery-oriented system of care is to carry out this work in the most efficient and effective, and the least coercive and restrictive, manner possible, respecting the dignity and autonomy of clients while ensuring the safety and wellbeing of the broader community (Davidson et al., 2021).

Under the ROSC model, there are several key principles that guide system planning for essential services (prevention, crisis intervention, treatment, case management, social services).

The idea is to ensure that effective, relevant, well-coordinated services are easily accessible in the community.

> [T]he ROSC model is focused on coordinating the current services and resources of a community and [but] does not provide a framework or model for identifying all of the components in a community that may improve the recovery process of individuals. Further, the ROSC model is used as a practical tool for systems transformation; a model that can assess community recovery readiness, or the ability to promote successful recovery, is needed in addition to the ROSC model (Ashford et al., 2020).

PRINCIPLES OF RECOVERY-ORIENTED SYSTEMS OF CARE

The focus of a ROSC is to create a well-resourced infrastructure to address substance use problems within communities. It encompasses a menu of individualized, person-centered, and strength-based services within a bounded network. Services are designed to be accessible, welcoming, easy to navigate, and support the many pathways to recovery. Recovery-oriented activities include providing a menu of traditional treatment services and recovery support services, including peer recovery coaching, employment assistance, and housing support, to assist individuals and their families in achieving and sustaining recovery (SAMHSA, 2010). There are nine principles of a ROSC:

1. There are many pathways to recovery.
2. Recovery is self-directed and empowering.
3. Recovery involves a personal recognition of the need for change and transformation.
4. Recovery is holistic.
5. Recovery exists on a continuum of improved health and wellness.
6. Recovery emerges from hope and gratitude.
7. Recovery involves a process of healing and self-redefinition.
8. Recovery is supported by peers and allies.
9. Recovery involves (re)joining and (re)building a life in the community.

Figure 2. Principles of Recovery-Oriented Systems of Care

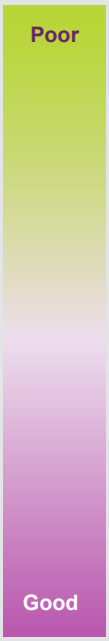
The *Recovery Ready Ecosystems Model is patterned after preparedness for health or disaster events*, which is appropriate given the ongoing opioid overdose epidemic. It identifies key elements at the micro, mezzo, and macro levels that need to be present in communities to support recovery and provides a framework for researching the impact on individual recovery when communities are more or less recovery ready. Its authors posit that "an abundance of these supportive structures and resources allows communities to greater support recovery processes" (Ashford et al., 2020).

The ROSC and RREM models re-orient systems, which is fundamental work. Using these models, government agencies design and fund services to meet the needs of diverse populations, decreasing fragmentation and improving interagency coordination in the process. Combined, these models help systems to be more efficient and effective in achieving clinical and service outcomes.

Yet, a system is only as strong as its individual parts. A third framework is needed to help government agencies assist communities to move from recovery ready to recovery rich. Beyond coordinating resources and assessing community recovery readiness, government agencies need to think more strategically about how well specific assets that are part of systems—programs, services, or organizations—support *recovery outcomes.*

Kelly (2022a, 2022b) uses the metaphor of the burning house to describe the strengths and limitations of the conventional treatment system, and the necessary elements for a recovery-supportive one. He notes that evidence-based addiction treatment services address acute clinical challenges well (*putting out the house fire*) and perform well addressing return to use (*preventing fire from re-igniting*). He also notes that the system is less well-designed for and has fewer resources directed toward developing individual, family, and community recovery capital (*providing rebuilding materials*), building skills to support a life in recovery (*providing scaffolding and other construction tools*) or removing barriers to recovery (*granting rebuilding permits*).

Rebuild	Granting re-building permits Removing structural barriers to recovery Supporting the structure Recovery Planning
Prevent	Preventing it from re-igniting Relapse prevention
Extinguish	Putting out the fire Stabilization
Emergency	Saving lives Overdose reversal/drug detox



This metaphor also can be a starting point for describing how to rebalance a behavioral health system to achieve recovery outcomes. While it is essential to deal with emergencies and extinguish fires, more resources need to be devoted to rebuilding and scaffolding—that is, to true recovery support services—to develop recovery-rich communities.

Figure 3. Strengths and Limitations of Conventional Treatment for Substance Use Disorder (Adapted from Kelly, 2022; Kelly et al., 2018)

Identifying Evidence-based & Emerging Best Practices

What Makes a "Service" a Recovery Support Service?

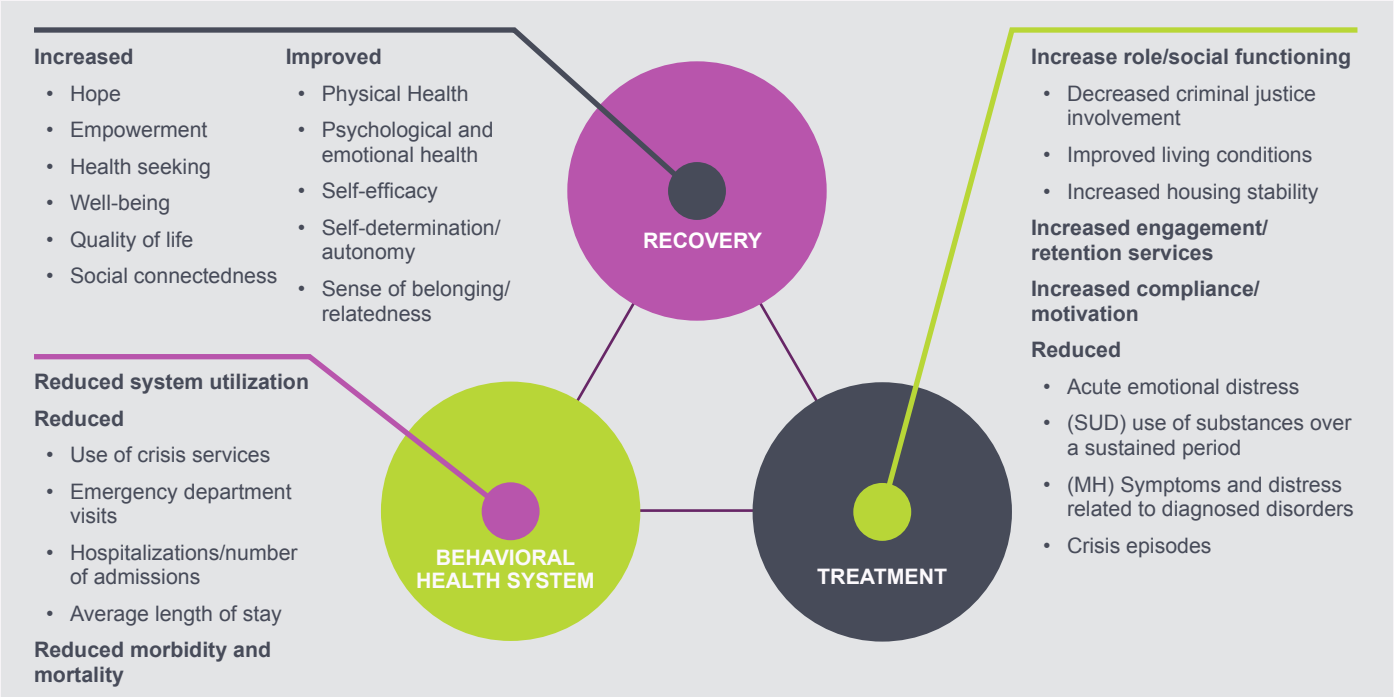


Figure 4. Comparison of Recovery, Clinical Treatment, and Behavioral Health System Outcomes (Adapted from Cano et al., 2017; Kaskutas et al, 2014; Rosenberg et al., 2015; SAMHSA National Outcomes Measures)

SAMHSA (2012) defines recovery as a [self-directed, person-centered] process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Given that definition, what is it that transforms a *conventional service* into a *recovery support service (RSS)?*

At its most simple, a true recovery support service is one that focuses on assisting individuals to achieve desired recovery outcomes, summarized in Figure 3.

The more complex answer relates to the centrality of lived experience in achieving recovery outcomes. Centering lived experience is an approach to dismantling the pathology paradigm, which is the conventional biomedical view of behavioral health that sees conditions as disorders or diseases. Centering lived experience accounts for not only the medical/physical but also the social and relational dimensions of recovery. It renders the recovery process intelligible with its focus on seven dimensions:

Hope.

Persons who share their own recovery journey with others who may be struggling convey hope and instill motivation. They show that recovery is real and send the message that if I can do it, you can too (King et al, 2009).

Sense of agency/empowerment.

RSS focus on enhancing a person's abilities and resources, or recovery capital, to manage their own behavioral health condition(s) and/or to increase their participation in the community activities of their choice (Davidson et al, 2021).

Commitment to recovery.

RSS support individuals in building and sustaining their commitment to recovery as they define it, and in reframing their definition of their recovery across time.

Health-seeking/health status.

RSS support individuals in becoming and being healthier, based on self-defined goals for physical, psychological, and/or emotional health.

Well-being.

RSS support individuals in enhancing their overall well-being, including spiritual, financial, familial health and wellbeing.

Quality of life.

Wellbeing is not the same as quality of life, which is also enhanced through participation in RSS. Key quality-of-life dimensions include sense of control, autonomy, and choice; positive self-image; sense of belonging; and engagement in meaningful and enjoyable activities (Shepherd, Boardman, Rinaldi & Roberts, 2014).

Social connectedness.

Beyond a sense of belonging, there are many dimensions to social connectedness that are enhanced by participation in RSS. RSS happen within experiential/ deep learning communities— environments where people can develop their own understanding of SUD/MH challenges and how best to manage them (Shepard, Boardman, Rinaldi, Roberts, 2014).

Considering the Characteristics of RSS Organizations

A New Framework

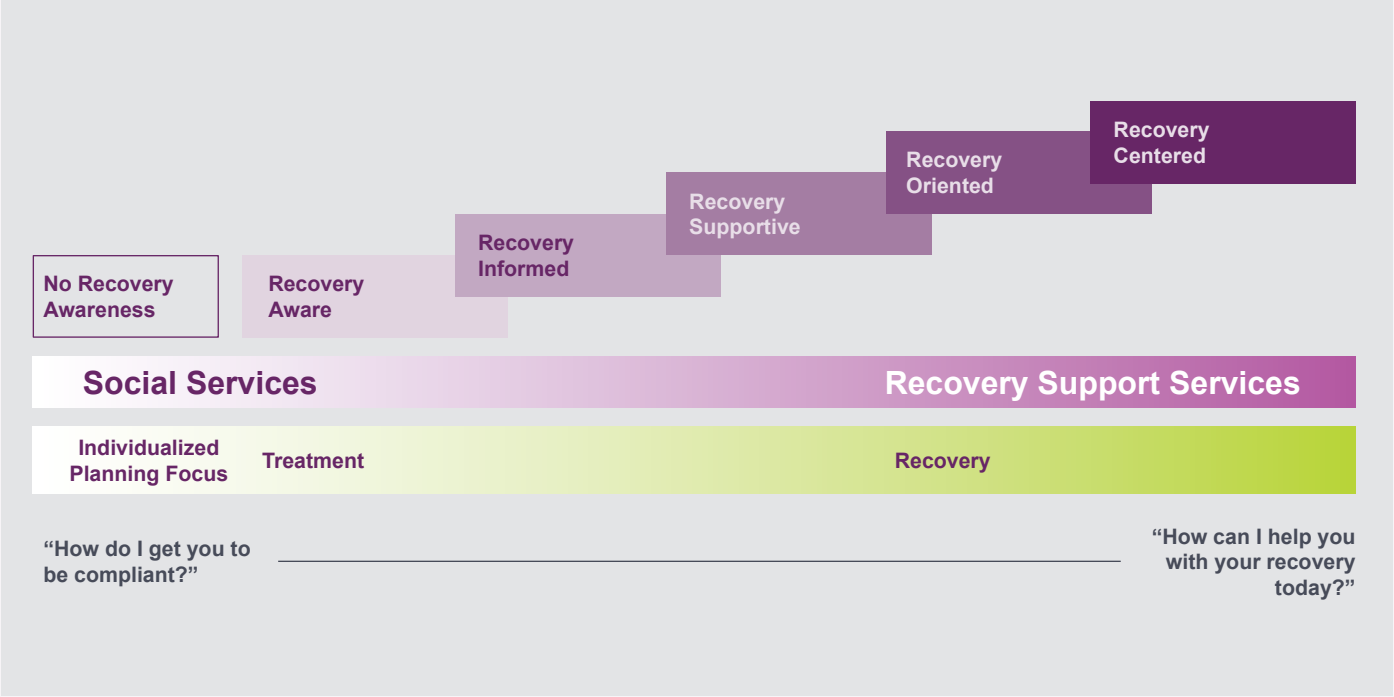


Figure 5. Recovery Consciousness and Integration Continuum (RCIC) framework

Organizations that support individuals in recovery can be described along a continuum between *no recovery awareness and recovery-centered, as shown in Figure 4, which outlines a new Recovery Consciousness and Integration Continuum (RCIC).* This framework incorporates elements of the research and implementation of several different models, including recovery-oriented systems indicators; the Recovery Oriented Practices Index (Mancini & Finnerty, 2005); the Recovery Promotion Fidelity Scale (Armstrong & Steffen, 2009); Recovery Enhancing Environments Measure (Ridgeway in Campbell-Orde et al., 2005); and the Recovery Self-Assessment (O'Connell et al., 2007).

The Archetype: Recovery-centered

Ideally, recovery support services are housed in organizations that are **recovery-centered**, the right-most position on the continuum. Such organizations have several important characteristics that could be described as *dimensions of recovery consciousness.*

First and foremost, the work is centered in the lived and living experience of persons in recovery. This means that all aspects of the organization -- its mission, vision, culture, infrastructure, policies and practices, governance, leadership, and staffing — are infused with the core philosophies and values that use lived/living experience perspectives to ground all aspect of the organization and its work. The lived/living experience perspective influences everything that leadership and staff do, what they say, and how they act. It requires organizations to listen to, invite in, embrace, and be led by the expertise of people directly impacted by substance use and mental health challenges. It is not sufficient for peer voices to be one of many voices at the table—persons with lived and living experience are the driving force.

Second, recovery-centered organizations are naturally peer-led and governed. This means they share power (based on the recovery principles of reciprocity

Figure 6. Recovery Centered Organizations

and mutuality); use participatory processes routinely; engage in creative problem solving with community; and are open to potential new ideas rather than being tied to replicating what has been done before. These organizations use a holistic approach to programming to meet the spiritual, emotional, and physical growth needs of persons on all paths to recovery. With this approach, programs and services grow naturally to meet the needs of the community — and help to create conditions under which recovery can thrive.

Third, recovery-centered organizations understand that recovery happens *in* community. Recovery communities are meeting places and arenas for reciprocal helping, shared problem-solving, and creation of deep experiential knowledge, defined as a holistic way of knowing "emerging from the continuous and layered experiences of living with a problem," including experiences of stigma, interpersonal relationships, and emotional and practical aspects (Noorani, Karlsson, and Borkman, 2019). In these settings, peer-to-peer knowledge creation supports members in developing and expanding recovery capital, putting new recovery skills into practice, and exploring and testing a new recovery identity.

Fourth, recovery-centered organizations support individuals in developing new networks that help to build their recovery capital. Mudry, Nepustil, and Ness (2019) define relational practices as "the recurrent relational interactions that people engage in, filling his or her daily life" that can promote *healing interpersonal patterns*. Recovery-centered organizations design programming and services from this relational perspective. There is an understanding of the context of self-directed recovery processes and the role that positive, recovery-supportive social relationships play in those processes. They foster spaces in which quality relationships across multiple dimensions—person-to-person, person-to-social network, person-to-community--can thrive.

Fifth, recovery-centered organizations are autonomous spaces in which each person is an expert in their own recovery journey. Individuals explore and discover together what each wants, what he/she/they can do to better his/her/their situation, and the possibilities for how it can be achieved practically. Each individual is viewed as having existing strengths and resources—and is given the space to develop new ones-- to make their own choices and exercise judgment in their

actions. In this environment, individuals are mutually empowered to solve problems and build skills to achieve personal goals for a life in recovery.

Six, recovery-centered organizations play a strong advocacy role within service systems and communities. They advocate for access and opportunity for healthy alternatives, particularly for individuals who have lost connection to their community or lack financial resources. They work to change attitudes and beliefs that do not serve to create space for recovery. Language is a powerful advocacy tool, shifting the frames from "client or patient" being served to the more person-centered and strengths-focused "person in recovery," and from goals related to "symptom reduction" to a mutually collaborative process with meaningful goals defined by the individual on the recovery journey. The main aim of recovery-centered organizations is to create environments where recovery can grow, be nurtured, and thrive. By changing language/ framing, they create conditions for changes in societal beliefs and attitudes, which in turn creates nurturing communities for recovery.

Seventh, recovery-centered organizations directly address issues of equity. Recovery-centered organizations have a comprehensive and multi-faceted approach to addressing equity. They combine advocacy, education, community engagement, and collaboration to create lasting change in systems and communities that lead to better improve the recovery outcomes for BIPOC individuals and communities. Some key strategies and approaches include: engaging in policy advocacy to promote equal access to recovery resources and address structural determinants of health; developing programs that improve housing conditions, educational opportunities, employment prospects, and other aspects of wellbeing related to social determinants of health; creating public education campaigns to raise awareness about stigma, discrimination, and health disparities related to substance use and the factors that contribute to them; providing communities with information on the reality of recovery and resources available; and addressing implicit and explicit bias, both individual and structural within their own organizations.

Other important dimensions of recovery consciousness include:

- Strength of belief — and embeddedness in policy and practice — that recovery is possible
- Length of engagement (acute episode vs. chronic vs. long term)
- Perspectives on the concept of care (i.e., care as a relational practice versus care as a service) and on who should, can, and does "direct" care (i.e., client, patient, or person seeking or in recovery)
- Shared decision making/ co-creation of wellness plans (e.g., treatment plans or recovery plans)
- Availability of peer recovery support services and their effective integration throughout organization (from programs being peer-led to peer staff participation on multidisciplinary teams)
- Strength of collaborations with other systems (such as housing, social services, and community resources)

A recovery-centered organization can be contrasted with one with no recovery-awareness in which services are designed and delivered with no consciousness of the principles, practices, and science of recovery. Stigmatizing and dismissive language is used (e.g., describing people with addiction as "addicts" or "drug abusers"), and behavioral health challenges are seen as personal failings. A

lack of recovery awareness does not mean a lack of care; such agencies can provide medically appropriate services (e.g., treating symptoms of withdrawal or stabilizing an individual experiencing an acute event) and still can have entrenched stigmatizing thinking and policy making (e.g., seeing individuals as "taking up beds," "frequent fliers," or "wasting resources"). These services might be grounded in the science of addiction — treating symptoms in that moment — but they do not incorporate the science of recovery to support health and wellbeing over the long-term.

Other Points on the Continuum

Between the two ends — no recovery awareness and recovery-centeredness — the rest of the continuum can be somewhat fluid. There is variability in the level of conscious integration (or not) of core recovery principles across key organizational systems, structures, and processes — such as leadership, governance, and decision making.

Recovery-aware organizations, the left-most point on the RCIC, focus on treating symptoms in acute events, stabilizing, and preventing return to use or recurrence of symptoms. Programmatic objectives are to treat patients when they present with symptoms, improve treatment outcomes, and reduce these patients' use of medical services. Although programs are designed and delivered from a system-oriented view, rather than a person-oriented or person-centered one, recovery-aware organizations begin to consider how to integrate the basic principles of recovery-oriented care into their services for their patients or clients, shifting away from stigmatizing mindsets to "this is a patient with a medical condition who needs treatment." For example, they may engage in shared decision making with clients on their treatment plans. The primary focus remains treating and reducing presenting symptoms as they present in that moment, followed by providing education about conditions and available services, and connecting patients to external services.

Recovery-informed organizations further shift toward more person-centered care. They tend to think of their organization as "serving clients." They understand that addressing social needs — such as housing, employment, and social connections — are important aspects of treatment and recovery. Therefore, they add case management and wrap-around services to their mix, with the goal of coordinating access to services to increase personal safety, enhance life skills, and increase social functioning. For example, programs with no recovery awareness may treat a patient for a physical injury and discharge the patient. A recovery-informed organization might instead identify that injury was the result of falling while intoxicated; they would address not only physical injuries but also the precipitating substance use challenges. The organization takes a more proactive approach to achieving outcomes by developing a comprehensive menu of services. Staff understand clients' needs that impact health and well-being and work to connect clients housing, employment, and social services. However, there can remain a bias towards building skills aimed at abstinence or symptom reduction rather than recovery outcomes as defined by the individual.

Peer staff are viewed as a resource to engage with clients to build trust. Peer staff engagement with clients is primarily in a care or office setting but may extend beyond the four walls. Often, recovery-informed organizations have staff with the term "peer" in their job titles, such as peer counselor, to help with patient engagement, but they function in limited, junior roles. Their purpose is to complete tasks that support the work of case managers, social workers, or other professionals. Although this support may be needed to decrease the workloads of overburdened staff, it is often a paraprofessional job that could be done by any qualified person, not an authentic peer role.

Recovery-supportive organizations start with a person-first, strengths-based approach; it is a holistic orientation based in the belief that long term recovery from mental health and substance use challenges is possible. Still, services often are focused on a single/current treatment episode, but there are more efforts at creating linkages to address social needs and beginning consideration of structural determinants of mental and physical health.

Treatment and recovery goals and plans are developed by the individual with support from peer support, clinical, and case management staff, which is a change from organizations to the left of this stage on the continuum. This may take the form of working with participants to develop self-directed plans such as a Wellness Recovery Action Plan (WRAP®). Moving from reactive (treatment focused) to proactive (recovery-supportive), the focus of program design and delivery shifts from past-focused — e.g., what happened to you and how do we stop it from happening again — to future-focused — e.g., what are your recovery goals, what are your strengths, and how can we help you capitalize on them for improvement and growth? The person in recovery is in the driver's seat when choosing goals that are meaningful.

The self-directed approaches extend to engaging participants in service design and evaluation. Community access boards (CABs, also known as *community advisory boards*) are a common way to do so. In the best examples, CABs help organizations to center lived/living experience. Its members — persons with lived and living experience — are involved in all aspects of organizational policy and program development. They review and refine programming by identifying what individuals, families, and communities need from a service provider; describe barriers and challenges to getting those needs met; and work with staff to develop solutions. They are advocates for changes to service delivery to better meet those needs and can be champions back to the community about the resources that providers have to offer.

Furthermore, in recovery-supportive organizations, peer staff are integrated more effectively. This means peer staff members have clearly defined roles that are consistent with the best practices of peer support; have specialized training to meet the requirement of the role; act as a bridge between program participants and clinical and other service staff; and are a valued member of the care team. A critical mass of peer workers can lead to learning from peer perspectives/ voices of lived experience, which in turn leads to a shift in organizational values, culture, policies, and practices; better support peer worker roles; and changes to services based on quality improvement efforts.

Effective integration of peer staff means there is appropriate supervision that has educative, supportive, and administrative aspects, as summarized in Figure 5. There are five key elements of effective, strengths-based supervision:

Establishing a safe and non-judgmental space.

Peer practice has unique challenges. It is essential for supervisors to create an atmosphere where workers feel comfortable discussing their struggles, successes, and concerns openly. This includes being non-judgmental, empathetic, and supportive, allowing workers to share their experiences openly. By fostering a trusting relationship, supervisors can facilitate honest and meaningful conversations, address issues proactively, and promote the overall well-being and growth of the workers.

Communicating clearly, openly, frequently.

Supervisors should engage in active listening, attentively hearing the concerns and needs of the workers. Through effective communication, supervisors can understand the unique perspectives of peer recovery support workers and provide appropriate guidance and support. Regular check-ins, team meetings, and one-on-one sessions can help facilitate this communication and promote co-learning and mutual support among peer workers.

Ensuring access to relevant training and professional development.

Peer workers benefit from ongoing education and skill development. In effective supervision, there is collaborative process to identify areas for growth and relevant training opportunities to expand knowledge and skills. Continuous professional development ensures that workers stay up to date with the latest research and best practices in the field.

Providing regular, structured supervision sessions.

Supervision sessions are crucial for identifying successes and challenges, providing constructive feedback, and setting achievable goals. During these sessions, supervisors can collaborate with workers to set specific goals that align with their professional development and the organization's objectives. Additionally, supervisors can address any challenges or concerns raised by workers and provide guidance and support to overcome them.

Promoting self-care.

Peer recovery support work is emotionally demanding. Peer workers are at risk of compassion fatigue and burnout. Supervisors should emphasize the importance of self-care practices, encourage work-life balance, and provide resources for stress management and self-care techniques. By prioritizing self-care, supervisors contribute to the well-being and resilience of peer workers, enabling them to continue their support of their peers.

Recovery-oriented organizations are grounded in the belief that people with mental health and substance use challenges can and do recover, that people in recovery can provide essential support to each other, and that people in recovery have a central role in designing, delivering, and evaluating services. These organizations connect individuals to a comprehensive continuum (or continuums) of care that includes support for housing, employment, education and other personal development opportunities, and other social services to help further build a recovery-focused foundation.

Figure 7. Supervision of Peer Work

Recovery-oriented organizations think of those they serve as "participants" who co-create a healing journey of recovery (rather than as "clients" or "patients" being served one-directionally). The process of developing solutions, approaches and treatment/service plans is collaborative. This extends beyond simply employing or adopting a "strengths based" perspective but represents an expansion of these ideas to the point of treating the participant as the "expert" of themselves and treating their lived experience as an aspect of expertise that complements and informs their recovery journey in an essential way. Staff has a solid understanding of the importance of this practice and the rationale behind this approach: The person receiving services is the expert in their own lives, the provider is a person with expertise based on training and experience, and their relationship is a partnership of individuals who recognize and respect the unique contribution of each.

Peer recovery support services are another core service, available to participants across all stages of recovery over an extended period. Recovery-oriented organizations are focused on deeply integrating individuals with lived experience into all aspects of their operations, including as core staff members of a multidisciplinary team.

Peer staff members have clearly defined roles based on the core competencies of peer work; they work in a complementary fashion with other staff.

A recovery-oriented system of care is defined as a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve improved health, wellness, and quality of life for those with or at risk of substance use or mental health challenges. Under this definition, RSS often are seen as an element that bridges between clinical services and life post-treatment.

Cultivating Recovery-supportive Organizations

to Seed Recovery-rich Communities

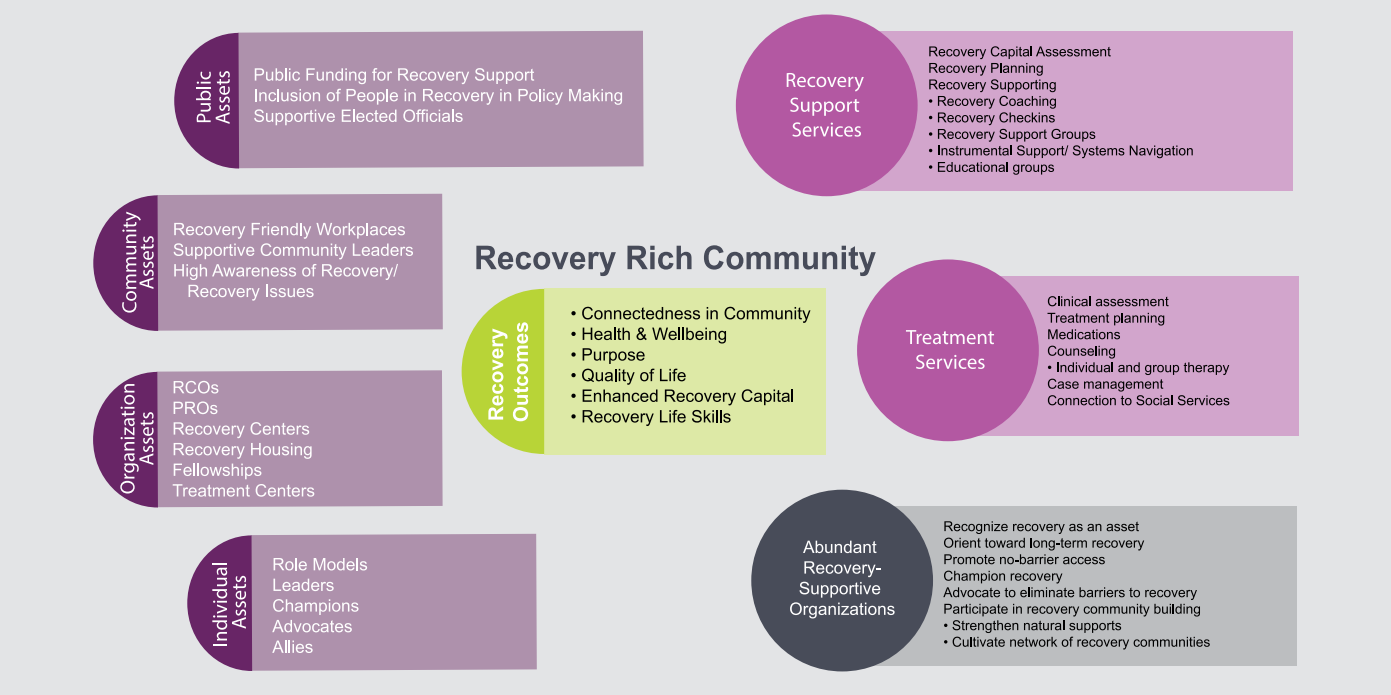


Figure 8. Key Elements of a Recovery-Rich Community

Within a recovery-rich community, there are abundant recovery-supportive organizations, and four key things that those organizations do. They:

Are champions of recovery.

Champions offer hope, inspire change, and empower individuals to reclaim their lives and find lasting recovery. They work towards eliminating stigma and discrimination associated with drug use and addiction, and they strive to create an environment that fosters understanding, acceptance of many pathways to recovery. They lend their voices to policy advocacy, pushing for evidence-based approaches to addiction treatment and supporting measures that expand access to recovery resources.

Orient their work towards long-term recovery, recognizing recovery as an asset.

Persons with lived and living experience are leaders, thinkers, planners, doers, and resources that others can draw upon. Centering lived experience is seen as an equity-focused practice that addresses implicit and structural bias in clinical and social systems.

Promote no-barrier access.

The organizations are gathering places for reciprocal helping, shared problem-solving, and creation of deep experiential knowledge, defined as a holistic way of knowing “emerging from the continuous and layered experiences of living with a problem,” including experiences of stigma, interpersonal relationships, and emotional and practical aspects (Noorani, Karlsson, and Borkman, 2019). In these settings, peer-to-peer knowledge creation supports members in developing and expanding recovery capital, putting new recovery skills into practice, and exploring and testing a new identity in recovery.

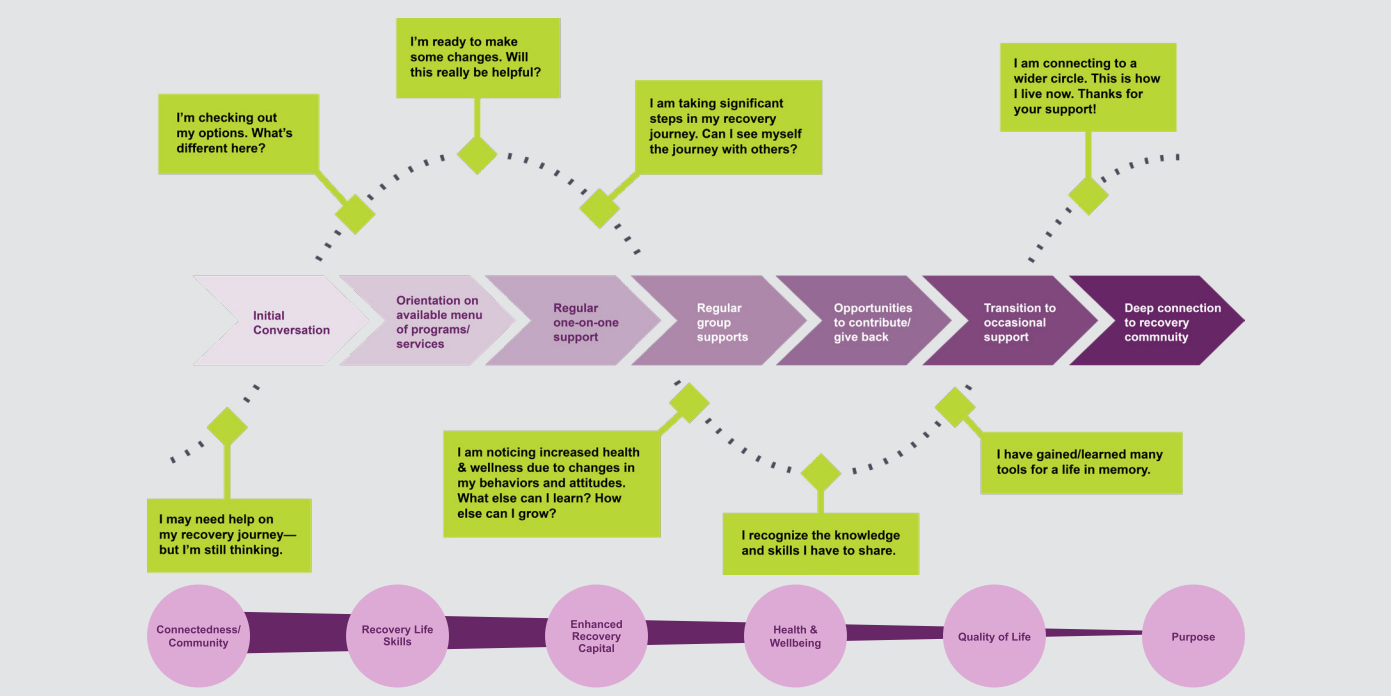


Figure 9. Recovery Support Services Along the Recovery Journey

Advocate to eliminate social and structural barriers to recovery and recovery community building.

Black, Indigenous, and other people of color (BIPOC) and low-income individuals face disproportionate challenges; research suggests that structural discrimination resulting from the racialized War on Drugs, rather than individual factors, is a primary cause of these disparities. Outdated laws and policies contribute to the criminalization of people who use drugs, impacting their experiences within service systems. BIPOC and low-income individuals often encounter obstacles in accessing appropriate treatment, receiving outdated medications, and being confined and restrained more frequently. Involuntary commitments and incarceration further exacerbate the problem. Overcoming these issues requires intentional implementation of equity-focused policies and practices within organizations and systems.

Recovery-rich communities help more people move into "natural recovery" — defined as overcoming substance use challenges without formal treatment or intervention; reduce the time from early recovery to sustained recovery; support recovery pathways that are not clinically based; and add more breadth, depth, and scope of supports for post-treatment pathways.

As drug overdose deaths increase, problematic substance use rises, and the incidence of mental health challenges grow, strengthening community matters (Vila, 2021; Holt-Lundstad et al., 2010; Umberson & Montez, 2010;). Recovery-oriented systems are an essential part of communities — but they are not sufficient to enact the level of change needed. Individuals live in communities that both have many assets but also have many structural barriers to health. If we return to the metaphor of the burning building, and instead imagine burning neighborhoods, it becomes clear that community-centered strategies are needed to complement those that are solely focused on treatment or social services systems to move beyond addressing emergencies and extinguishing fires. This may require inverting funding streams, as depicted in Figure 8.

Figure 10. Funding Priorities in Recovery-rich Communities

Rebalancing the Continuum of Recovery Support Services

Shifting funding from substance use disorder treatment to recovery support services can be a strategic approach to prioritize long-term support for recovery. While substance use disorder treatment plays a crucial role in addressing the immediate needs of individuals struggling with substance use challenges, investing in recovery support services can help maintain and enhance their long-term well-being. There are 10 key strategies for effectively redirecting funds towards recovery support services (Anthony, 2000; Van Dyke and Naoom, 2016), summarized below.

Assess and evaluate current system based on recovery outcomes.

Conduct a comprehensive assessment and evaluation of the current substance use disorder treatment system. Identify the gaps and areas where funding can be reallocated to enhance recovery support services. This evaluation should consider factors such as the recovery-orientation of existing programs and services, the availability and accessibility of recovery support programs, and the recovery-consciousness of host organizations.

Develop funding models that prioritize the long-term recovery outcomes.

Traditional funding models often focus on the number of individuals treated or the duration of treatment, rather than the sustained recovery outcomes. Shifting towards outcome-oriented funding models incentivizes recovery support service providers to focus on achieving meaningful, measurable results in terms of sustained recovery, improved quality of life, and increased community connections.

Assist organizations in strategic organizational redesign and redevelopment.

Organizations providing — or wanting to provide — recovery support services may require assistance in restructuring their operations and strategies to align with the shift in funding priorities. This assistance may involve conducting organizational assessments, identifying areas for improvement, and developing strategic plans to enhance service delivery. It could also include capacity-building initiatives, such as training staff on recovery-oriented practices and cultivating partnerships. Supporting organizations in their organizational redesign and redevelopment ensures that they are well-equipped to provide effective recovery support services.

Fund partnerships and improve linkages between substance use disorder treatment providers and recovery support service organizations.

By collaborating, these two sectors can share resources, expertise, and funding to create a continuum of care that addresses both the short-term treatment needs and long-term recovery support requirements. This collaborative approach ensures a seamless transition from treatment to recovery, enhancing the chances of sustained recovery outcomes.

Support the development of comprehensive infrastructure, systems, and mechanisms for implementation and sustainability.

To facilitate the effective implementation and long-term sustainability of recovery support services, it is necessary to develop a comprehensive infrastructure. This infrastructure may include creating referral networks, establishing data collection systems, promoting information sharing, and integrating services across different sectors. By building a supportive infrastructure, the coordination and collaboration among various agencies and organizations involved in recovery support services can be improved, ultimately benefiting individuals in recovery.

Work with persons with lived experience, peer workers, and recovery community organizations to identify and describe a core set of needed recovery support services.

It is essential to identify and define a core set of recovery support services that individuals in recovery require. These services may include peer support, counseling, housing assistance, employment support, educational programs, and holistic wellness activities. Each dimension of support should be clearly described, outlining the specific goals, methods, and outcomes associated with it. This approach ensures that funding is directed towards services that address the diverse needs of individuals in recovery comprehensively.

Identify, adopt, and support the implementation of evidence-based and best practices in recovery support services.

To maximize the impact of recovery support services, it is crucial to identify evidence-based and best practices. This involves conducting research and reviewing existing literature to determine interventions and approaches that have proven effective in supporting long-term recovery. These practices should then be adopted and integrated into service delivery models. Ongoing support and training should be provided to service providers to ensure that they have the necessary skills and knowledge to implement these evidence-based practices effectively.

Research, evaluate, and ensure fidelity and quality of new and existing recovery support services.

Continuous research and evaluation are necessary to maintain the fidelity and quality of recovery support services. Rigorous program evaluation methodologies should be employed to assess the effectiveness, efficiency, and outcomes of these services. Regular monitoring and feedback mechanisms can identify areas for improvement and ensure that services align with established standards. This commitment to research and evaluation helps refine and enhance recovery support services, ensuring that funding is directed towards programs that yield positive results.

Raise public awareness about effective recovery support services.

Public education and awareness campaigns play a crucial role in making recovery a shared value within society. These efforts should focus on informing the public about the effectiveness of recovery support services, dispelling myths and stigma surrounding addiction and recovery, and highlighting personal stories of individuals who have benefited from long-term support. By increasing understanding and empathy, these campaigns can garner support for reallocating funds towards recovery support services.

Advocate.

Efforts to increase public awareness highlight the importance of recovery support services. Advocacy takes this a step further, educating legislators and stakeholders about specific policy approaches that can foster recovery-rich communities. Through strategic advocacy campaigns, the need and specific strategies for reallocating funds from treatment to recovery support services can be effectively conveyed.

By implementing these strategies, funding can be effectively shifted from substance use disorder treatment alone to recovery support services, ensuring that individuals in recovery receive the necessary support to sustain their progress and lead fulfilling lives. This shift acknowledges the long-term nature of recovery and emphasizes the importance of ongoing care and assistance in achieving positive and lasting outcomes. Together, they create a robust framework for prioritizing long-term support and fostering a recovery-oriented society. The SAMHSA Peer Recovery Center of Excellence can support systems in implementing these strategies, through technical assistance and consultation.

Conclusion

Understanding fundamental system parts is an important step in transformative systems change. The Recovery Consciousness and Integration Continuum (RCIC) framework and related tools included in this brief can help systems administrators and stakeholders in their efforts to cultivate recovery-rich communities, gaining insights into strengths and gaps. Rather than expecting treatment organizations to be something they are not, systems can fund clinical services and recovery support services at levels that are commensurate with their importance to developing recovery-rich communities. Using the RCIC framework can help systems to rebalance resources to support recovery outcomes as well as help individual organizations increase their awareness and implementation of the science, principles, and practices of recovery.

References

Abrahams, I. A., Ali, S., Davidson, L., Evans, A.C., King, J.K., Poplawski, P., & White, W. L. (2013). *Transformation Practice Guidelines for Recovery and Resilience Oriented Treatment.* City of Philadelphia Department of Behavioral Health and Intellectual Disability Services.

Advocates for Human Potential. (n.d.) What is WRAP? https://www.wellnessrecoveryactionplan.com/what-is-wrap/

Anthony, W. A. (2000). A recovery-oriented service system: Setting some system-level standards. *Psychiatric Rehabilitation Journal*, 24(2), 159–168.

Armstrong, N. P., & Steffen, J. J. (2009). The recovery promotion fidelity scale: Assessing the organizational promotion of recovery. *Community Mental Health Journal, 45(3), 163–170.*

Ashford, R. D., Brown, A. M., Ryding, R., & Curtis, B. (2020). Building recovery ready communities: The recovery ready ecosystem model and community framework. *Addiction Research & Theory*, *28*(1), 1–11.

Best, D., Irving, J., Collinson, B., Andersson, C., & Edwards, M. (2017). Recovery networks and community connections: Identifying connection needs and community linkage opportunities in early recovery populations. *Alcoholism Treatment Quarterly, 35(1), 2–15.*

Campbell-Orde, T., Chamberlin, J., & Carpenter, J., & Leff, H.S. (2005). Measuring the promise: A compendium of recovery measures, volume II. Cambridge, MA: The Evaluation Center @ Human Services Research Institute.

Cano, I., Best, D., Edwards, M., & Lehman, J. (2017). Recovery capital pathways: Modelling the components of recovery wellbeing. *Drug and Alcohol Dependence, 181, 11–19.*

Cleveland, H. H., Brick, T. R., Knapp, K. S., & Croff, J. M. (2021). Recovery and recovery capital: Aligning measurement with theory and practice. In J. M. Croff & J. Beaman (eds.)*, Family Resilience and Recovery from Opioids and Other Addictions (pp. 109–128).* Springer International Publishing.

Davidson, L., Rowe, M., DiLeo, P., Bellamy, C., & Delphin-Rittmon, M. (2021). Recovery-oriented systems of care: A perspective on the past, present, and future. *Alcohol Research: Current Reviews,* 41(1), 09.

Evans, A. C., Lamb, R., & White, W. L. (2013). The community as patient: Recovery-focused community mobilization in Philadelphia, PA (USA), 2005–2012. *Alcoholism Treatment Quarterly, 31(4), 450–465.*

DiClemente, C. C., Norwood, A. E. Q., Gregory, W. H., Travaglini, L., Graydon, M. M., & Corno, C. M. (2016). Consumer-centered, collaborative, and comprehensive care: The core essentials of recovery-oriented system of care. *Journal of Addictions Nursing,* 27(2), 94–100.

Foster-Fishman, P. G., Nowell, B., & Yang, H. (2007). Putting the system back into systems change: A framework for understanding and changing organizational and community systems. *American Journal of Community Psychology*, *39*(3-4), 197–215.

Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: a meta-analytic review. *PLoS Medicine, 7(7), e1000316.*

Humphreys, K., & Lembke, A. (2014). Recovery-oriented policy and care systems in the UK and USA. *Drug and Alcohol Review, 33(1), 13–18.*

Kaplan, L. (2008). The role of recovery support services in recovery-oriented systems of care. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration

Kaskutas, L. A., Borkman, T. J., Laudet, A., Ritter, L. A., Witbrodt, J., Subbaraman, M. S., Stunz, A., & Bond, J. (2014). Elements that define recovery: The experiential perspective. *Journal of Studies on Alcohol and Drugs, 75(6), 999–1010.*

Kelly, J. (2022, June 17). *Recovery processes and milestones: Science-informed conceptualizations.* Advancing the Science on Recovery Community Centers: Seminar 17. Recovery Research Institute.https://www.youtube.com/watch?v=iLGJqMBEsNw

Kelly, J. (2022, April 11). *Fifty years of the War on Drugs: What's next?* NATCON22, National Harbor, MD.

King, J.K., Achara-Abrahams, I., O'Hara, T., Shair J.,& Menkir, S.M. (2009). *Tools for Transformation Series: Peer Culture/ Peer Support/ Peer Leadership.* Philadelphia, PA: Philadelphia Department of Behavioral Health and Mental Retardation Services.

Mancini, A.D., & Finnerty, M.T. (2005). Recovery-Oriented Practices Index, unpublished manuscript, New York State Office of Mental Health

Mudry, T., Nepustil, P., & Ness, O. (2019). The relational essence of natural recovery: Natural recovery as relational practice. *International Journal of Mental Health and Addiction, 17*(2), 191–205.

Noorani, T., Karlsson, M., & Borkman, T. (2019). Deep experiential knowledge: Reflections from mutual aid groups for evidence-based practice. *Evidence & Policy: A Journal of Research, Debate and Practice, 15*(2), 217–234.

O'Connell, M. J., Tondora, J., Kidd, S. A., Stayner, D., Hawkins, D., & Davidson, L. (2007). RSA-R, person in recovery, family member/significant other, administrator/manager, and provider versions. https://medicine.yale.edu/psychiatry/prch/tools/rec_selfassessment/

Peer Recovery Center of Excellence. (2023). *Optimizing Recovery Funding.* Peer Recovery Center of Excellence, University of Missouri – Kansas City.

Price-Robertson, R., Obradovic, A., & Morgan, B. (2017). Relational recovery: Beyond individualism in the recovery approach. *Advances in Mental Health, 15*(2), 108–120.

Rosenberg, D., Svedberg, P., & Schön, U.-K. (2015). Establishing a recovery orientation in mental health services: Evaluating the Recovery Self-Assessment (RSA). *Psychiatric Rehabilitation Journal, 38*(4), 328–335.

Saubers, Tim. (2023). Exploring the role of employers and systems in workforce retention survey. 11 May 2023, www.docs.google.com/forms/d/1eLA7S2IrL9dzmG1FATX4rijjx4Js385269Sm35CoqzY/edit.

Substance Abuse and Mental Health Services Administration. (2010). *Recovery-oriented Systems of Care Resource Guide.* https://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf

Substance Abuse and Mental Health Services Administration. (2012). *Working definition of recovery.* https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf

Sheedy, C. K., & Whitter, M. (2009). *Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know from the Research?* (HHS Publication No. (SMA) 09-4439). Substance Abuse and Mental Health Services Administration.

Shepherd, G., Boardman, J., Rinaldi, M., & Roberts, G. (2014). *Supporting recovery in mental health services: Quality and Outcomes* (Implementing Recovery Through Organisational Change). Centre for Mental Health.

Sobell, L. C., Ellingstad, T. P., & Sobell, M. B. (2000). *Natural recovery from alcohol and drug problems: Methodological review of the research with suggestions for future directions. Addiction, 95(5), 749–764.* https://doi.org/10.1046/j.1360-0443.2000.95574911.x

Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I., & Davidson, L. (2006). *Others: The role of family, friends, and professionals in the recovery process. American Journal of Psychiatric Rehabilitation, 9*(1), 17–37.

Umberson, D., & Montez, J. K. (2010). Social relationships and health: a flashpoint for health policy. *Journal of Health and Social Behavior, 51 Suppl(Suppl), S54–S66.*

Van Dyke, M.K. & Naoom, S.F., (2016). The critical role of state agencies in the age of evidence-based approaches: The challenge of new expectations. *Journal of Evidence-Informed Social Work, 13(1), 45-58.*

Vasan, A. (n.d.). From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response. *Fountain House.* https://www.fountainhouse.org/assets/From-Harm-to-Health-2021.pdf

Vila, J. (2021). Social Support and Longevity: Meta-Analysis-Based Evidence and Psychobiological Mechanisms. *Frontiers in Psychology,* 12, 717164.

WRAP (Wellness Recovery Action Plan). (n.d.) *What is WRAP?* https://www.wellnessrecoveryactionplan.com/what-is-wrap/

Tools for Assessing and Strengthening Recovery-consciousness

in Organizations, Programs, and Services

Peer-led and peer-run organizations are the quintessential model of recovery-centered organizations but not the only one. Every organization can strengthen its recovery-centeredness. Single state authorities play an important role in assisting organizations to do so — and thereby assisting communities to become more recovery-rich, healthier, and more equitable.

Following are two tools that can be used to assess and strengthen organizational, network, and system recovery-consciousness.

Consider engaging key populations in completing the assessments, either individually or as a group. In a group process, participants review and discuss each element, assigning it a consensus rating, and write brief notes describing the basis of the rating. In some ways, the discussion is more important than the rating. A good discussion will surface important aspects of criteria and domains, such as items that are practices in some areas of the organization but not others. This discussion, and the written description of the rating can be useful for improvement planning.

Tool 1. Simple Organizational Assessment

This brief assessment evaluates key aspects of an organization's approach to participant-centered services and recovery support, to identify strengths and areas for improvement within the organization's practices related to dimensions of recovery consciousness. (*Adapted from Saubers, 2023; Rosenberry, Svedberg, and Schon, 2015.)*

Part 1: Recovery Orientation

1. Is the organization focused on participant-defined life goals?
2. Are participants' choices respected by staff?
3. Is there substantive involvement of service users, persons with lived and living experience from the community, in the developing, providing, and evaluating programs?
4. Does the organization offer a diverse menu of recovery support services, either directly or through partnerships with other organizations?
5. Are the recovery support services individually tailored? Culturally relevant?
6. Does the organization have proactive processes in place to connect participants with peer-led/ peer-run/ mutual support organizations and networks?

Part 2: Commitment to Effective Peer Employment

Does the organization have:

1. A nuanced understanding of the peer ethos, values, and history?
2. Intentionally designed policies and procedures that consider the peer ethos, values, and history?
3. Substantive involvement of peer workers in the developing, providing, and evaluating programs?
4. Peer workers playing a leading role in making decisions related to the peer services offered?
5. Outcomes measurements that are centered on recovery, not clinical understandings of success, such as medication compliance, maintaining abstinence, or decreasing mental health "symptoms"?
6. Hiring practices for peer workers that does not require adherence to specific recovery pathways (e.g., abstinence, participation in therapy, periods of time in recovery)?
7. Comprehensive onboarding for peer workers?
8. Opportunities for peer workers to advance their career without obtaining clinical training?

Tool 2. Organizational Assessment: Recovery Consciousness

(*Adapted from Byrne et al, 2022; Armstrong and Sheffen, 2009; Shepherd et al., 2014; Anthony, 2000*)

This assessment is designed to help an organization reflect on their processes related to participant-centered services and recovery support across seven domains. Each domain contains several statements that relate to recovery-centeredness.

Using a five-point scale, indicate the degree to which the organization or program puts the criteria into practice.

1 = Never

2 = Rarely

3 = Sometimes

4 = Often

5 = Always

D/K = I am not sure I understand this criterion, or I do not know if the organization practices this criterion

Domain 1. Demonstrating Organizational Commitment to Recovery-centered Practice(s)

Establish and maintain a work environment that is conducive to promoting recovery-centered practice.

The organization	Never	Rarely	Sometimes	Often	Always	
Has a recovery vision that is clear and shared.	1	2	3	4	5	D/K
Staff can explain what recovery is and why and how it guides agency work	1	2	3	4	5	D/K
Encourages hopefulness/facilitates the instillation of hope.	1	2	3	4	5	D/K
Has new staff training on recovery principles as part of onboarding process.	1	2	3	4	5	D/K
Has continuing education/training on recovery principles and recovery-related topics for all staff.	1	2	3	4	5	D/K
Has hiring practices that reflect / respect the value of lived experience.	1	2	3	4	5	D/K
Has defined clear recovery outcomes for each program.	1	2	3	4	5	D/K
Has recovery-driven quality improvement processes/goals.	1	2	3	4	5	D/K

Domain 2. Fostering a Recovery Culture and Environment within the Organization

Establish and maintain a culture of recovery.

The organization	Never	Rarely	Sometimes	Often	Always	
Has a culture that focuses on and adapts to the needs of people rather than those of the services	1	2	3	4	5	D/K
Is open and transparent	1	2	3	4	5	D/K
Is a learning organization, open to challenges						
Is linked with the wider recovery movement						
Is an autonomous space	1	2	3	4	5	D/K
Participates in advocacy	1	2	3	4	5	D/K
Demonstrates commitment to equity practices and principles through its policies and practices	1	2	3	4	5	D/K
Demonstrates commitment to diversity and inclusion through its policies and practices	1	2	3	4	5	D/K

Domain 3. Centering Lived Experience in Program Design, Development, and Practice

Prioritize the perspectives and insights of persons with living and lived experience of substance use and recovery.

The organization	Never	Rarely	Sometimes	Often	Always	
Involves persons who use drugs, and persons with living and/or lived experience of recovery on agency committees.	1	2	3	4	5	D/K
Engages peer staff and other persons with lived experience in the co-creation of programs and services.	1	2	3	4	5	D/K
Has mechanisms for integrating suggestions from persons in recovery into service improvement efforts.	1	2	3	4	5	D/K
Pursues flexible, adaptive, and contextual solutions to address barriers to recovery.	1	2	3	4	5	D/K
Engages peer staff and other persons with lived experience in the design and delivery of recovery-related training.	1	2	3	4	5	D/K
Engages peer staff and other persons with lived experience in the design and delivery of communications and advocacy initiatives.	1	2	3	4	5	D/K
Has senior or management-level lived experience or peer roles with authority.	1	2	3	4	5	
Has many peer workers all levels within the agency, commensurate with the number of individuals served.	1	2	3	4	5	
Has sufficient ratio of peer to non-peer staff.	1	2	3	4	5	
Addresses power dynamics and imbalances among staff roles, seeking to minimize the imbalances.	1	2	3	4	5	

Domain 4. Establishing Working Relationships with Participants

Partner with individuals and their families to shape their own future.

The organization	Never	Rarely	Sometimes	Often	Always	
Believes that each person has a positive future.	1	2	3	4	5	
Defines care as a relational practice.	1	2	3	4	5	D/K
Views individuals as more than a “case” or a diagnosis; staff get to know each as a person.	1	2	3	4	5	D/K
Treats individuals as a whole person.	1	2	3	4	5	D/K
Is responsive to cultural heritage.	1	2	3	4	5	D/K
Is responsive to gender identity and sexual orientation.	1	2	3	4	5	D/K
Ensures that language and access barriers are proactively addressed.	1	2	3	4	5	D/K
Uses trauma-informed approaches to support individual recovery.	1	2	3	4	5	D/K

Domain 5. Supporting Personally Defined Recovery

Focus on personally defined recovery, with recovery at the heart of practice.

The organization	Never	Rarely	Sometimes	Often	Always	
Supports individuals as they define their own needs, goals, dreams and plans for the future, and uses those to co-create the content and context of services/ care.	1	2	3	4	5	D/K
Offers individualized services to meet unique, individual needs.	1	2	3	4	5	D/K
Assists individuals to develop knowledge and skills that are needed for self-defined recovery.	1	2	3	4	5	D/K
Offers (or partners to offer) wellness programming.	1	2	3	4	5	D/K
Offers support for basic needs (income, housing, health care).	1	2	3	4	5	D/K

Domain 6. Promoting Purpose/ A Life in the Community

Support people to develop and build a meaningful life in the community.

The organization:	Never	Rarely	Sometimes	Often	Always	
Asks what is meaningful to individual participants.	1	2	3	4	5	D/K
Encourages individuals to do things that give their lives meaning, as defined by the individual.	1	2	3	4	5	D/K
Facilitates development and accumulation of recovery capital.	1	2	3	4	5	D/K
Assists individuals in building a recovery network—positive relationships with other persons in recovery.	1	2	3	4	5	D/K
Encourages individuals to stretch and grow, taking on new challenges.	1	2	3	4	5	D/K

Domain 7. Supporting Authentic Peer Work

Establish and maintain a work environment that is conducive to peer work.

The organization	Never	Rarely	Sometimes	Often	Always	
Has a commitment to peer work, that is designed to be long-term and ongoing.	1	2	3	4	5	D/K
Has clear and meaningful peer roles.	1	2	3	4	5	D/K
Engages peer workers in multidisciplinary teams.	1	2	3	4	5	D/K
Has supervision that is appropriate for peer practice.	1	2	3	4	5	D/K
Has effective onboarding, orientation, and context-specific training for new peer staff.	1	2	3	4	5	D/K
Has ongoing training, mentoring, networking, and professional development opportunities for peer staff.	1	2	3	4	5	D/K
Has reviewed and refined policies and workflows to effectively integrate peer work.	1	2	3	4	5	D/K
Regularly reviews policies and workflows with peer staff to preserve the integrity and authenticity of peer roles.	1	2	3	4	5	D/K
Has career pathways or bridges for more challenging peer work.	1	2	3	4	5	D/K
Has policies/ practice in place to support staff wellness and self care.	1	2	3	4	5	D/K

Next Steps

- Look at your responses in each domain. They provide a picture of the organizational strengths, gaps, and potential barriers to success. Consider:
    - Where were the 5s?
        - Are they clustered in a specific domain or related domains?
        - What do these indicate about the recovery-related strengths of the organization that can be built upon?
    - Where were the 4s?
        - What do these indicate about the recovery-related strengths of the organization?
        - What could be done to shift those to 5s?
    - Where were your 1s and 2s?
        - Are they clustered in a specific domain or related domains?
        - Which domains are a high priority for improvement?
- Share information with agency leadership and staff.
- Educate community members and leaders.

About the Peer Recovery Center of Excellence

The Peer Recovery Center of Excellence (PR CoE) is housed at the University of Missouri- Kansas City (UMKC). Partners include the National Council for Mental Well Being, University of Texas-Austin, University of Wisconsin-Madison and our appointed peer-led Steering Committee. Peer voice is at the core of our work and guides our mission to enhance the field of substance-use disorder peer recovery-support services.

The Peer Recovery CoE has five focus areas: (1) integration of peers into non-peer/non-traditional settings, (2) recovery community organization capacity building, (3) peer workforce development, (4) evidence-based practice & practice-based evidence dissemination, and (5) diversity, equity, and inclusion. In addition to trainings and publications, the Peer Recovery CoE accepts technical assistance requests from any individual, organization, community, state or region in need of training relating to peer recovery support services for substance use challenges.

Partnership with the National Council for Mental Wellbeing

This toolkit was authored by The National Council for Mental Wellbeing as part of their work leading our efforts focused on the integration of peer recovery support specialists into new and expanding settings. The National Council for Mental Wellbeing has more than 40 years of experience as a national thought leader advancing modern, research-based training, TA, and knowledge transfer activities on topics of behavioral health. The NCMW has designed, implemented, and evaluated over 1,500 initiatives to improve behavioral health practice at local, state, and national levels. The NCMW has trained staff at numerous organizations in domains of mental health literacy and appropriate interventions to address behavioral health challenges.

About the Authors

Elizabeth Burden, MS

As a Senior Advisor with the National Council for Mental Wellbeing, Elizabeth Burden works to advance substance use prevention, treatment, and recovery support services, providing training and technical assistance to a wide range of organizations and participants.

Ms. Burden has more than 20 years experience working with local, statewide, and national recovery-centered organizations, assisting them in translating knowledge to action in the areas of community building, organizational development and transformation, and program planning and development. She has facilitated participatory processes and provided trainings for grantees of several federal agencies and programs including the SAMHSA Center for Substance Abuse Prevention, the SAMHSA Center for Substance Abuse Treatment, the US Health Resources and Services Administration, US Department of Housing and Urban Development, and the Centers for Disease Control and Prevention.

Aaron Williams, MA

Aaron Williams has more than 20 years of experience providing training and technical assistance in the field of behavioral health services, with an emphasis on substance use treatment, prevention, recovery, workforce development, and the implementation of evidence-based-practices in clinical settings. Mr. Williams has written and contributed to numerous articles and reports on drugs of abuse, primary care and substance abuse integration, SBIRT, mental health and primary care integration, workforce development of behavioral health providers, and the implementation of medication assisted treatment services.

Mr. Williams holds a bachelor’s degree in psychology from Morehouse College and a master’s degree in psychology from The Catholic University of America.

Acknowledgements for Contribution to the Document

Thank you to those who assisted with content expertise, review, design, and editing:

Adam Viera

PR CoE Co-Director, University of Missouri – Kansas City

Johanna Dolan

PR CoE Steering Committee, Peer Integration

Kevin Comeau

Senior Advisor, National Council for Mental Wellbeing

Kris Kelly

PR CoE RCO Capacity Building Lead, University of Wisconsin – Madison

Matt St. Pierre

Senior Advisor, National Council for Mental Wellbeing

Shannon Roberts

PR CoE Program Manager, University of Missouri – Kansas City

Sharon Hesseltine

PR CoE Steering Committee, Chair