■ MEETING OVERVIEW

Building Peer-Driven, Peer-Led Recovery Support Services

SUPPORTING RECOVERY: BUILDING INDIVIDUAL, FAMILY, AND COMMUNITY WELLNESS

A Community Breaking New Ground

Grantees were facing new challenges when they gathered at the fourth annual meeting of the Recovery Community Support Program (RCSP) sponsored by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA). They were in the earliest stages of designing new peer-to-peer services that would help people recover or support their recovery.

■ Agenda and Structure of the Meeting

Representatives of 31 currently and formerly funded local, State, and regional project communities of people in recovery from addiction, their families, supporters, and allies, attended four types of community-learning sessions:

- Plenary presentations, where new concepts were introduced and processed through sharing and discussion
- Interactive Training Institutes, offering skills-building opportunities in task areas important to developing peer-driven and peer-led service initiatives
- Grantee-facilitated Discussion Groups to: (1) advance the conversation about complex issues and ways to maintain and build on RCSP core values and lessons learned, and (2) describe models of service that have already emerged
- Events focusing on resource sharing and networking, training in evaluation (for project staff), and honoring the recovery experience.

The Context for the Meeting

From 1998 until 2002, the RCSP grantees had directed their attention to building new recovery community organizations to participate in the public dialogue about addiction, treatment, and recovery. The recovery community gained recognition as a community with a distinct voice and new ideas to bring to the field.

From the beginning, recovery communities participating in the RCSP had pointed to the need to support people before and during early stages of recovery or when there was a danger of relapse. The need to focus on sustaining long-term recovery and the role of peer support also had been identified by leaders in healthcare fields. Now, changes in Federal priorities had made the development of recovery support services a possibility.

Grantees learned in March 2002 that the program's emphasis would be refocused on peer-driven recovery support services. By July, grantee leaders had taken the initial steps toward defining and explaining new peer-driven recovery support services to their communities. They were determining what specific services they would offer to people in their communities. Still, despite their progress, they came with many questions.

Grantees Defined Meeting Goals at Earlier Meeting

In March, CSAT also had asked representative grantee leaders how this meeting could be planned to help them move into their new role. The RCSP leaders said they wanted help in:

- Expanding thinking about the process of recovery and conceptualizing the healing dynamics of peer support in ways that could be integrated into the design of peer-driven recovery support services
- Exposure to models of peer-driven services, including those already emerging within the RCSP and in other communities of care
- Intensive skill-building opportunities that would build on lessons learned from past RCSP experience and that would introduce new knowledge and skills
- Opportunities to "advance the conversation" about promising approaches to peer-led, peer-driven support services
- Guidance on specific grant requirements, especially data collection and evaluation
- Continued building of community and staying in touch with the emerging recovery movement.

These requests from grantees became the goals for the meeting.

Meeting designers aimed to present recovery as a wellness-driven process facilitated and supported by communities of peers. Through dialogue and shared learning, it was hoped that deliberations at this meeting would add to the growing body of experience and knowledge coming from the recovery community and contribute to building peer-driven, wellness-based services.

Guide to *Meeting Highlights*

These *Meeting Highlights* can be used for more than just reviewing the high points of the July 2002 meeting. This document reflects the current thinking about recovery support services, as articulated at the RCSP conference, and it comes from those now engaged in developing them. Thus, it can be a useful resource for explaining new concepts to RCSP membership and community organizations, as well as leading projects in designing services.

Because the agenda was action-packed with helpful information, *Meeting Highlights* also has been designed to be helpful in the actual design of services. It includes numerous learning aids or tools that can be used by

project leaders as they work with members, supporters, and allies to develop models of peer-driven, peer-led services. Also included are tips for establishing good relationships with organizations that need to understand what the recovery community is developing and how new peer-driven services will complement the work they are doing.

Four Meeting Reports summarize the high points of the meeting. The first three reports contain highlights of sessions conducted at the meeting, in Plenary Sessions, Training Institutes, and Grantee Discussion Groups. Meeting Report No. 4 containsa variety of tools used by presentners at the meeting.

- Meeting Report No. 1—Plenary Sessions, page 5
- Meeting Report No. 2—Training Institutes, paage 21
- Meeting Report No. 3—Grantee Discussions, page 41
- Meeting Report No. 4—Tools You Can Use, page 53.

Different readers will be interested in different parts of *Meeting Highlights*, and the "cross-walk" below may help direct you to sections of greatest interest.

To find information on these topics → See pages:

■ MEETING REPORT NO. 1

Plenary Sessions

SUPPORTING RECOVERY: BUILDING INDIVIDUAL, FAMILY, AND COMMUNITY WELLNESS

A Community Eager to Learn

The entire community gathered in plenary sessions to hear the current thinking about peer-led recovery support services from three sources—SAMHSA/CSAT officials, leaders from fields with well-developed peer services, and two current pioneers in the development of addiction recovery support services. Much food for thought was provided to take back to local RCSP projects to help define the nature and scope of peer-to-peer recovery support services for people seeking recovery from addiction.

■ Presenters:

H. Westley Clark, M.D., J.D., M.P.H., FASAM, CAS, Director, CSAT

Anna Marsh, Ph.D., Deputy Director, CSAT

Catherine D. Nugent, M.S., RCSP Project Officer, CSAT

Michael Picucci, Ph.D., MAC, The Institute for Staged Recovery, New York City

William L. White, M.A., Chesnut Health Systems, Bloomington, Illinois

Antigone Hodgins, National Association of People With AIDS, Washington, D.C.

Jean Campbell, Ph.D., Missouri Institute of Mental Health, St. Louis, Missouri

The SAMHSA/CSAT Perspective

SAMHSA/CSAT officials explained how the RCSP works, including its emphasis on peer-driven recovery support services, and how it fits into the mission and priorities of the Federal Government. Their presentations provided a broad context for the important work of the individual RCSP projects gathered from across the country.

■ "We know the way out."

Catherine D. Nugent
CSAT Project Officer

In her welcoming remarks, Cathy Nugent shared her growing sense of excitement about the future of the RCSP.

Welcome, RCSP grantees, to the 2002 Annual Grantee Meeting!

Since 1998, the RCSP has involved much community learning. One of the things that we learned from the experience of the 1998 grantees is that, in your many recovery communities back home, there is a hunger to be very concrete in supporting the sustained personal recovery of others.

The new RCSP emphasis on peer-to-peer recovery support services responds to that felt need. SAMHSA and CSAT are confident that recovering peers have something special to offer. In keeping with the rich traditions of the recovery community, I will tell a story to illustrate the capabilities you have to offer.

A man falls into a hole. It is very deep, and the walls are so steep that he can't get out. A doctor walks by, and the man calls out, "Can you help me?" The doctor writes out a prescription and throws it into the hole.

Then, a priest walks by, and the man yells, "Can you help me?" The priest writes a prayer and throws it into the hole.

Finally, a friend walks by, and the man again asks for help. The friend jumps into the hole with him, and the man says, "Why did you do that? Now, we are both in this hole."

The friend replies, "Yes, but I've been in this hole before, and I know the way out."

Anyone with any knowledge of recovery from addiction can relate to the power of that friend's experience and knowledge, as well as to the desire and willingness of people in recovery to extend a helping hand to others with the problem they once had themselves.

■ "I believe that we can establish models for the rest of the treatment delivery system."

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
CSAT Director

The recovery community has become a key player in the addiction, treatment, and recovery fields. RCSP grantees now have an opportunity to pave the way to concrete improvements in the systems serving people addicted to alcohol and other drugs. Here are the key messages from the Director of the Center.

When SAMHSA first supported the development of recovery community organizations, no one was certain what would emerge. Today, we see the recovery community as an important stakeholder.

We have heard a new voice and felt a new vibrancy within the field. For too long, people in recovery and their families were not even in the dialogue about addiction and treatment. That is changing now.

Peer-Driven Services Will Become Central

SAMHSA's Administrator, Charles Curie, strongly supports community-based services to help prevent relapse and promote early intervention and recovery. I know the approaches you develop will contribute to the overall improvement of services to people with addictions to alcohol and drugs. You will become more central to the field by providing recovery support services, and I salute you for your efforts.

Research shows, and the field recognizes, the importance of communities of peers in keeping people clean and sober. You in the recovery community have always been messengers of hope and providers of support to your peers. We hope that the RCSP's emphasis on peer-driven recovery support services will respond to your passion for giving back, and fire your imagination to devise additional ways to expand the comfort and support you have traditionally offered. We believe you will find new ways to help people in recovery to avoid relapse, strengthen their resolve to stay clean and sober, and lead healthy, productive, and fulfilling lives. We have faith in you. We believe you can do this.

Through the Recovery Community Services Program, I believe that we can establish models for the rest of the delivery system. By helping prevent relapse, by helping people stay in recovery rather than recycling through treatment, you will be helping to free up much-needed treatment capacity for others. You also will be in a position to intervene early with troubled peers, helping them quickly get the support and services they need. We think this will help minimize the negative consequences of relapses when they do occur, and may translate to shorter lengths of stay for relapsers.

Services Linked to SAMHSA/CSAT Priorities and Principles

Peer recovery support services can, in the long run, reduce the number of people in the criminal justice system, increase high school graduation rates, lower our Nation's social and health costs, and significantly increase our people's productivity and collective happiness. When you get down to the essentials, those are the end goals of the SAMHSA/CSAT priorities and principles.

■ "You will be in a position to provide a safety net."

Anna Marsh
CSAT Deputy Director

The CSAT Deputy Director placed the RCSP within the context of the President's policies and priorities as established in the National Drug Control Strategy overseen by the ONDCP, the cross-cutting priorities and principles identified by SAMHSA as its tools for implementing these policies and strategies, and the National Treatment Plan that emerged from CSAT's focused strategic planning process.

The RCSP is now a powerful and positive force at CSAT, with significant accomplishments in a remarkably short time. Though relatively small, the program is central to our mission and fits quite nicely into the SAMHSA/CSAT overall program in many ways.

RCSP and the Federal Drug Control Strategy

With your new focus on peer-driven recovery support services, you are positioned to help carry out the Demand Reduction Strategy of the President's National Drug Control Policy in each of the three main emphases: stopping the initiation of drug use, intervening when it becomes a problem, and improving treatment. Your powerful recovery message and example will help stop the **initiation of drug use.** Peer-driven recovery support services will help prevent the **re-initiation of drug use.**

You will be in a position to provide a safety net for those in recovery. You will be able to **intervene** early with persons who may be at risk for relapse—or who have relapsed—helping them quickly get the help they need to return to a sober and drug-free lifestyle.

And, finally, the innovative peer support services you will be offering will add to the existing continuum of care, providing long-term supports that exceed anything offered in traditional aftercare—and that are qualitatively different because they are peer-run. In this way, you will be improving the service delivery systems in your communities.

The RCSP Within SAMHSA's Priorities

The peer-driven recovery support services you are planning now—and soon will be doing—fit with many of **SAMHSA's priorities and cross-cutting principles.** All of you are dealing with **recovery and stigma**. You are **forging collaborative relationships** and **addressing issues of cultural competence** as you make the shift to the new services emphasis.

Many of your projects have addressed how addiction coincides with **violence, abuse, and trauma.** All of us at CSAT are looking forward to the insights and lessons you generate from your recovery support efforts as we all focus more attention on the devastating problem of trauma. This has been an important topic at CSAT because such a high number of people in treatment and recovery also have a history of trauma.

As you begin planning, I hope you will consider new services that will support and promote these priorities. Many of these priorities involve populations with which you are already working. Consider your outreach to communities that are **homeless, senior citizens**, have

been **affected by HIV**, have **co-occurring disorders**, have experienced **trauma**, or have had **experience with the criminal justice system**. How can your services address the needs of these populations?

Addressing these issues should be helpful as you consider the sustainability of your program within the CSAT funding portfolio, because to survive in our current environment, it is important that all programs address the ONDCP priorities and the SAMHSA Administrator's strategic vision and priorities.

Those of us who have survived the turmoil of pain and devastation in our lives are sometimes blessed with a particular gift. That gift is an increased sensitivity to hearing the cry for help of other people suffering from similar affliction. As with the cry of a child in need, we feel compelled to respond. We wish to prevent the suffering we have known. We want to give back—because we are grateful for our own growth and recovery. And we want to teach others what we have learned.

At CSAT, we stand behind you in support as you share your experience, strength, and hope with others in recovery. Together, let us work toward the day when each cry for help can be met with a helping hand.

■ MEETING REPORT NO. 1: PLENARY SESSIONS, PART II

Voices from the Field

Three plenary sessions explored the conceptual and historical context in which RCSP grantees will be developing peer-to-peer recovery support services. Keynoter Michael Picucci introduced his research and therapeutic work on "staged recovery," inviting participants to expand their concept of recovery beyond recovery from the primary addiction to drugs or alcohol to encompass a holistic recovery of a full and integrated life within the community.

Luncheon speaker William White shared with participants his vision of how refocusing on recovery could transform the treatment system from its current pathology-based acute-care focus on crisis intervention and stabilization to a focus on resiliency-based recovery. Panelists who have been in the trenches developing peer-led services in fields related to addiction—HIV/AIDS and mental health—shared tips and lessons from their experiences.

■ "If we can heal addiction in community, we ought to be able to address our other needs for healing in community, too."

Michael Picucci
The Staged Recovery Project
The Institute for Authentic Process Healing
New York, New York

"Hi, my name is Michael Picucci and I am in recovery from alcohol and drugs. I am also in recovery of my emotional, spiritual, and sexual wholeness. This understanding has become a groundbreaking distinction for me." With these words, RCSP grantees were introduced to a researcher and therapist who has focused on the continuation of healing after early recovery tasks have been completed. Picucci conducts heuristic research. In heuristics, the researcher is part of the research and reports from the center of it, which is his own life experience. This reporting of one's experience is accompanied by rigorous definition, careful collection of data, and a thorough and disciplined analysis. Picucci's research journey started at a retreat for singles on spirituality in recovery, where he had a life-changing insight that led to his conceptualization and design of what he now calls staged recovery. He shared the steps of his journey, as well as some of his findings, with the audience.

My journey in developing Authentic Process Therapy began at a retreat when I shared with others my struggles in attempting to maintaining a long-term intimate relationship. After sharing, I asked the group: "Do any of you identify with my experience?" Amazingly, all 45 hands in the room went up. Way up.

"Wow!" I said to myself. "What is happening here?" Obviously, all of the participants strongly identified with my struggles. I felt comfort in recognizing I was not alone. But I was also furious that no one had told me that what I was experiencing was universal.

Then I had an epiphany. If we can heal alcoholism and drug addiction in the community, with our 12-step and other programs, why aren't we speaking to each other about *other* challenges we are facing in recovery, and healing them together, too? I also wondered what else we were all struggling with, but not talking about.

Today, I look back at that retreat as a clear demarcation of my crossing the threshold into a second stage of recovery, dealing with other problems then not spoken about. It was a threshold in my personal journey of recovery. The curiosity ignited at that retreat also inspired my future research and professional work on the two-stage recovery model.

Building on Others' Work

Ernie Larsen birthed the term Stage Two Recovery, the idea that recovery from an addictive disease involves two major phases. He defined the first stage as attaining abstinence and the second stage as putting one's life back together. John Bradshaw developed the first framework to staged recovery in *Healing the Shame That Binds You*. Since those early days, I have also integrated advanced thinking from other fields, especially trauma healing, and have learned from such thinkers as Peter Levine, author of *Walking the Tiger: Healing Trauma*.

People Want a Higher Level of Wellness

We learned much that was interesting in our research. What do people want from recovery? Do they just want to be sober? Or are they looking for something more? After extensive survey and research, we discovered people wanted a higher level of recovery, which we called Stage Two Recovery. This stage focuses on wholeness, and includes physical, psychosocial, and spiritual wellness.

We have identified "five powers" for dissolving barriers to wholeness. In illustrating this concept, we graphically surround these powers with a respect for self and others. We do that because we think of this respect as essential, surrounding and running through the powers as an electric current. (See next column.)

When we say respect for self and others, those words are intentionally placed, as respect for self comes first, before respect for others is possible.

Facing any complex situation, we can always check in with ourselves: Am I respecting myself? Am I respecting the other? And if we can say yes to both of those, we are on solid ground.

Messages in the Powers for RCSP Work

Each of these powers has messages for the RCSP grantees developing recovery support services. They help define the nature and essence of peer-to-peer support. These powers are:

- ***The Power of Community-Based Healing***

  You know this power because you have experienced it. Now, let's stake and hold our claim that we know it, and use this power intentionally.

- ***The Power of Shared Intentionality***

  Intentionality is one of the most powerful forces in the universe, but our culture is not consciously aware of it. We use it in our 12-Step experiences, where the entry requirement is simply a desire to stop drinking. When people in a community share the intention to become sober, they are successful. The Constellation of Desires is the basis of shared intentionality for Stage Two Recovery.

The Five Powers:
Dissolving Barriers to Wholeness

Respect for Self and Others

The power of community-based healing
The power of shared intentionality
The power of shared belief
The power of authentic process
The power of grounding through resource.

Respect for Self and Others

- ***The Power of Shared Belief***

  People in recovery also have experienced the power of shared belief. In Stage One, at first, our belief that we can become sober is very weak, and we sometimes have to borrow that belief from others in the community. Slowly we make it our own, and our success accelerates. In Stage Two, we use this power of shared belief very consciously.

- ***The Power of Authentic Process***

  In 12-Step jargon, we might think of this as rigorous honesty. Authentic Process is an update with an energetic twist. It means power lies in being real. You don't have to do anything to impress anybody. Just be you. The authentic process is the process of being real with one's self and each other.

- ***The Power of Grounding Through Resource***

  This last power comes with our growing understanding that a power is available to us all, whenever we need it, an invisible resource that we can draw on. We begin to learn, in Stage One recov-

ery, about the power of love, connection, and possibility, but the power of grounding is invisible. We don't pay as much attention to it as to what we can see or touch. But we experience it.

In Stage Two, we pay attention to invisible realities. They become guiding powers and principles. We learn, often through imaging, to tune into these unseen guides, experiencing them as felt senses in the body, directing our course. We learn to experience the unseen realities the same way we learned to experience how good it felt to be clean and sober.

I noticed, when I began doing this work, that many of us in recovery have had a history of trauma. My working definition of trauma is "a broken connection with spirit." It is a loss of connection to a part of ourselves and the wholeness that is our birthright. We lose the connections among parts of ourselves, our resources, resilience, and our spiritual and erotic selves.

Trauma: Healing Broken Connections Through Resiliency-based Structures

Healing these broken connections can be the central focus of Stage Two Recovery work. Healing can occur when we create and engage within communities organized around resiliency bonding. In safe settings, one's traumas present themselves organically, one by one, for resolution. Life traumas become points of strength in an authentic presentation of oneself, as a survivor, alive, and happy.

If we don't create resiliency-based Stage Two structures to move through, we can get stuck in a "trauma bond." This is certainly better than when we were drinking and drugging, but we are stuck, nonetheless, in terms of wholeness and self-realization. Healing of a primary addiction (in a 12-Step or other community setting) is for most of us the dissolving of the first barrier to wholeness. After this is accomplished, resilience-based peer-driven communities can help us efficiently dissolve other barriers shrouded by the addiction.

Note: Dr. Picucci was awarded the prestigious Outstanding Leadership in Research award for the year 2000 by the National Institutes on Health (NIH), the National Institute on Drug Abuse (NIDA), and the National Association of Alcoholism & Drug Abuse Counselors (NAADAC). He is the author of *Journey Toward Complete Recovery: Reclaiming Your Emotional, Spiritual and Sexual Wholeness.* Additional information on staged recovery and authentic process healing can be found on the website http://www.theinstitute.org/ and his full RCSP keynote address is available at http://www.theinstitute.org/keynote.htm.

■ "We say addiction is a chronic disease. But we don't treat it that way."

William L. White, M.A.
Chestnut Health Systems
Bloomington, Illinois

Noted recovery-community historian William White, author of Slaying the Dragon: The History of Addiction Treatment and Recovery in America, *posed challenging questions. If addiction is a chronic disease, he asked, why do we treat it in the same way we treat a broken leg or a bacterial infection, with self-encapsulated treatment interventions offered to the client as a prescription for fixing the problem once and for all? Why, when this acute intervention approach fails to deliver a sustained recovery and the client relapses, do we recycle him or her through the same treatment regimen provided before? Has the treatment system, White asked, become nothing more than an acute intervention modality, aiming at crisis stabilization rather than long-term recovery? White then invited meeting participants to integrate the insights emerging from recovery community advocates into the new RCSP emphasis on peer-driven recovery support services.*

Recovery advocates are concerned that mainstream treatment has become detached from recovery. The new emphasis on peer-driven recovery support services is an invitation to strengthen the linkage between treatment and recovery. It has the potential to widen the doorways of entry to recovery as well as deepen the quality of recovery.

You must do more than simply develop and provide recovery support services. You can help bring about a fundamental, and much needed, shift—from an acute treatment model to a recovery model. You, as recovering individuals and families, have an opportunity to become more than a loosely attached appendage to the treatment system.

You also have the opportunity to move peer services inside that system and help to fundamentally redefine what treatment is. As you move into these service roles, you will become ever more powerful advocates and internal change agents, working to change the treatment system as we know it.

The Recovery Management Model

The phrase I use to describe the vision that I believe you and other recovery advocates have articulated is "recovery management."

The concepts underlying recovery management do not come to us out of left field. They are consistent with clinical research and treatment outcome studies, including research from managed care. They are consistent with the learnings from the application of chronic disease management models in primary care and mental health fields. They are consistent with consumer advocacy approaches in many fields, including our own.

Recovery Management and the Current Treatment System

From the outset, we have to recognize that recovery management does not, and cannot, replace acute treatment. It wraps it in a larger continuum of pretreatment (recovery priming), in-treatment, and post-treatment recovery support services. In so doing, it balances the

focus on acute treatment with a focus on promoting recovery readiness and supporting recovery maintenance.

You will not be able to promote recovery management in a vacuum, separate and apart from the acute treatment system. You will need to work with it, respecting its capacities, while recognizing your own. You will be seeking partnership, not competing, with existing services. See Meeting Report No. 5, *Peer-Driven Services as Part of a Recovery Management Model*, page 79.

What is Recovery Capital and How Does it Fit Into Recovery Management and Peer-Driven Recovery Support ?

Recovery capital, a term recently introduced by Robert Granfield and William Cloud (see note at end), refers to the total store of resources that a person can bring to his or her initiation of recovery. It can mean many things: financial resources, treatment resources, a supportive family, a supportive community. All these things add up to hope, which is the most effective recovery medicine that we know.

Recovery capital also can be depleted by many things: trauma and abuse, co-existing physical and mental disorders, financial and educational deficits, stigma (including compounding stigmas relating to race, ethnicity, sexual orientation and so on). These things add up to an absence of hope.

"We have long held the theory that a person needs enough pain to hit bottom before he or she can begin to get better. Treatment, mutual aid—these are ways to begin to build hope in the face of that pain. These theories, and these strategies of intervention, were developed by people who were largely white, middle class, and male. Did we miss an underlying assumption? Where did the hope come from? Did it come as a gift because it was an entitlement received at birth?"

Recovery capital is not evenly spread among the population of addicts, or among the many communities in our country. In our communities of addiction recovery, peer support has been an enduring source of recovery capital. Today you are invited to spread the recovery capital of peer support more widely, and to contribute to the building of recovery capital where it is most needed.

Think Broad, Not Narrow

Each of your projects will face resource limitations—both human and financial—in terms of what you can accomplish. Collectively, however, you need to keep a big picture in front of you.

Recovery support services should not be merely a post-treatment "add-on." People need recovery support services before treatment starts, while it is going on, and afterward. Recovery support services need to be there at every stage of the process. Indeed, they need to reach people who are not in, and perhaps cannot succeed through, formal treatment. The goal is a continuum of recovery support services that can meet the stage-appropriate needs of people who are seeking to initiate recovery or working to sustain it.

Recovery Includes More than the Individual

Furthermore, recovery is not simply about a person's relationship to alcohol or drugs. The norm for those entering treatment today is a person with many interlocked problems nested within a larger complex of family and community problems. Recovery support cannot ignore co-existing needs, cannot ignore family, cannot ignore community.

The term client is now used to refer to an individual patient in treatment. The meaning of that term needs to be redefined and enlarged to include the individual's intimate family members and the social network that surrounds that system.

A person can "get sober" in treatment. But attention also must be given to the individual's other needs, as

well as the needs of his or her family and the community in which family needs are nested. Otherwise, recovery—in its broadest sense of achievement of individual, family, and community health—simply is not in the cards.

RCSP Challenges

The journey you are embarked on is not for the faint of heart. You will face many challenges. You will face conceptual resistance and funding challenges. You will face stigma and therapeutic pessimism. A risk is that the recovery management model will be misapplied —as the current treatment model sometimes is—to people whose problems with alcohol and/or other drugs are transient, not chronic, or that the emphasis on chronicity will undercut the message that sustained recovery is possible. There is a danger of professionalization and commercialization.

History teaches us, as well, that you will need to struggle with important ethical challenges, including relationship boundaries. I emphasize this strongly: good intentions can feed into ethical vulnerabilities, and can lead to the "shadow side" of both peer and professional helping relationships with the vulnerable and the sick. You will need to heighten your ethical sensitivities, and generate standards out of your own local cultural contexts, to guide your work.

You will need to pool your collective experience to articulate standards to protect people who will receive your services, and to protect yourselves and what you and your recovery community are trying to achieve.

But these challenges need to be put in context. The recovery advocacy message, as I have heard it across the country, is that mainstream treatment has become disconnected, and must get reconnected, to the larger and more enduring process of addiction recovery. The task you have set yourself is large, and the challenges are a measure of the task. But your recovery message resonates in many quarters, and you will find that you have many allies.

Notes:

1) The concept of recovery capital was introduced by Granfield, R. and Cloud, W. (1999) *Coming Clean: Overcoming Addiction Without Treatment.* New York: New York University Press.

2) A more expansive version of William White's remarks will be published in an addictions journal in the near future. Further information on his work on recovery management is available at the Behavioral Health Recovery Management website at http://www.bhrm.org.

■ "People were stigmatized and desperately needed services. Someone had to provide those services."

Panelists

Jean Campbell
Missouri Institute of Mental Health
St. Louis, Missouri

Antigone Hodgins
National Association of People With AIDS (NAPWA)
Washington, D.C.

Discussant

William White
Chesnut Health Systems
Bloomington, Illinois

Moderator

Elizabeth Burden
Burden & Burden Consultancy
Tucson, Arizona

RCSP grantees can learn from the experience of consumers who demanded improved care and took the initiative to define and build peer-driven services. Successful actions by consumers to achieve improved care were described by two survivors of the medical care system—"a psychiatric survivor" and one who is living with HIV. Both speakers experienced being labeled within professionally driven service systems in ways they felt diminished their humanity, and both pointed to consumer-driven programs as means of regaining their personhood. Here are some of the questions asked and the responses to them, together with highlights of the discussant's reflections on the panel from the addiction recovery perspective.

What led to the development of peer-driven and peer-led services in your fields?

Hodgins: Our society did not respond to the needs of injection drug users and gay men who were HIV-positive and/or dying of AIDS and desperately needed care. Because they were so stigmatized, someone had to advocate for people with this illness. But, because advocacy takes a long time and the people were in crisis, someone also had to provide immediate services. People needed help now, and who could they look to but their peers?

Campbell: When hospitals released patients previously locked away in psychiatric wards, people with mental illnesses began to appear on the streets. Society's response was to dehumanize them. Peers and supporters had to take action. They began to band together and use the tools of the civil rights movement to advocate for the rights of people with mental illness—for their civil rights and their right to health care. But existing health care models fell short, as well. Medical models looked at the disease but not the person.

Both of you highlight the need for services to address shortcomings of the existing medical model. What are some of the peer models that have worked? What are some of the specific peer services provided?

Campbell: We have now identified three models of peer programs. The first is the peer support model, which essentially consists of peers just being there for people. The second conducts peer advocacy and training, in which peers develop curricula and train people so they can be strong advocates for themselves and for others. The third model is the drop-in center, providing a wide range of supports. Peers working in the third model would be there 24 hours a day if they could, providing all manner of peer support, along with the provision of washing machines, telephones, and other types of basic assistance.

We are now studying these three models to define their core ingredients. We want to find out if having services run by peers is as important as we think it is. We may find that the reason these services are succeeding lies in the peer principle itself—that belief in helping others and giving people the opportunity to tell their stories.

Many parallel types of service have evolved. Some have increased in sophistication, and staff are now thinking about science-based services. Funding is available if you can provide evidence that your approach works. Peer service providers are going to be hearing the phrase "from science to practice." Some peer-driven groups have reached the stage of measuring their outcomes.

Hodgins: We found it was important to have a social support system provided by peers who could offer counseling, recreation activities, and mentoring. People need to talk to someone who looks and talks like they do. Someone needs to tell people how to access the services they need, and sometimes go with them to the sites of the services. Most people need help in understanding what professionals tell them to do.

So we began providing a buddy support system in which we went with the individual to visit a case manager or care provider. People needed a support person to help them get in the door of the health services. We started as volunteers, offering people a place to talk and share information. We found ourselves developing into a service of helping people make the connection to services. We had to obtain funding and hire paid staff who would help ensure people got the care they needed.

We hired some staff, however, who had good helping instincts, knowledge, and a caring manner, but were not peers. The qualities they had were not enough. Our clients needed to be able to talk with peers who had personally experienced HIV and AIDS. Staff without the shared experience were not as effective as those who had been through it.

What are some lessons you have learned that might be useful to people developing recovery support services?

Hodgins: When a person who experienced the illness transitions to being a peer support service provider, that person also needs support services. Dealing with other people's issues, which may trigger thoughts about your own issues, is heavy. It is not fun. So we have a secondary services program for staff.

You also have to consider who is the right peer for a particular client. Am I a peer with someone who had an experience completely different from mine? In some ways, yes. In other important ways, no. Or we may be able to share an experience on some levels but not on others. If you are managing and supervising peer services, you have to really understand what your individual service providers can and cannot do. That is one reason a strong supervisory system is needed in a consumer-operated program.

Campbell: Not everyone who wants to be a provider of peer services can be. Those who have the skills have to be supervised and they have to learn some basic lessons. You can't sleep with your client. You can't date clients. You have to be able to recognize when you are outside your knowledge and skill capability. You have to know when, and when not, to ask for help from someone else. You have to understand boundaries and limits. You don't give out your phone number or pager number. You have to know how to keep from working yourself into the ground, from burning out. You have to save yourself as well. You can't be culturally inappropriate, or you will lose your client. Many well-meaning peers have to learn these basics, and you have to make sure they do.

We are realizing we have to build an infrastructure and we have to show we are providing evidence-based services if we want funding. We are starting to talk about developing Medicaid-reimbursable systems. We are developing information systems. We are certifying people who provide peer services. If we don't do these things, we won't survive.

On the other hand, if you know the right things to do, you just keep doing them. You can't be passive. History doesn't happen to you. You are history. Just keep using the capacities you know you have. The moment will come when you are recognized.

Reflections on Panel Discussion

White: We have just heard much helpful information. As these two speakers have illustrated, drawing from their own experiences, peers who have been through the recovery experience can do something special for people trying to recover that cannot be done by people without the experience.

Peer-based models began in other fields as a protest or backlash against failures of the health and human services systems and as a result of individual clients' feeling devalued. Peer-based models started by looking at the deficits of mainstream systems to meet people's needs and build from there.

The panelists reported the development of many different types of services. Peer efforts to provide services have a generalist quality. They provide the answer to the key questions that must always be asked: "What do people need and what can we do for them?" The answer to this question is not the same in every community, and your models, too, will be localized.

That will be so because the gaps in the health and human service systems are almost always local, and likely to differ from one area to another. In one area, people seeking recovery may have a great need for housing. In another, services are needed for people with HIV infection or AIDS or hepatitis C, as well as addiction. In still other areas, many people may need assistance with legal rights.

As both panelists pointed out, peer-based models have many strengths, but they also have a shadow side of vulnerabilities which we need to think about and carefully address in our planning:

- When you are working to break down barriers and open doorways, you experience dynamic passion, which can result in overextension and burnout, resulting in high turnover. Both speakers alluded to that problem, and recommended that support services also must be provided for the peers providing support services.

- Peer service is not about creating an organization or an agency, but truly about community. Developing peer-driven, peer-based recovery services should not be thought of as an attempt to replace hierarchical, transient, commercialized services with peer services. Treatment services are provided over specific periods of time—they have a beginning and an end. In

contrast, effective peer relationships endure over time and do not become commercialized.

- We must articulate models of service. As we do so, we must avoid "us-vs.-them" thinking. The issue is not which is better, a doctor or a friend. I don't want a friend operating on me. But I also don't want a doctor talking to me about recovery, because most doctors don't understand it.

- Peer services can help level the playing field for the provider and the recipient of services. But we must guard against bringing peers into an unambiguously defined arena of "peer support" without articulating standards of conduct. Boundaries of ethical behavior need to be established.

- The mental health consumer–survivor movement is to some extent a backlash against coerciveness in mental health systems. Coercion is a factor in addiction treatment as well. We want to empower people by helping them develop recovery self-management techniques.

- What do we do when we encounter individuals who pose a threat to other people? Are we going to become mandatory reporters? We will need to understand these issues, and articulate guidelines.

- We must not undermine the natural systems of the recovery community. We need to develop peer service alternatives in ways that do not weaken the indigenous 12-step programs and alternative support groups in our communities.

■ MEETING REPORT NO. 2

Training Institutes

SUPPORTING RECOVERY: BUILDING INDIVIDUAL, FAMILY, AND COMMUNITY WELLNESS

Members of a Community Seeking Ideas

Ten 5-hour interactive Institutes provided knowledge and skills important to developing peer-driven recovery support services. Each grantee's team members "spread themselves out" through the ten Institutes so they could carry as much new learning as possible back home to begin the job ahead. The leaders of the Institutes had been selected because of their acknowledged leadership skills in the particular task areas, listed below.

The Institutes

1. Community Assessment: Building on Strengths
2. Using Focus Groups to Design Peer Recovery Support Services
3. Best Practices in Developing a Participatory, Peer-Driven Organization
4. Drawing on the Richness of Your Community: Diversity and Inclusion
5. Stigma in Our Work, In Our Lives
6. Becoming Well and Creating Change
7. Friends in High Places: Networking and Stakeholder Development
8. Marketing Your Program
9. Community-Based Healing: Using Concepts of Staged Recovery in the Design of Peer-Driven Recovery Support Services
10. Building the Power of Community through Story and Relationships

■ Community Assessment: Building on Strengths

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During the course of the Institute on community strength assessment, participants moved from initial skepticism to buy-in of the process. They initially saw no difference between a strength-based assessment and a needs assessment. By the end, they realized the difference and agreed that using a strength-based assessment would help them better plan recovery support services.

What is a Strength-based Community Assessment?

As the chart below illustrates, **needs assessments** traditionally focus on the deficiencies and problems of a community. Usually, the process "clientizes" community members and creates the belief that the community needs to rely on the expertise of professionals and professional organizations to solve its problems. The community is taught to focus on its deficiencies and to accept solutions developed and designed primarily by individuals and/or groups outside of the community.

In contrast, a **strength-based assessment** focuses on the inherent capacities of a community and actively involves community members as problem solvers. In most instances, a strength-based approach empowers communities through the development of "peer-to-peer" (versus client to professional) relationships in which experiential, as well as professional, knowledge is valued and respected.

A strength-based assessment has three main components:

- **Identifying community assets**. Typically, community assets can be defined as the individuals, citizen associations, and/or formal institutions found in a particular community.

- **Connecting community assets**. Once the assets in a community have been identified, it is possible to identify the concerns and issues that individuals, citizen associations, and/or formal institutions may have in common. Connecting these individuals and/or groups to each other allows for the development of partnerships, mutual support, and coalition building toward common goals.

	Needs Assessment	***Strength-based Assessment***
What they reveal:	Deficiencies Problems	Capacities Solutions
Who conducts them:	Professionals	Peers
Relationship:	Professional to client	Peer to peer
What is revealed:	Professional insight External solutions	Experiential knowledge Community wisdom
Effect on community:	Disempowerment	Empowerment
Results:	Fragmented services	"Whole"istic approach

- **Bringing into the process those individuals, groups, and institutions not currently involved**. Another component of a strength-based assessment is the identification of assets within a community that can be mobilized to support the goals and activities of a community effort. For example, a community group that is working on youth violence prevention might learn that the local high schools have not been invited or mobilized to support this effort.

Strength-Based Assessment Characteristics

- It is participatory.
- Participants become invested in the process.
- Participants come from the community, citizens' associations, and formal institutions.
- The participation of individuals is valued.

Building Skills for Strength-based Assessment

Skills for conducting a strength-based assessment include identifying community leaders, conducting personal interviews, identifying community priorities, and conducting problem-solving sessions using root cause analysis. A number of tips were offered.

For example, in a community "walk through," participants typically select various locations (such as a community center, park or particular intersection) to conduct observations. They conduct observations during different times of the day at the same locations. In the case of recovery-related assessments, this kind of "geographical walk-through" may need to be supplemented by observations of different kinds of space, such as support groups, public agencies, and other areas where recovery is either supported or undermined.

Identifying community leaders is not simply a matter of identifying individuals with power or position. It involves identifying individuals whom your members and other community residents see as leaders. These community leaders could be people who are respected within support groups, role models in the community, people who take a lead in faith organizations, adolescents who are looked up to by their peers, and so on.

Participants also learned about the "snowball" approach to interviewing. To get a "snowball effect" when interviewing people in the community:

- Begin by asking a resident of the community to identify the leaders in that community he or she thinks you should interview.
- With these names, start a list of the leaders identified.
- When you interview the next person on your list, ask the same question and add the names provided to your list.
- Continue doing this until you have interviewed all the individuals on your list or until the information provided during the interview becomes redundant.
- When the information provided becomes redundant, you are reaching "data saturation" and can stop conducting interviews.

Participants also learned how to do a root cause analysis. In this exercise, they identified a fictitious problem: people committing suicide during conferences. Through this exercise, the group was able to discern how in most communities, problems are caused by many factors, not just one. The learning concluded that solutions should focus on an understanding of all the factors that cause or contribute to a particular problem. A *Process Guide for Community Assessment Using Root Cause Analysis* is included among the tools in Meeting Report No. 4, page 54.

One final tip from this Institute: Be sure to celebrate the victories of the community assessment team. A strength-based assessment is about building community. Celebrating and saying thank-you is not only about courtesy to the community members who participated. It is also about empowerment and building community capacity. So, find ways to publicly recognize your team in your community, such as newspaper articles, getting their work described on a community radio or TV show, or holding a community event to honor them. Even a small thing like a Certificate of Appreciation can be highly valued.

■ Using Focus Groups To Design Peer Recovery Support Services

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Many attendees at this Institute had some previous experience with focus groups, and wanted to acquire more "know-how" about using one to assess community need for peer-driven services. Others wondered if focus groups could be used to assess their current program activities. Conversation quickly turned to the various and appropriate uses of focus groups. Focus groups can be conducted:

- Before a program begins: needs assessment, program development, marketing research
- During the course of a program: exploring peer satisfaction, developing new program aspects
- After a program ends: evaluation and feedback.

In all three situations, a good focus group can provide new insights into program operations, provide details needed by project leaders, help develop or enhance programs and policies, clarify areas of uncertainty, and provide guidance to community leaders.

A focus group is a way to gather research by conducting a discussion among six to ten people who share similar attributes or experiences. The discussion, usually lasting 1 - 1.5 hours, is led by a trained moderator who uses a topic guide to ask the group open-ended questions. The moderator uses "probe" questions to get deeper or more detailed information.

Focus groups are a means of yielding qualitative data—information expressing beliefs, opinions, feelings, and attitudes. They are a way to get quick, low-cost results that are easy to understand and believe. Because of this, focus groups are an excellent tool for grassroots groups to use. They are also a great way to identify potential peer-leaders for recovery support projects.

Focus groups do not produce quantitative data—they do not yield numerical findings or statistics. While they can stand on their own as solid research, they also can be used to set the stage for statistical surveys. Then you will have statistical information about the community that is sound and resonates with community values. In your surveys, you will be asking better questions and getting more meaningful answers.

Four Steps
in conducting focus group research:

1. Planning the focus groups
2. Recruiting the participants
3. Moderating the focus groups
4. Analyzing the data.

Planning and Recruitment

Planning is an integral step in the focus group process and you may want to assemble a grassroots "research team" with interested project members. Individuals who serve in an advisory role in planning and preparation will be of use during the analysis and report writing stages.

Before beginning, it is important for the group to decide why you want to conduct this study, what kind of information you hope to obtain, and what you expect to do with it. Then, assess your resources and decide how many focus groups it is feasible to conduct and what groups it would be most beneficial to target. During the planning phase, you will want to draft the protocol of questions that you want to ask (See Tools, *Focus Group Guide/Protocol, Developing a Focus Group Protocol*

and *Do's and Don'ts for Focus Group Questions,* pages 56 and 59) and designate your moderators and information recorders and decide on meeting logistics. You will need to secure a quiet space, in an accessible location, that can comfortably accommodate your groups.

Some of the factors involved in identifying participants might include geographic location and region, age, gender, race and ethnicity, sexual orientation, income, family size, and ages of children. In addition, categories based on participants' status concerning route to and duration of recovery, disabilities, dual diagnosis and HIV or hepatitis C histories may be pertinent to recovery community findings.

Once you have decided what audiences you wish to target, you will need to put together a recruitment plan. Where are you going to find the participants and how will you recruit and screen them? You may want to consider incentives to entice people to attend, including child care, transportation, refreshments, and a stipend.

Moderators

For the purpose of efficiency, you may decide to contract a moderator and a recorder. However, if you train members of your community for these tasks, the process and end results of the study will be something the recovery community more completely owns. Again, you will need to assess your resources to decide how many moderators you would like to have. Using more moderators will encourage involvement from many different people who are familiar with the target audience and issues at hand. This, however, requires more moderators to be trained, requires heavy coordination, and is likely to prolong the analysis and report process.

Moderators should have good listening skills, be familiar with group dynamics, and know how to create a safe and comfortable environment. While they do not have to have knowledge of the topic at hand, they should be comfortable with and curious about the subject matter, with a degree of enthusiasm.

To become a good moderator requires training. You must learn to ask questions that are not leading, to probe for clarity, draw out all of the participants, and handle conflicts that may arise. In addition, moderators must learn to refrain from giving their personal opinions, coming off as an expert, and using facial expressions that may influence answers. A faculty member at a nearby college or university or someone with established skills in group leadership might be a good trainer.

Analysis and Report

When the focus groups have been conducted and the recorded notes have been transcribed, it is time to analyze the data. Your research team will want to sit down with the information and organize it in a way that builds to what you wanted to find out. A common way to begin is to group the material according to themes and trends. Some of these you may have identified during the planning stages, but some patterns may have emerged through the course of the focus group process.

When your findings are organized, it is time to write them up into a report. This will include a background of your study, your design protocol, and a summary of your findings, as well as more detailed information. This report will be a valuable research tool and will help to guide program initiatives.

This report should be distributed among your membership, to community stakeholders, and to others. It will demonstrate that you have done your footwork and highlight some of the issues in your recovery community, as well as ways your project can address them. It also will serve to heighten their level of members' involvement and "buy-in."

Focus Group Exercise

Institute participants broke into small groups to design a focus group to find out what peer-driven recovery support services were needed. The first group decided to split into two gender-based groups, to facilitate a more comfortable discussion level. Another decided to convene a group in early recovery and another in later recovery. The third group said they would convene groups in different parts of the city.

After experimenting with writing a focus group topic guide (or script), a number of participants found it difficult to ask questions that were not leading or did not use professional jargon. In a section on conducting the focus group, they learned skills in dealing with shy, dominant, difficult, and expert participants.

The workshop closed with a mock focus group, led by two co-moderators from one of the groups. Others played the role of focus group members, some of whom were secretly assigned specific roles (such as the shy participant) or told to behave in particular ways (such as starting a side conversation). After 20 minutes of the mock session, everyone gave feedback and discussed the dynamics of the group.

■ Best Practices in Developing A Participatory, Peer-Driven Organization

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When you found out you were going to be providing peer-driven support services, did you immediately have an image of what they would be and how you would deliver them?

Or was your mind a blank, and you couldn't see your group providing services that would help people get into recovery and/or stay in recovery? Or, did you have so many ideas you didn't know what to do first?

If you had any of these responses, you probably can benefit from using participatory processes with your members to come up with plan for service provision. You can't do it alone, and you will need the help and support of other people, as well as their ideas.

Plus, during this period of change, you will want to sustain your organization. Using participatory processes helps achieve that goal.

Given the many challenges facing them, participants in this Institute agreed they needed help from everyone. The risk of failure was too great to try to come up with a plan by themselves and superimpose it on their organization.

As Elizabeth Burden led them through some principles of using participatory processes, they saw the value of this approach as a principal means to ensure sustainability. And conducting organizational activities in a participatory way would probably increase the likelihood of providing services that would serve their communities well.

What are Participatory Processes?

Participatory means "able to join in, share, or take part in." In organizations that use participatory processes, members are able to contribute to the group, become connected to it, and become integrated into it. Most important, they are able to join in making the decisions. As a result, they are empowered. Many leaders believe that if they share information with members, they are

using participatory processes. They are mistaken. They are just passing on information to a passive audience.

When the main process at group meetings is passing on information, members have no opportunity to develop a sense of involvement or ownership. Since there is no chance to participate, they are likely to stop coming.

We all know that when we join an organization, we want to contribute something to it. When the leader or a small group of people make all the announcements and all the decisions, we don't get a sense of being needed. They can do all of that without us.

Building trust, openness, and honesty among people is essential for groups to congeal and make progress. But, like recovery, building a group with these characteristics is a process. Once a group goes through this process, it will have an open climate in which everyone can participate. When this happens, there will be more ideas, and more possible solutions to problems, and people will feel valued.

How Do You Make the Change to Using Participatory Processes?

This is very hard for people who know all the answers and want to make all the decisions. Many leaders fear that they will lose control, or that members will make the wrong decisions. Others shy away from using participatory process because they don't know how to lead discussions or dialogues. Or, they are afraid they won't be able to. They fear they won't know what to do if members get into a disagreement.

Some guiding principles are:

- Make a commitment to moving from being a leader-driven organization to being a member-driven organization.
- Tell members that you would like to make this move, and ask for their support. Acknowledge that you may make some mistakes.
- Two simple techniques can be used at the beginning of every meeting helps to build trust over time. These are "check-ins," with everyone taking a minute to talk about how they are doing, and ice breakers to get people talking to each other. That's your goal.
- Begin your meeting by stating a problem that needs to be solved. Ask people for their ideas for a solution. Let a dialogue or discussion get started.
- You may want to spend some time talking about the difference between discussion and dialogue. That can help your members start functioning cohesively.

Does your recovery community group have an open or closed climate?

Open Climate

A group with an open climate is accessible, unrestricted, receptive to new ideas, free of bias, and characterized by honesty. In an open climate, trust, effective dialogue, and feedback abound. The level of participation is high, and members engage in a great deal of reflection. Everyone contributes. People keep coming back. Things happen, and results are positive. The group grows. People come to meetings because they want to.

Closed Climate

Members in this group are expected to come to meetings and carry out assignments. Leaders hand out information, based on decisions they made. There is little dialogue or feedback. People don't know each other very well, and don't expect to contribute anything. They may or may not show up when they are given an assignment. They probably don't come back. The group has limited results, struggling to keep members. People come to meetings primarily because they feel obligated to do so.

- Restrain yourself from explaining things to people. Let them find the answers.
- Suggest an assessment of the communitiy's strengths (See Tools, page 54, for a *Process Guide for Conducting Assessments Using Root Cause Analysis*) or a needs assessment. Help people understand the difference between these two forms of assessment.
- After a few meetings, as members begin to feel empowered, you will see the group develop an open climate, in which people trust each other.
- Give responsibilities to members, and let them do things their way. See what happens.
- This isn't easy. It's a process. Trust the process.

And always remember—A leader of the group may be convinced he or she has a great idea for implementation by the group. But it is always a risk to implement it without listening to the group's thinkging. What if most members just don't like the great idea?

The Difference Between Dialogue and Discussion

- In discussions, people hold on to their views and argue for support.
- In dialogues, people's ieas build on each others' ideas, and the group reaches consensus.

Two tools that will help you begin to use participatory processes are included in the Tools, page 60, *Exercises to Help You Begin Using Participatory Process in Your Group.*

■ Drawing on the Richness of Your Community: Diversity and Inclusion

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This Institute explored the complexity of issues that are intimately related to the recovery core values of diversity, and inclusion. Desired group diversities include race, gender, sexual orientation, ability, and economic status, as well as a person's history of using substances and his or her chosen route to recovery.

Participants brought many issues and concerns about achieving a diverse recovery community group to the Institute. Many of these were related to specific situations they were experiencing in the RCSP projects. To address the needs of the group, Stacia Murphy facilitated a discussion of issues that face recovery communities and how these could be resolved. What follows is a summary of some of the learning from the discussion.

Within the recovery community, many complex factors threaten the achievement of recovery core values and inclusion. Cliques may form around diversity issues, and the group can become fragmented. Consequently, we consider the values and ideas of diversity and inclusion extremely important, and as we continue our work, we will continue to find ways to make them real.

Community Activism Can Overcome Stigma

Our recovery communities can help eliminate stigmas about us by activism and the image we present of people in recovery. As work by recovery community organizations continues, a new definition of diversity is emerging. It includes factors such as peoples' routes to addiction and recovery.

How we make people feel comfortable, valued, and included is in our hearts. We want to make everyone feel invited, that we have a place for them. Our

continuing recovery experience deepens our capacity for this kind of hospitality.

As we open our hearts and our doors, we learn about different cultures, thinking less often of them in terms of differences (about which we may have accepted stigmatized views ourselves), and more frequently about the richness that they bring to our work. We have to keep thinking about our collective power, and the potential we have for changing things in our own communities by ensuring they become diverse and include everyone.

Still, there are things that we need to acknowledge. We need to acknowledge that some of the people we work with actively stigmatize us as people in recovery, as well as our organizations. We must acknowledge the internalized stigmas that we all hold. We need to look at the names that we call ourselves and the words that we use to describe ourselves. We must remember that no one can make us feel inferior without our permission.

We Acknowledge Stigma in Our Own Recovery Communities

We need to be alert to the ways we stigmatize others in the recovery community who are not like us or do not look like us. We must acknowledge the profound influence that racism has had not only on our culture in general, but also on the culture of our recovery communities. Racism and stigma are both about power and control and occur in recovery communities just as they do in any organization. We have to think about how they play out in our groups.

Of course, we have to consider internalized stigma and institutional racism, the forms we may not be aware of. If we are not aware of their presence, that means we have to look for them, if we want everyone to be comfortable in our group.

When we recognize evidence of racism, racist thinking, or any form of stigma toward those who are different from the dominant group, we have a responsibility to call it by its name and be held accountable for taking action against it.

We need to address all forms of stigma and to understand that many people in our communities suffer from multiple stigmas. We are well positioned to educate and enlighten others about the complexities of stigma, as well as the merits of diversity. When we experience or witness rejection, we can use it as an opportunity for a "teachable moment."

Finally, we need to realize that, as we do our work in our recovery communities, we raise the community's overall level of consciousness. As consciousness is raised, people will begin to think more about stigma, how it is practiced on them and others, and how they, in turn, stigmatize, both externally and internally. As activists engage in consciousness-raising work, people become more enlightened and change occurs.

> Our recovery communities, though young, are already having an impact on our communities. We are raising the level of consciousness overall, even if we still have much work to do in confronting stigma and racism.

Change often happens very gradually, requiring both vigilance and patience, so that we can be around to claim the prize of a unified and strengthened group. For recovery communities, actions to combat stigma and promote diversity and inclusion are part of our work. If we approach these actions forthrightly, we will have modeled to the world one more aspect of the power of recovery.

Participants expressed the desire to achieve actively functioning diverse groups, which has always been a goal of the RCSP projects. Murphy distributed a list of core competencies for organizations seeking to provide inclusion and work successfully with clients. It can serve as a guide for recovery organizations starting to provide services. See Tools, page 62, *21 Cultural Competencies for the 21st Century.*

■ Stigma: In Our Work, In Our Lives

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On Our Own is a peer-driven and peer-led organization providing services to people with mental illness. Thomas Arthur described the formation of the Anti-Stigma Task Force by the Maryland Mental Hygiene Administration in the early nineties. He emphasized that it was only through a lengthy participatory process and consensus building that the task force came up with the following working definition of *stigma*:

> *A set of predetermined attitudes or beliefs regarding an individual or a group which disempowers or devalues that individual or group and undermines relationships with them.*

To make a point, Jennifer Brown contrasted this with a definition, taken from a 1962 edition of Webster's Dictionary:

> *A scar or brand left by a hot iron on the face of an evildoer.*

Defining Stigma

Participants in the group were invited to suggest their own definitions and descriptions of stigma in their own words that were recorded on flipcharts. Some of the responses focused on stigmatizing behavior and attitudes as being based on power and inequality. Others were concerned with fear and hatred, ignorance, and closed mindedness. In all cases, stigma was recognized as discriminatory and oppressive, sometimes quite subtle and other times blatant.

Brown and Arthur noted that in systems of stigma, shame is both projected and felt. Stigma and shame make people feel stupid, "less than," belittled, embarrassed, and unlovable. Participants also shared about carrying the burden of a history of being stigmatized and the long-lasting effects of this heavy load on individual lives. Many people spoke of the isolating effects of stigma, as well as the tendency to internalize stigma as a self-manifestation.

Finally, participants shared how stigma often allowed them to settle for less, forced them to work harder to prove themselves as worthy, cultivated negative attitudes, destroyed self-esteem, and presented roadblocks that prevented getting help. One participant shared a significant insight, describing stigma as "life-shortening."

> Being stigmatized can be likened to having an illness that drains one's energy. We all know how hard it is to "act as if" when we don't feel well. Stigma can be considered among the many factors that affect one's health negatively—a good reason for trying hard to remove it from our organizations, which are aimed at promoting recovery and wellness.

Following this discussion, participants were split into dyads and asked to share with one another a personal incident in their lives in which they had experienced stigma. Both individuals in each dyad were asked to present a brief synopsis of each other's story to the larger group. The stories helped to personalize the subject and to "bring it home" to the group, saving the subject from becoming too academic. While some examples were recent and others were drawn from earlier experiences in people's lives, all conveyed a sense of inflicted harm which has deep and often permanent implications.

Role Plays Dramatize Stigma

Next, Brown and Arthur performed a series of role plays, in which various forms of stigma were dramatized. Through these vignettes, they illustrated the many venues in the addiction field where stigma might be promoted: between two clients in a treatment setting, between two substance abuse counselors not in recovery, and between a medical professional and a counselor during a client assessment.

One vignette highlighted denial, another was about shifting the focus to someone else, and a third valued professional credentials over the experience of recovery. The vignettes also exposed stigmatizing attitudes in treatment settings, not only toward clients, but also toward practitioners who are in recovery.

Language Matters

The facilitators led participants through practice exercises in how to communicate in ways that do not promote stigma. The exercises included use of language that is clear and free of judgment and use of body language that promotes inclusion and equality.

Among the handouts given to participants was a poster entitled, "Stigma: Language Matters." This poster, targeted to the mental health community, counters disrespectful language with language that honors the person. It also suggests some "Rules of Thumb" that include using "person-first" language ("person with a disability" rather than "disabled"), and avoiding language that emphasizes victim status.

After reviewing the material on language, participants were invited to offer names that have been used to stigmatize people with addictions. Participants had no trouble coming up with words that were disparaging or negative. However, things became more difficult when participants were asked to suggest names that would be less stigmatizing. In this process, there were few names that the group could decide on and many names provoked much discussion and debate. This became especially evident when the names centered around disease. In the end, participants decided that it was okay to "agree to disagree" and that the process of dialogue would need to continue until the recovery community was at a more advanced stage of thinking about language that is no to stigmatizing.

Do we have an illness? Or don't we?

Some participants felt that referring to a person with addiction as a "sick person" was a way to garner empathy and discourage moral judgment. Others said they would rather be considered sick than irresponsible. Still others felt that, while it may be useful in some contexts to indicate we are sick, rather than shiftless, using the term tends to "lock" people in recovery "in their disease," promoting pathology and emphasizing sickness over wellness.

Systemic Change

The session on Systemic Change was broken down into four components:

- **Self-awareness:** A tool for self-assessment that includes skill building in awareness of one's personal role in promoting stigma, one's personal style of communication, and making a commitment to action. (See Tools, page 64, *Self Awareness About Stigma*.)
- **Education:** Understanding the role of education and practicing ways to expand the limits of understanding the roots of stigma and conscious ways to combat it.
- **Contact:** Ways to break down barriers, promote connection and affiliation, and value diversity and inclusion.
- **Action:** Examples were identified by the group, including finding unlikely allies, showing up as a volunteer at other groups' community events, being intentional about building relationships, networking

both consciously and unconsciously, and establishing and maintaining power in numbers by building a broad, diverse membership base.

Learning from Mental Health Consumers

Brown and Arthur generously shared ideas from the work on stigma done by mental health consumers. They were quite successful in guiding the participants through a process that involved defining what stigma means to the recovery community, discussing how people in recovery internalize stigma, looking at stigmatizing language and inventing new terms, dissecting stigma in the workplace, and finding areas for systemic change.

The facilitators were impressed with the participants' insightfulness and capacity to self-reflect on some issues that have potential to enlighten the recovery community and advance its thinking. Many participants agreed that this is work that needs to be undertaken throughout the recovery community, from small consciousness-raising work groups to large public venues.

Two additional tools, *Avoiding Stigmatizing Communication* (from this Institute) and *Creating Messeages to Reduce Stigma: Some Helpful 'Do's' and 'Don'ts'* (from the Institute on Marketing) are provided on pages 65 and 66.

■ Becoming Well and Creating Change

Carmen Vazquez
SpeakOUT! LLGBT Voices for Recovery
New York, New York

This Training Institute demonstrated the relationship between creating wellness-oriented change at the personal level and promoting community change. Institute activities included:

- Learning about a change model that prioritizes building foundational relationships, facilitates successful outcomes at personal and organizational levels, and contributes to personal and community processes for change.
- Learning about the role of the change team in creating a foundation for results.
- Identifying problems and working as change teams to develop action plans.

Relationship Between Individual and Community Responsibility for Recovery

Through a participatory process, Institute members identified a number of factors that contribute to health in general, and to recovery in particular. They are important to leaders, members, and service recipients.

Participants also explored contradictory social assumptions about achieving and maintaining individual health:

- The approved message in our dominant culture is one of rugged individualism; thus, the individual bears the responsibility and brunt of "self-care."
- When self-care fails, the individual, rather than the lack of personal and societal supports, is blamed.

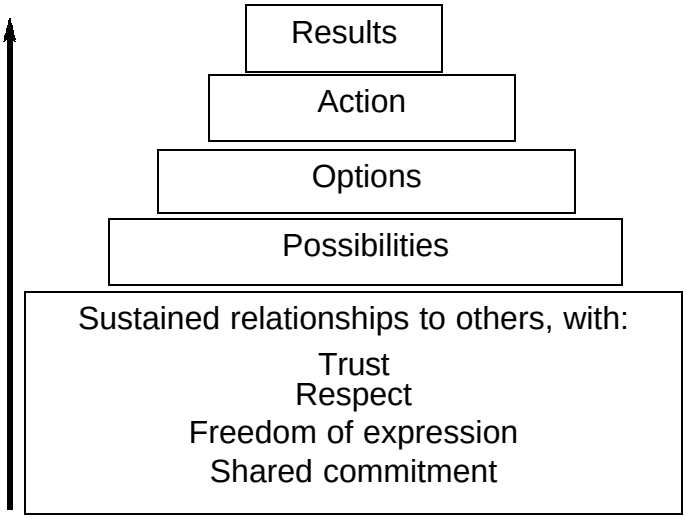
This led to the conclusion that support for healing—including recovery from addiction—cannot happen in isolation. Communities have to work together in a par-

Factors Contributing to Health and Recovery

Culture	Environment
Education	Family and friends
Economy	Government
Media	Self-awareness
Creativity	Good nutrition
Exercise and physical activity	

ticipatory way that values each person. (See page 26). Recovery is about individual change, but that change needs to be supported by community change as well.

Creating Wellness-Oriented Change



Vazquez introduced the model above for creating change. Building from a solid base of relationships works on both the personal and the community levels.

We work to produce results (the change we seek). Whatever results we are trying to produce are a function of the actions we take or don't take. We determine our actions based on available opportunities and options. When we see limited openings to act, our actions are constrained and carefully measured. When we see lots of opportunities to act, our movement is free, robust, and creative. Openings are a function of the kinds of possibilities we see, or even create. The more possibilities, the more opportunities.

Possibilities are determined by the relationships we have with the people with whom we are attempting to create something new. It is limiting and difficult to create anything with people with whom we have little or no relationship.

Vazquez shared with participants Mel Austin's research into how community organizations achieve success in implementing change and remaining well:

- To expand your results, expand your relationships.
- Enhanced relationships facilitate positive growth and change.
- Unfortunately, however, most people spend more time on implementing actions and exercising options than on building relationships.
- Spending time to build relatedness through successful team-building opens more possibilities.
- The size and depth of relationships are based in how much trust, respect, and freedom of expression are present and enhanced by a shared commitment.

Building Groups that Support Personal and Community Wellness-Oriented Change

Participants explored how to build an organization that appropriately invests in relationships and collaboration. Vazquez also provided the five-stage organizational model of awareness and action for creating change, summarized below. Leaders can use it constantly as a benchmark for measuring progress.

1. **Confrontation**—Identifying the need, developing a vision and mission, and establishing accountability
2. **Commitment of Leaders**—Conducting recruitment with clear goals, timetables, and "rewards," and training staff and members.
3. **Sustaining the Effort**—Mentoring, training, "rewards," supportive public stance, ensuring the means to foster retention of members
4. **Continual Problem-Solving**—Self-assessing, getting deeper training, willingness to struggle
5. **Continual Renewal and Recommitment**—Nurturing a sense of team or family, mutual caring overtly shown, benefits for all clearly shown.

Vasquez stressed the importance of having a plan, and provided a model for developing one. (See Tools, page 67 and 69, *Support Services Planning Record and Personal Responsibility Plan.*)

■ Friends In High Places: Networking and Stakeholder Development

Susan Hailman
Campaign Consultation, Inc.
Baltimore, Maryland

We all know organizations and projects that seem to sail through the challenges of building new initiatives. They seem "well placed" to find, negotiate, and fund these opportunities. It is easy and tempting to write off such groups by shrugging and saying, "They have connections."

Susan Hailman challenged participants to consider the possibility that, without compromising their integrity or independence, recovery community organizations could have, and may already have, "connections." Is it possible that the recovery community organization is actually well connected – or at least placed to be well-connected – but simply is not leveraging (that is, using or taking advantage of) its connections?

She helped participants see how their organizations could become better connected by establishing links with powerful people and organizations in their communities. Many of these individuals, if they knew what the recovery community organization was doing, would gladly lend their good name (and maybe their money) to the effort. But first they have to know what the recovery community organization is doing.

After developing concrete networking tips (see below) that have worked for other recovery community organizations, participants discussed stakeholder development. They decided stakeholder development involved a form of networking but was highly strategic and intentional.

Tips on Stakeholder Development

Stakeholders are people and groups who have an interest in what your group is doing, either as individuals or as representatives of a group.

Networking Tips

If you are in recovery, you are a champion. Think of yourselves that way and you will start acting that way, as you familiarize others with your organization's work.

1. Among your members, identify champions with skills such as:
   - People who can walk in the door anywhere and talk about the good work you do.
   - People who can set up and make formal visits to organizations and community groups.
   - People who can prepare publicity materi als.
   - People who can plan simple events.
2. If your members need help developing these skills, start a training program. That's part of leadership development. Leadership develop ment is, in and of itself, a recovery support activity.
3. Make an "accomplishments list," showing what your recovery organization has already accomplished, and a "next steps" list that shows your concrete plan. Keep these lists up to date and make sure everyone can talk about them.
4. Hold simple events that create a "buzz" in the community, such as picnics, block parties, talking circles, wisdom circles, or focus groups.

- They don't know they have an interest in what your group is doing, until you tell them about it.
- If they don't know about your group, they won't know they can help you (or that you can help them).
- Different stakeholders will be interested in different parts of what you are doing.
- Identify your stakeholders and remember who they are. Network with them at every opportunity. Make sure they are on your newsletter mailing list.
- All stakeholders have self interests. (So does your recovery community group.) It is a good idea to approach stakeholders on the basis of their self-interests.
- All stakeholder groups have a turf. So does your group. The objective is to avoid conflicts between turfs, or over turfs, or about turfs.

Gems of Wisdom

- If you want the support of powerful allies, you have to seek them out and educate them about your issues.
- It is everyone's job to **"friend-raise"** for the project.
- Offer stakeholders the opportunity to feel they can make a difference.
- Involve selected stakeholders and encourage them to champion your program.
    1. Analyze honestly the support you have and the opposition you face.
    2. Use this information strategically as a basis for action.
    3. Thank your supporters and ask your opposition for a chance to sit down and talk together.
- Decrease conflict by:
    1 Separating positions from interests
    2. Emphasizing common ground
    3. Using the support of powerful allies to persuade opposing parties into more supportive —or at least more neutral—positions.

Make a chart of your stakeholders and you will be surprised how many you have. Participants made the chart below for a new peer-driven recovery support organization. For more tips, see Tools, page 70 and 73, *Champions for Your Peer-Drived Support Services*, *and Some Tips for Handling Turf Battles and Commptetition.*

A Recovery Support Group's Network of Stakeholders

■ Marketing Your Program

Daphne Baille
Treatment Alternatives for Safe Communities, Inc. (TASC)
Chicago, Illinois

What are the steps in creating a successful marketing effort to let the community know about the recovery support services you are developing?

Step 1. Who are we trying to market and why?

Participants came up with the following suggestions:

- Families of substance users, people in recovery—so they will know about the services we are offering and use them or tell others. So we can work in tandem with treatment.
- People who live in our community, the public—so they will know about recovery and us. So they understand how we can help people chart their way through recovery.
- Treatment centers and providers of related services—so they will know about the SAMHSA/CSAT RCSP nationwide effort to develop peer-driven recovery support services. So they become familiar with what recovery services are and can refer people to us.
- Stakeholder organizations—so they can help us carry the banner for strong, solid recovery.
- Policymakers—so they understand how our work is helping our communities.
- People in need of recovery and their family members—so we can help them get insurance, get into programs. So the whole family (however it defines itself) knows what we offer and how we can help.
- Faith-based community members and clergy—so they can tell their members about our services.
- People who exhibit risky behaviors or are living in environments that put them at risk—so they know we can help them and are encouraging them to seek our services now.
- People with disabilities; Native Americans; lesbian, gay, bisexual, and transgender people; ex-offenders and other diverse and underserved populations—so they will know they are welcome and that we want to help them.
- People living with HIV and family members who want to recover—So we can help them understand the connections between HIV/AIDS and addiction and help them find services.

Step 2. Segment your audience, so that your messages can be targeted in terms each segment understands.

Once you have defined who you want to reach, then identify a target audience as narrowly as possible. You do this by prioritizing groups in importance, to you and to them. How important is it that group X gets the message? Group Y? Unfortunately, many groups skip this step and jump to the creation of products that fail to achieve desired objectives.

The recovery community includes people in recovery, family members, supporters, allies, etc. People in recovery include all ages, colors, ethnicities, sexual orientations, and paths to recovery. These groups may need different messages, if you are going to be effective in marketing.

Step 3. Gauge your audience's perception of addiction and recovery: What do we know about the people we want to reach?

You want to know about the needs, values, and concerns of the people you are trying to reach. For example, what do they know or think about addiction?

Recovery? Do they feel threatened by it? Do they feel this is a problem in your community?
What do people in the group probably think about us? What is their position and where does it come from? Their thinking about morals? Knowing about the medical model? Knowing something about recovery?

Researchers suggest that people go through five stages in accepting new information and viewpoints they haven't thought about before, moving from precontemplation to contemplation, preparation, action, and finally to maintenance.

Many people are probably in what researchers have called the contemplation stage. They have heard a lot about addiction and recovery, but have not come to specific conclusions. Others may have strong preconceived notions.

Conducting research is the best way to get to know your audience. This can be as simple as talking to some people in the group you want to reach and asking them to tell you their thoughts, feelings, and concerns about addiction and recovery.

- **Precontemplation**—Starting to think about a new view, with no intention of acting on the basis of it.
- **Contemplation**—Considering whether to accept the new view and maybe beginning to think about taking action.
- **Preparation**—A stage of knowing they want to take action; "preparing for the start of something new."
- **Action**—Doing something to show acceptance; changing behavior; actually doing so.
- **Maintenance**—Sustaining the new ideas or behavior.

Step 4. Marketing: What is the goal you are trying to achieve?

One important step in marketing your support services is deciding what goals you are aiming for. Without this step, you can't develop a marketing plan that will reach the people you want and attract them to what you are doing.

What is your goal? What do you want to make happen? Short term and long term? What do you want to see different as a result of what you do? What would your audience do differently as a result of your marketing? Change their own behavior? Give money to a recovery support program?

The classic marketing model consists of four elements, known as "the 4 P's:"

■ **Product**—What are we promoting?

How would you describe the benefits of the services you are offering to the community? What benefits are to be gained by people who avail themselves of your "products?" What do you want community members to do to benefit from these "products?"

■ **Price**—How much does this cost?

In social marketing, there may not be a monetary price, but there is still a price. What do people have to give up in order to get these benefits you are offering? What can you do to minimize those barriers?

■ **Place**—Where does the consumer get information about the product?

Where will people get the information about what you are offering? What distribution channels can you use to best reach your audience? Why have you chosen these channels? What can you offer to help groups reduce their barriers to working with you?

■ **Promotion**—How are we promoting the product?

The promotion element is last, because it is necessary to accomplish the other three before taking it on. Promotion is what everyone thinks of when they think of marketing—but this part only comes after you've done the research and thinking. You begin by asking, "Who are we trying to reach and what are we trying to say?" Then, look at how people think about the idea.

How are you going to say it, and where are you going to put it so people see or hear it?

Step 5. Answer the following questions:

1. To what extent did you achieve your desired outcomes? Can you tell why?
2. Which strategies and messages were successful? Why?
3. Which strategies were unsuccessful? Why?

This reflective review can assist you in assessing the effectiveness of your work, placing emphasis on ways to get the message our more successfully in future endeavors.

Note: A helpful guide, *Creating Messages to Reduce*

■ Community-Based Healing: Using Concepts of Staged Recovery in the Design of Peer-Driven Recovery Support Services.

Michael Picucci
Ana Venezia
Institute for Staged Recovery
The Institute for Authentic Process Healing
New York, New York

Michael Picucci started the Institute by asking participants to share in co-creating an environment in which everyone could learn more about his model of Staged Recovery and experience some aspects of Stage Two work, while holding in their minds three questions:

- What can I take from this Institute and share with my friends and colleagues at home?
- What one or two pieces of Staged Recovery can I see working with what my recovery community is planning to do in terms of supporting recovery at home?
- Does knowing about Staged Recovery have an effect on my vision of what is possible, and of what the future of treatment and recovery could look like?

Participants began by looking more closely at the Powers of Recovery described during the Keynote Address (see page 12). Picucci then introduced the Tree Diagram of the Staged Model of Recovery, shown on the following page. At the base of the tree is Stage One, consisting of conscious material experienced by most people in the first two or so years of their recovery, frequently but not always, in connection with 12-Step or other support group work.

Continuing up the trunk as it begins to branch out, comes Stage Two, consisting of unconscious material to be worked through. From the branches of the tree hang the fruits of the tree.

Dr. Picucci described the fruits as *states of being* which are the rewards of the journey to complete recovery. Being able to *name* these states of being when they are happening makes them real, and builds the foundation for a life of holism and full recovery.

During the morning session participants explored these concepts. Picucci and Anna Venezia also shared frameworks and formats for some of their work.

Wisdom Circles

Anna Venezia described a Wisdom Circle in which she participates. A Wisdom Circle is a way for small groups of people to create a safe space within which to be trusting, authentic, caring, and open to change.

A Wisdom Circle is based on ten "constants" or guidelines. It is designed to encourage people to meet in small groups, to listen and speak from the heart in a spirit of inquiry. By opening and closing the Circle with a simple ritual of the group's choosing, using a talking object, and inviting silence to enter the circle,

the group creates a space together that is qualitatively different from an ordinary discussion or support group.

The Wisdom Circle process provides a way to deepen life-sustaining values, and strengthens commitment to those values as a basis for service in the world. The circle also helps develop greater self-awareness, as well as the strength of mutual support. (See *Wisdom Circles, A Guide to Self-Discovery and Community Building in Small Groups*, Hyperion, 1998; http://www.wisdom-circle.org/.)

During the afternoon session of the Institute, Picucci described some of the research into the connections between trauma and addiction. Trauma happens when we experience too much, too fast, too soon. It overwhelms our systems, and our physiological systems get bound up in powerful energies.

When we are traumatized, an enormous amount of activation and energy is released in us. It remains in the body somewhere and we spend the rest of our lives avoiding anything that could come near this trauma. Or, we spend the rest of our lives reliving the trauma over and over and over again in a cycle of trying to break our way out of it. The results are that we either feel disconnected, deadened and depressed or like we have our foot all the way down on the accelerator and brake at the same time.

Picucci also described some emerging trauma healing technologies, many based on cognitive restructuring with body/physiological integration, and his approach to doing this work as part of Stage Two Recovery in communities of peers bonded around resilience. In addition to gentle experiential work, coupled with a teaching exercise, the group explored these concepts and the role of a peer who is also a trained therapist and facilitator in creating a safe and comfortable place.

Stigma, is presented in the Tools section on page 66.

Building the Power of Community Through Story and Relationships

Kim Matic **Terry Leckron**
Ron Williiams **Kelly Fitzpatrick**
Recovery Association Project (RAP)

The primary organizing tool used by RAP is face-to-face conversation among small groups of people talking about issues and problems that are important to them and why. As these discussions continue, people begin to relate to each other in new ways. They make connections, and a group takes shape, developing relationships around shared issues.

Ultimately, the group develops shared power, as demonstrated by changes in public health policies and practices affecting people in recovery or trying to recover in Portland, Oregon.

This doesn't just happen by itself, and Kim Matic and Ron Williams explained and demonstrated the process of using shared stories to build collective power. Building this power is very intentional and focused. RAP begins with what it calls an intentional conversation between a RAP leader and a person in the community. Following a series of small meetings with several individuals, each person is invited to a reflection group session, in which main points brought up in the one-on-one conversations are discussed. After each meeting, individual reflection occurs, and then the groups meet again, for collective reflection.

The Theory of Relational Culture

Matic laid out the theory of relational culture, which suggests that, in today's society, people are not in touch with one another. She noted that sometimes people are disenfranchised through their efforts to survive. Families struggle to make it, and those that are relatively comfortable get on a focused track of consumerism.

In a consumer-driven society, people are not in community and, as a result, are isolated and powerless. Even the democratic process has been minimized to a voting procedure that is conducted without dialogue. People may think they are connected, but the time comes when they realize they are isolated and powerless.

She said people who have been in 12-step programs can understand the relational process readily because it is similar to the sharing that occurs at 12-step meetings, where people learn that they can and do change together. What they cannot do alone, they can do together.

Story Telling Works in the Public Arena

Similarly, RAP uses story, connection, and community to claim its stake in decision-making in the public arena. Ron Williams noted that sharing stories of our struggles and successes enables people to become connected to each other, invested in each other. Thus, they develop common bond and move, through this connection, and use structured story telling with officials to develop power in the community around them.

At the RCSP Institute, the RAP team held a fishbowl, in which Matic and Williams were joined by Terry Leckron and Kelly Fitzpatrick in a session in which the audience asked them questions about their experiences. Each RAP leader highlighted, in personal ways, how acquiring relational power has changed their lives.

These changes included the satisfaction of watching new and emerging leaders grow and develop their own skills in relational sharing, and seeing how the realization of the group's power in the public arena created personal growth among members of RAP. People formerly considered "throwaways" by society were now affecting change in the community at a highly effective magnitude.

■ MEETING REPORT NO. 3

Grantee Discussion Groups

SUPPORTING RECOVERY: BUILDING INDIVIDUAL, FAMILY, AND COMMUNITY WELLNESS

Members of a Community Sharing Experience

Members of RCSP grantee projects conducted 10 Discussion Groups. In "Share-and-Discuss" presentations, they presented models of peer-driven recovery support services that have already emerged as viable local community activities. In "Advancing the Conversation" sessions, the topics included complex issues and finding ways to maintain and build on RCSP core values and lessons learned by the first cohort of grantees between 1998 and 2001.

DISCUSSION GROUPS

ADVANCING THE CONVERSATION

1. Defining Peer-Driven, Peer-Led Services
2. Maintaining Authenticity As an RCSP Core Value
3. Building and Developing Leaders
4. Finding Your Niche in the Community
5. Working with Multiple Stigmas and Multiple Needs: HIV, Hepatitis C, Dual Diagnosis
6. Targeting Outreach to Medication-Assisted Recovery Communities
7. Fostering Self-Care

SHARE-AND-DISCUSS PRESENTATIONS

8. Recovery Center
9. Peer Mentoring
10. Peer-Driven Recovery Re-Entry Supports

■ Defining Peer-Driven/Peer-Led Services

Barbara Minot
Easy Does It, Inc.
Reading, Pennsylvania

Peer is not a static identity; it is a role within a context

- Examples of roles include member, supporter, leader, "focalizer," peer educator, and sponsor.
- Examples of contexts are an organization, a meeting, a group, a workshop, a community, or a movement.

Between peer participants in such a context, there is a sense of:

- Equal power and authority
- Shared challenge and/or intention
- Shared experiences (similar, not exactly the same)
- Shared goals, outcomes, beliefs, values, and desires.

The definition of peer as a role within a context has meaning for peer-driven, peer-led recovery support services:

- Services must come from the group conscience—from a community of peers who share a consensus about needs to be met.

Barbara Warren
SpeakOUT! LGBT Voices for Recovery
New York, New York

- Those services must reflect respect for existing realities within a community context.
- Peer leaders are nonprofessionals, meaning there is no exchange of money.
- Peer leaders must be aware of the limits and extent of their power and authority in each situation that requires leadership.
- Peer leaders seek to empower peer recipients to take up their own authority, power, and, eventually, leadership.

Peer leaders need training, support, discussion, and guidance regarding ethics, boundary issues, and the ability to shift roles appropriately, according to the situation at hand. For example, the same person, in different circumstances, may be a member of the group, a group leader, or a peer providing support. A peer who is also professionally trained may also move into a professional role when appropriate.

■ Maintaining Authenticity As an RCSP Core Value

Tom Aswad
Partners in Recovery Alliance (PIRA)
Martinez, California

The authentic voice of recovery belongs to the person with the story of recovery. It belongs not only to people in recovery, but also to family members (including children), friends, and allies. The authentic voice of recovery tells personal stories of lives that have been ravished by addiction and fortified with recovery. They are stories of strong personalities using simple, original language and told with honesty and compassion.

To capture the authentic voice, we must go to where the stories are born and to the places where recovery happens. To get the stories, we must ask questions and listen to what people say. We can find out what people in recovery want, need, and have to offer by conducting focus groups and surveys.

Beverly Haberle
Promoting Recovery Organizations-Achieving Community Togetherness (PRO-ACT)
Doylestown, Pennsylvania

The authentic voice will emerge when peer-driven recovery support services are defined by project members. Services might include information and referral, mentoring, peer support, social and recreational activities, education, faith-based and spiritual guidance, computer training and access, and newsletters.

Strong communication links among RCSP grantees will be necessary to encourage sharing of both positive and negative experiences with peer helpers regarding such matters as training, ethics, protocols, resource information, obtaining funds to implement new initiatives, and ongoing technical assistance and problem solving.

■ Building and Developing Leaders

Elaine Bryant
Friends of Recovery - Rockland
South Nyack, New York

The characteristics of peer leadership should include both having a vision and knowing how to cultivate a shared vision among project members. A peer leader is focused on recovery, promotes a sense of ethical integrity, and models behavior for others. Peer leaders foster an environment of shared power and decision-making. When potential peer leaders are identified in community settings and nurtured and trained to become confident and skilled peer leaders, this sends a message of hope to newcomers and gives credibility to the integrity of the recovery community.

Potential leaders can be identified in a variety of community settings, including recovery support groups, educational events, training institutes, focus groups, and workshops. When projects are conducting a community assessment, it is a good time to identify community leaders and potential RCSP leaders.

Flo Hilliard
STAR Project
Madison, Wisconsin

Leadership development is often accomplished one-on-one, with the potential peer leader shadowing another leader to learn mentoring skills. This process requires nurturing, as well as skill development.

To provide peer-driven services, peer leaders will need new skill sets. These may include group facilitation, conducting focus groups, designing and implementing service programs, mentoring, and understanding legal and ethical applications. Because of this, peer leaders will need to be trained and supervised in ways that grantees may have not had to consider before.

■ Finding Your Niche in the Community

Sonya Baker
Santa Barbara Community Recovery Network
Santa Barbara, California

Tom Hill
RCSP Technical Assistance Team
Washington, D.C.

If RCSP grantees plan carefully, we can make a difference by providing peer-driven services to the community. To begin, it will be important to assess what needs are not being met currently by either the treatment or 12-step communities. A community needs and assets assessment can get underway with a series of focus groups. (See Institutes, pages 20 and 24, and Tools, page 54, 56, and 59.)

While we might know what support service gaps exist, we will never know what people want or need unless we ask them. We can also obtain information that may contribute to the success of our projects. For example, people may not show up for our services because the services are offered at the wrong time or on the wrong day, or because we failed to ask if they needed transportation or child care. Besides, as William White pointed out, if we don't ask the community what it needs from the very beginning, how can we expect our projects to be authentically peer-driven? Gathering information and conducting outreach can happen at the same time.

Focus groups are not only a positive way to gather information, but also a way of garnering allies who might otherwise mistrust our intentions or have an agenda of their own. Getting treatment and 12-Step leaders in on the preliminary planning stages will give them opportunities to "buy in" to our project's programs and goals.

Other community leaders also need to know in advance what we are planning (see Institutes, page 34, and Tools, pages 70 and 73). This will let them know that we do not intend to tread on their turf, while also making a clear point that we are establishing a turf of our own. Establishing common ground with allies will be essential to the success of peer-driven recovery support projects which are placing emphasis on supplementing or enhancing existing services in their domain.

An important way to begin establishing these relationships is to get the word out there through education and outreach. Building and maintaining contact with the community through information and resource tables at health fairs and other community events can be a good starting point. Providing resource information and community referrals will demonstrate good faith and a capacity to share.

Grantees also can consider becoming a community hub by convening regional meetings for training, networking, and leadership development. One way to think of this is as becoming a recovery community broker, leveraging community resources and putting forward a positive face of recovery.

■ Working with Multiple Stigmas and Multiple Needs: HIV, Hepatitis C, Dual Diagnosis, and Physical Disabilities

Ilene Baker
People With Recovery & Disabilities (PWRD)
Tucson, Arizona

David Whiters
Recovery Consultants of Atlanta, Inc.
Atlanta, Georgia

In the preliminary design and planning stages of our peer-driven projects, we need to be mindful of eliminating any barriers to people with multiple needs and multiple stigmas. We can create an environment that fosters hope, trust, and empathy and sends a message that the discrimination people have experienced elsewhere will not be tolerated in our projects.

We need to look at our designs for any restrictive qualities and ask ourselves, "How can we remove these barriers, both physical and mental, and make our services more inclusive?" We need to remember that people who will be seeking our services may have had negative experiences with other systems of care and may need some initial bolstering. Our project may be the first place that they feel comfortable. (See Institute report on diversity, page 28 and Tools, page 62.)

As our projects become fully rooted in the community, we can train, educate, and be models for our peers, professional providers, and our communities. By the way we treat individuals with multiple stigmas and needs, we can help demonstrate that these persons:

- Have value beyond their label or disability.
- Often experience difficulty navigating multiple, unconnected systems of care that can be hostile or indifferent to their needs.
- May experience difficulty achieving and maintaining recovery because of this hostility or indifference.
- Need supports that are tailored and integral to the complexity of their addiction and recovery.
- Are as deserving of recovery as anyone else.

When serving individuals with diverse needs and stigmas, it is important for us to recognize our limitations. We must be careful not to promise more than we are physically able to deliver or to suggest that someone else can. Appropriate services may include individual mentoring, peer-led support groups, and case management to help people navigate difficult systems. We will need to conduct proper outreach to communities with multiple needs and stigmas, to find out what they need and want to support their recovery. The important thing is that our projects develop and maintain a culture of hospitality to all.

■ Targeting Outreach To Medication-Assisted Recovery Communities

Denise Devlin
New England Alliance for Addiction Recovery (NEAAR)
Manchester, New Hampshire

Mark Beresky
Alice Diorio
New England Alliance of Methadone Advocates -**citystate**

If there is to be, indeed, "No Wrong Door to Recovery," we must help make it a reality in our communities. We need to institutionalize this concept as a core value. We can start this process with a major presentation, focusing on the commonality of all paths to recovery, at the next annual RCSP meeting.

We also need to plan training and education initiatives to take these learnings to treatment providers, schools of addiction studies, policymakers, the medical profession, and the 12-Step communities.

We need to recruit people from the medically assisted recovery communities, with a real sense of purpose.

Our recovery communities are incomplete without them. We need to target these communities and ask them to join our efforts.

We can start the ball rolling by issuing statements to the public that medication-assisted recovery is a valid form of recovery that we acknowledge, embrace, and celebrate. We can start identifying and helping to establish the commonalities between the cultures of abstinence-based and medically assisted recoveries. We can model inclusion by securing places on our boards and leadership groups for persons in medically assisted recovery. For tips on being an organization open to all, see Institute on diversity, page 28.

■ Fostering Self-care

Denise Everett
Frontier Recovery Network
Reno, Nevada

Roberto Garcia
Connecticut Community for Addiction Recovery (CCAR)
Wethersfield, Connecticut

Recovery requires self-care. This is as true for the peer service provider as for the peer recipient of services. Being in the helper role can have many benefits, but can also place stressors on an individual's recovery.

In keeping with our RCSP value on the primacy of recovery, we want to create an environment in which we can assess risk factors and provide protection to ensure the physical, emotional, psychological, and spiritual well-being of both our peer helpers and recipients.

Our peer helpers may need help and encouragement in learning to maintain a balance between the care of others and the care of themselves. If this balance is not maintained, burnout will occur and we will experience a constant turnover of volunteers that may threaten the sustainability and success of our projects.

Becoming personally engaged in a helping role can sometimes "kick up" issues that were previously dormant or buried. These issues might threaten an individual's recovery, as well as interfere with the helping process. The helper will need a safe place to bring these issues, such as supervision sessions with professional staff.

Helpers also will need supervision and monitoring in areas that require them to maintain dual relationships

with both community and staff, and help in understanding nuances in appropriate role shifts. Prior to all of this, the peer helpers will need training and education in these areas. (See Institute on wellness, page 32.)

As grantees consider the legal and ethical implications specific to our projects, we will want to put protective safeguards in place that protect both ourselves and the communities we serve. This includes having adequate insurance for our projects (including staff and volunteers). Peer helpers will need be trained in adherence to ethical codes and educated in pitfalls that could bring legal trouble on themselves or the project as a whole. In addition to needing assistance with the previously mentioned roles and relationships, helpers will need to be coached in the skills of appropriate disclosure, establishing boundaries, maintaining confidentiality, and avoiding the exploitation of vulnerable people.

■ Recovery Center

Angie Carter
Don Carter
Jerry Mathis
Missouri Recovery Network (MRN)
Jefferson City, Missouri

he steps involved in getting the Recovery Center on its feet were described by the key players in the process. Jerry Mathis, Project Director of The Missouri Recovery Network, a 1998 RCSP grantee, described how MRN became the catalyst for the development of recovery programs, including a Recovery Center in a facility that became available to them.

The Recovery Center is operational, but still a work in progress, with current attention focused on defining the nature of peer-led recovery support services the Center will begin in August 2002.

It's All About Outreach

The first step was finding people who were "passionate believers" in the need for the Center, and who were willing to lead the effort or provide volunteer services in getting the Center up and running. Don and Angie Carter, both in recovery and employed in addiction work, were recruited to spearhead the effort, and MRN members were eager to volunteer.

One-on-one outreach is conducted with people in recovery to recruit "operations volunteers" to serve four or more hours each week to perform these tasks:

- Conceptualize and contribute ideas on the operation of the Center
- Serve as volunteer functional managers, responsible for taking care of the facility, ordering and maintaining supplies, coordinating fund-raising, leading activities, and designing and managing special events.

Finding the volunteers has been relatively easy, probably because Jefferson City is small, and identifying potential volunteers was not difficult. Don Carter, Executive Director, is paid for 12 hours' work each week. One of his earliest outreach tasks was recruiting a Board of Directors, representing all the major constituencies and sectors in the city.

Outreach efforts to the community have centered around special theme celebrations. Initially, folks already involved with or connected to MRN were invited, and asked to bring families and friends. These themed events provide a platform for letting people know what the Recovery Center will offer, what's needed, and how people can become involved.

Defining Peer-Driven Recovery Support Services

Some of the issues that leaders were grappling with were reflected in discussions at the grantee meeting. In Jefferson City, one of the first questions that arose was how they would distinguish themselves and the Center itself from treatment providers. Another was whether they would keep records on individuals who accessed support from the Center. How could they ensure confidentiality? How can they handle people in crisis? What's the difference between a recovery center and a drop-in center?

All these issues were still being addressed at the time of the grantees' meeting. The MRN team said they have a clear philosophical view of themselves as people in recovery helping others, but many details have to be worked out. Fortunately, they said, they have the advantage of credibility with the treatment community, which should allow them to work out boundaries and linkages in a collegial manner.

■ Peer Mentoring

Kim Matic
Ron Williams
Recovery Association Project (RAP)
Portland, Oregon

Mentor: Greek word for a trusted counselor or teacher. One who has gone before, has successfully overcome the barriers, and has emerged successfully as a guide to motivate and lead their mentee toward action.

Kim Matic and Ron Williams started their presentation with a discussion of this definition. All participants agreed that the definition "speaks volumes to the necessity of having recovering addicts fulfill the role of recovery mentor."

A more specific definition of what mentors do is reflected in the Mentor Mission Statement RAP developed:

> *To offer guidance to a new way of life by providing basic needs, role modeling, hope, and empowerment. Mentors lead the path to recovery by being living examples of those who have successfully survived and flourished in spite of the hideous existence that active addiction led them through.*

The RAP Mentor Program began in 1999 as an intervention in response to the epidemic of heroin deaths and low success rates in treatment of heroin addicts. As a recovery community membership organization mobilized around shared story and relationship (see Institutes, page 40) RAP members deduced that the low engagement rates of heroin addicts resulted from lack of housing, food, money, knowledge, and support to maintain sobriety.

The Mentor Program uses peers to help the recovering addict meet these needs and has had significant success. In the first year working with heroin addicts discharged from detox, the rate of engagement in outpatient treatment increased from 51.6 to 85.2 percent, and the outpatient completion rates for mentored clients was 45.2 percent, compared to 16.1 percent for the same population prior to intervention.

The Mentor Program operates as part of a collaboration of agencies called the Family Alcohol and Drug Free Community Network, including treatment centers, shelters, an interfaith network, Department of Human Services, a mental health provider, and the County Adult and Community Justice Institute. A contract among the agencies ensures all agencies linked to a specific client will work collaboratively to meet that client's needs. When one agency is unable to meet a client's needs, another is there to pick up the slack.

Specifics of the Mentoring Task

- Mentors select clients in an interview with individuals expressing an interest.
- Each mentor works with no more than 15 mentees.
- They work actively with each mentee from 45 to 90 days.
- Mentors take mentees to outpatient treatment where they are enrolled in a variety of interventions.
- Mentors help mentees become engaged in 12-step programs, help them obtain housing, food, clothing, and any other resources needed.

The program, which works in conjunction with a detox center, began with three mentors, all recovering heroin addicts with a minimum of two years of successful recovery. The mentor program currently has 13 mentors, each working with a particular population: correc-

tions clients, opiate addicts, families in recovery, people with addiction and mental illness, and alcoholics and polydrug users.

The mentors work as a team, which provides a continuity of care if a specific mentor is unavailable. Also, the sharing of information (about new resources that become available, for example) has been very useful. Belonging to the team provides a support tool for the mentors, helping reduce stress, burnout, and turnover,

RAP peer mentors are paid, so in that sense the program is different from many peer support efforts. RAP advocated for initial funding from the County and, as the program has demonstrated successful outcomes, funding has increased to reach new populations.

RAP uses a Mentor Fidelity Scale to define key features essential to program integrity. It describes the components and philosophy of the program, and is used by evaluators to assess how faithful a program is to the original program model. The *Mentor Fidelity Scale* is reproduced in the Tools section, page 74.

Mentor Self-care and Personal Limitations

For grantees considering a mentor program, the self-care and limitations directions provided to mentors will be very useful:

1. Identify clients you can and can't work with.
2. Communicate when you feel a need for support and if you are feeling overburdened.
3. Use your vacation time.
4. Use supervision and team support.
5. Work your own personal program.
6. Remember which situations encountered in a client require intervention by specialists:
   - Severe and persistent mental illness
   - Need for therapy
   - Physical health problems
   - Suicidal issues

Roles of Mentors and Relationships with Others

A mentor is not a 12-Step sponsor. The sponsor does the step work, while the mentor helps the mentee meet his or her basic needs and engage with the recovery community. Also, the mentor–mentee relationship has a time limit, whereas the sponsor–sponsee relationship can continue indefinitely.

The program makes sure there is no conflict between the mentor role and the sponsor role for the mentee. The mentors have a network and positive relationships with the people in the 12-step programs who can be sponsors. Initially, the mentor helps the mentee link up with a sponsor. In time, the mentee becomes able to go to meetings alone, or with the sponsor, and establish relationships there without the mentor's help.

After connecting the mentee with a 12-step sponsor, the mentor–mentee relationship becomes more focused on engaging in life activities, developing and maintaining life skills, and securing necessary supports such as housing and employment. One challenge has been to keep the mentee engaged after basic needs and supports, such as housing, are met.

The relationship between the mentor and the mentee's treatment counselor often works out very well, especially when the counselor understands the mentor's role. The mentor does things that the counselor can't do, such as following through on health care, employment resources, and 12-step meeting attendance.

■ Peer-Driven Recovery Re-Entry Supports

Robert Carty
Jerome Collins
Treatment Alternatives for Safe Communities, Inc. (TASC)
Chicago, Illinois

Sustaining recovery, remaining crime free, re-establishing family ties, and entering or re-entering society when you have a criminal record constitute a gargantuan effort. Many ex-offenders experience the stigmas of both addiction and criminality, which can create major barriers to finding health care, housing, employment, and education or vocational training.

Getting to and keeping appointments, filling out paperwork, and undergoing interviews can be a frustrating process that offers few immediate rewards and many dead ends. With no support system in place, many ex-offenders (61 percent in Illinois) return to drugs and crime.

Recognizing the success of 12-Step groups, a Texas group designed the peer-run Winners' Circle support group for ex-offenders in 1994, adapted from a model that had been successful in Connecticut. In 1997, TASC began facilitating Winners' Circles in Chicago and, later, throughout the State of Illinois.

Through their affiliation with the Winners' Circle, many members have been able to regain employment, re-establish relations with their families, and stay in recovery. The Winners' Circle model can be adapted and implemented in a host of community settings, making it attractive to many RCSP grantees.

Inner Circle, Winners' Circle, and Release Plans

The process of becoming a Winners' Circle member often begins for an inmate while he or she is still in a corrections facility. Ideally, this consists of joining an Inner Circle, a recovery support group that addresses issues of transitioning to life outside the institution. However, it can begin in a work-release center or wherever the ex-offender leaves the criminal justice system. The important thing is that ex-offenders make a commitment to attend Winners' Circle meetings before they return to their home environments and communities, where they may be at risk of relapsing.

Establishing a relationship with people who work in the correctional system is key to the success of any Winners' Circle group. It is necessary to secure the warden's approval and establish good relationships with correctional officers to win their approval and support. A major selling point is that the Winners' Circle supports the work done by corrections officers, especially through Inner Circles, by making their work easier and helping inmates achieve the goal of rehabilitation.

TASC staff assist in setting up the initial Inner Circle, but the groups are peer-led from the start. In time, TASC staff do not have to attend every meeting, although they frequently check in to monitor and provide support. At each group, corrections officers must be present, another reason to obtain their "buy-in."

Working with the Department of Corrections

In order to gain the cooperation of the Department of Corrections, it is necessary to outline the program and its goals very carefully. It is important to explain that a primary goal is to get inmates thinking about questions such as: What will I do when the gates close behind me and I'm outside? What plans have I made to keep from drinking and drugging? What sources for support are out there for me? Who will I turn to if staying clean and sober becomes a problem? Helping inmates develop a plan for getting out is essential to their success.

Emphasis on Peer Leadership

When starting a Winners' Circle group, the first step is securing space to hold a meeting. This has sometimes proved to be a challenge. When approaching churches and community groups for space rentals, it is important to emphasize that this is a program that will benefit not only individuals and families, but also the entire community. TASC has found also that having a Winners Circle in the community can enhance community-building, by establishing trust between ex-offenders and the greater community.

Winners' Circle groups are peer-driven and peer-led. Members are encouraged to use the support groups to explore a range of issues regarding recovery and maintaining a crime-free life. Members offer one another support and help regarding seeking education, employment, and housing. They also act as a sounding board for the joys and frustrations of adapting to a new life outside the correctional system and without the use of substances.

Members also provide important social networking, often helping one another with job and housing leads, as well as establishing better relations with their families. Most members attend 12-Step groups, as well, and often refer to 12-Step recovery in the Winners' Circle groups.

Through their RCSP Restoring Citizenship project, TASC has developed a leadership group that is parallel to, but separate from, the regularly scheduled Winners' Circle meetings. This group meets once a month, to conduct business on such things as community outreach and the formation of new meetings, fundraising events, community service, and supports needs. The project is conducting a clothing drive to obtain "interviewing outfits," as well as setting up a lending library for the recovery community.

TASC staff have put together a handbook, which they are willing to share with other RCSP projects, that assists in setting up a Winners' Circle group. In addition to a standard meeting format, it also includes "Milestones in Recovery," similar to the 12 steps; the Winners' Circle Preamble; a Code of Ethics; and a long list of one-word topics for leading meetings, as well as *Support Group Do's and Don'ts*, which is reproduced in the Tools section, page 78.

■ MEETING REPORT NO. 4

Tools You Can Use

SUPPORTING RECOVERY: BUILDING INDIVIDUAL, FAMILY, AND COMMUNITY WELLNESS

Many of the Institutes and a few of the Share-and-Discuss Presentations featured handouts that were given to participants. We have included information from the handouts, whenever possible, in our reports. We felt that some of the handouts, however, could be used intact as "tools" to help and guide you through your process of defining, shaping, and implementing peer-driven recovery support services. We have selected portions of some of the handout material and included them in this section for your use.

Your Tools

1. Process Guide for Community Assessment Using Root Cause Analysis
2. Sample Focus Group Protocol
3. Focus Group Guidelines
4. Exercises to Help You Begin Using Participatory Processes in Your Group
5. Self-awareness About Stigma
6. Avoiding Stigmatizing Communication
7. Creating Messages to Reduce Stigma: Some Helpful "Do's" and "Don'ts"
8. Support Services Planning Record
9. Personal Responsibility Plan
10. Cultivating Champions for Your Peer-Driven Support Services
11. Some Tips for Handling Turf Battles and Competition
12. Winner's Circle Code of Ethics
13. Peer-Driven Services as Part of a Recovery Management Model

■ Process Guide for Community Assessment Using Root Cause Analysis

Community Assessment: Building on Strength - Jose Salazar

This is a process for identifying a community's strengths and deficiencies, which can be an important step in identifying what particular support services are needed by people in the community. It is conducted over three meetings of the community assessment team, with assignments given to members for tasks to be performed between the meetings.

PRIOR TO THE FIRST MEETING

- Select your facilitator. It is a good idea to select someone with experience in leading group discussions and facilitating group work.
- Select your recorder. The recorder typically takes notes during the meeting and doesn't participate in the group process.
- Have newsprint and marking pens available. If participants will be writing and passing information, pro vide index cards, markers, and pens.

AT THE FIRST MEETING

Start the meeting with some sort of icebreaker. It might be something simple, such as having individuals introduce themselves by sharing their first name and an adjective that describes them, beginning with the same letter as their first name.

Tell everyone that we are here to find out all we can about why this problem occurred, but not to find fault. There will be disbelief, but please trust the process. Most errors result, not from human error, but from failures in faulty systems.

- Start by sequencing the events leading to the problem.
- Instruct people to suggest causes, solutions, etc.
- Construct a detailed event sequence.
- Identify the corrective actions that could have prevented the problem. Mark every item that might have contributed.
- Now brainstorm what could have been done. One person's ideas will stimulate another's.
- Identify the barriers created by something that failed to function or did not exist.
- Form logical clusters of the barriers.
- The first meeting ends.

AFTER THE MEETING

Following the meeting, the team leader and facilitator develop a Contributory Factor Diagram. This is simply a flowchart that shows what contributed to the problem. If there are empty spaces in your chart, assign persons to get the missing information before the next meeting.

(Continued on next page)

At the Follow-up Meeting

- Spend about an hour discussing why events failed.
- Discuss how the failures can be prevented, and you will have a map for preventing **suicide.**

At the Third Meeting

- Develop an action plan.
- Have the team generate corrective actions for each contributory factor.
- Develop a root cause analysis reporting grid with columns for:
  1. Contributory factor
  2. Corrective action
  3. Person responsible for action
  4. Action due date
  5. Measurement technique
  6. Person responsible for measuring
  7. Follow-up date.
- Review everything the group has done, and ask for feedback.
- Give everybody copies of the work.
- Thank everyone for their hard work.
- Do something to celebrate the work that has been done.

■ Sample Focus Group Protocol

Using Focus Groups to Design Recovery Support Services - Hilary Bellamy and Jamie Hart

Focus Group with Latina Women in Recovery With Children Under 5 Years of Age

Tampa, Florida

Research Objective: To find out what services are needed most by Latina mothers in recovery so that Friends of Recovery can design peer-driven recovery support services to meet their needs.

I. Introduction — 10 Minutes

Let's go around the table and introduce ourselves. Please tell me your name, your country of origin, how many years you have been in the United States if you were not born here, how many children you have, and a little bit about them (name, gender, age, etc.).

II. Being in Recovery — 40 Minutes

I would like to go around the table once more. This is the last time we will do this in the group. Now I would like everyone to tell me your drug of choice, how many years you have been in recovery, and a little bit about how you got clean and sober.

- How do you currently maintain your recovery?
- What have been some of the positive changes in your life since you have been in recovery?
- What has been challenging about being in recovery?
  - *Probe*: What has been the most difficult?

- How does being a Latina woman affect your recovery process?
  - *Probe*: How does your family support your recovery?
    How does the Hispanic community support your recovery?
    How do your religion and faith strengthen your recovery?

III. Parenting in Recovery — 10 Minutes

All of you have children under five years of age and some of you may have older children as well. I would like to talk about your role as a parent for a few minutes.

- How have you explained your addiction and recovery to your children?
  - *Probe*: What and how much do you think they understand about your recovery?

(Continued on next page)

Sentence Completion Exercise. Pass out pieces of paper with this sentence written on them and ask people to fill in the blanks.

"I feel _____ about my recovery when my children _____."

Discuss individuals' answers one at a time, asking each what they wrote on their papers.

- What are your greatest parenting challenges at the moment? Are they related to being in recovery?
- What are your greatest joys and fears about being a parent? About being a parent in recovery?

IV. Support Services for Families in Recovery — 10 Minutes

- What were some of the support services you received in **early** recovery?
- Did you need services that you did not receive?
- For those of you who have been in recovery for more than five years, what services do you feel you need now to maintain your recovery process? Which of these services do you actually receive?

*Pass out ten index cards with words written across them and ask people to rank them from greatest **current** needs to least greatest. Leave two cards blank and ask people to write in anything they feel is missing. These cards should be ranked with the others in order from 1-10.*

Rank Order Exercise:
Housing
Parenting
Mental health counseling or psychiatric assistance
Job training
Transportation
Child care
Legal assistance
Spiritual or religious guidance

After everyone is done arranging their cards, ask everyone to talk about their top 3 choices and explain why these are their greatest needs. Then ask them if the needs are currently being met. After the exercise is finished, collect the cards (in order) from everyone and review later.

- Where do you seek and get support for things related to parenting, such as discipline, developmental issues, etc.?
- What kinds of parenting support do you feel you need and do not get?
  Probe: How would this kind of support help you maintain your recovery?

- What kinds of support services do you think your children would benefit from in terms of your addiction and recovery process?
  Probe:
  Help in school
  Support or play groups for children with other parents in recovery
  One-on-one counseling

(Continued on next page)

V. Awareness and Outreach — 15 Minutes

Now I would like to talk about the organization that I represent, Friends of Recovery, and ask you how to reach out to other Latina women in recovery.

- Why has Friends of Recovery been helpful for you?
- Where did you learn about the recovery support services that you actually received?
  - *Probes*: Friends and family
    Others in recovery
    12-step meeting
    Addiction counselor
    Social worker
- We have done a lot of research to find out the best way to locate women like yourselves. Our research says the best ways to find women are through churches and the waiting rooms in pediatrician's offices. Do you have any other ideas for how to find other Latina women in recovery who have young children?
  - *Probes*: Community newspapers
    Churches
    In Spanish or English?

VI. Peer Driven Services for the Recovery Community — 10 Minutes

One of the goals of our program is to find people in our community who are in recovery who can get involved in programs and policies to help others in recovery.

- What is the best way to approach people about becoming members of Friends of Recovery?
- What would **you** be willing to do or help with?
  - *Probes:* What special skills do you have?
    What do you think that you could share with other people in recovery?
    What do you really feel passionate about when it comes to recovery?
- What might keep you from becoming a member of Friends of Recovery?

VII. Closing — 5 Minutes

■ Focus Group Guidelines

Using Focus Groups to Design Recovery Support Services - Hilary Bellamy and Jamie Hart

- Includes an introduction, 10-20 questions, and a closing section
- Can list questions in full sentence form or by topic
- Can be divided into sections by topic
- Includes probing questions
- Begins with general questions and moves to the more specific in order to "focus" the group discussion.

Steps in Developing a Focus Group Guide or Protocol

- Review the literature to identify most salient issues.
- Examine information collected by colleagues and other programs (needs assessments, survey results).
- Review other focus group guides.
- Hold a brainstorming meeting with research team to identify the possible questions.
- Continually refer back to the study objectives in the research plan.
- Review the list and identify the highest-priority questions or issues.
- Write questions for the focus group protocol.
- Each audience may have a different version of the same protocol.

"Do's" and "Don'ts" for Focus Group Questions

Do:

- Write short, clear questions.
- Begin with general questions and move to the more specific.
- Include potential probing questions on the protocol.
- Include approximate time limits on each section.
- Ask most important question twice.

Don't:

- Ask yes/no questions—they do not generate discussion.
- Write double-barreled questions.
- Word the question in alternative ways in an attempt to provide clarity.
- Provide examples of answers in your questions—it limits the range of possible answers.

■ Exercises to Help You Begin Using Participatory Processes in Your Group

Best Practices in Developing a Participatory, Peer-Driven Organization - Elizabeth Burden

If your group has not used participatory processes, here are two exercises you can use for practice. They can be used in regular meetings, and trying them will help you see other points in your meetings where you can use this approach.

EXERCISE: OPEN AGENDA-SETTING

Purpose: To use consensus decision-making to set an agenda for a meeting
Useful: For groups using consensus decision-making
Time: 10-15 minutes

How to do it:

1. Ask participants to state agenda items they want discussed at the meeting. These items are listed on newsprint so that everyone can see, with the name of the person (initiator) suggesting the item written next to it.

2. Ask initiator to estimate how long it will take to consider the item. Write this time (for example, "10 minutes") on the newsprint next to the item. Facilitator should check this time with the rest of the group, and adjust as needed.

3. Add times of all items together to get length of meeting. If the total time needed is longer than the time of the meeting, have a round where each person nominates his or her two most important agenda items from the list and place a check mark on the newsprint next to each person's preferences, to create a priority list. Ask participants to keep in mind:

   - Which items must be discussed today
   - Which are important but not urgent
   - Which can be left until another meeting or handled though another process (for example, delegating task to a work group).

Now, you have your agenda for the meeting.

(Continued on next page)

EXERCISE: BRAINSTORMING

Purpose: To generate a number of ideas quickly, without judgment and to encourage creativity
Useful: To spur thinking on a topic
Time: Five to 10 minutes (maximum)

How to do it:

Choose a topic of current interest to your members, and make sure everyone is clear about the topic you are brainstorming about. Ask that participants to say whatever comes to mind without censorship and as quickly as possible. Write their ideas on the newsprint as they present them.

1. Get as many ideas on the newsprint as possible.

2. Write each idea as spoken by the person who suggested it. You don't need to understand it during the brainstorming.

3. Do not judge others' suggestions or ideas.

4. Be creative; the crazier the ideas, the better.

5. It is okay to combine or add to ideas already on the newsprint.

After the statement of ideas, you can go back over them and make sure everyone understands. Now you have your topics for discussion and consideration.

■ Self-awareness About Stigma

Stigma in Our Lives and Work-Jennifer Brown and Thomas Arthur

Stigma Self-Awareness Checklist

What is my own role in stigmatization?

- Do I use language that expresses judgment? What words or expressions do I have to be careful of using?
- Do I avoid individuals because of their group affiliation? When was the last time I "crossed group lines?"
- Do I constantly check my assumptions and myself? How?
- Do I treat people differently because of their affiliations? When have I noticed that my reaction to some one changes after I have found out hisor her group affiliation?

What is my communication style?

- How do I communicate like an angry bull?
- How do I communicate like a sneaky hyena?
- How do I communicate like a passive puppy?
- How do I communicate like an adult chimpanzee?

What is my level of commitment to action?

- Am I willing to disagree with the whole group? How often do I disagree with the whole group?
- Am I willing to commit my energy to change? How have I committed energy to change in the past? Where is my line?
- Am I willing to make personal change? How do I self-evaluate? When have I made changes in the past?
- Am I open to learn and experiment with varied levels of action? When have I tried new ideas?

■ Avoiding Stigmatizing Communication

Stigma in Our Lives and Work-Jennifer Brown and Thomas Arthur

Note: This was prepared for use in the mental health field. People in recovery community organizations can adapt it to the addiction, treatment, and recovery fields, and may want to add additional points or examples.

Effective, Nonstigmatizing Communication

1. Use language that is clear and free of judgments.

   A. Be specific—Avoid generalization.

   - Use language that is definable and not subject to multiple interpretations.
   - Do not use psychiatric diagnoses as metaphors for other descriptions.
   - Use language that is specific to the issue.
   - Use language that does not categorize people into generalized groups.

   B. Use objective language.

   - Use language that is not open to interpretation, such as slang.
   - Use language that individuals who are not in the mental health field can define.
   - Keep humor focused away from individuals.

   C. Use inclusive language.

   - Use "we" (not "us" and "them").
   - Use language that does not separate groups by diagnoses or character traits.

2. Use body movement and expression that connote inclusion and equality.

   A. Level the playing field.

   - Physically lead only when you need to lead.
   - Arrange work space that allows for equal exchange of information, not "power plays."
   - Arrange the work environment so all individuals have equal working conditions.

   B. Mean what you say.

   - Make sure that your words are "packaged" in a way that supports their meaning. In other words, make sure that what people hear and what people see convey the same thing.
   - Check your voice for any unintended communication barriers, such as condescending tones, pitch, and volume.
   - Check your own belief in what you are saying. If one uses "politically correct" words, but doesn't believe in the message, the body will convey the real belief.

■ Creating Messages to Reduce Stigma: Some Helpful "Do's" and "Don'ts"

Marketing Your Program - Daphne Baille

Do:

- Be aware of your own language, attitudes, and biases.
- Create messages that respond to the concerns, values, and fears of your audience.
- Keep it simple and relevant. Communicate the right message at the right time.
- Provide clear, specific information – not generalizations.
- Use reliable research.
- Present people with addictions as people first, rather than creating labels that define them by their addictions.
- Portray addiction not as an acute illness, but as a chronic condition that can be treated and managed.
- Present a picture of recovery that reflects your audience.
- Remain truthful and respectful.
- Focus on positive messages, such as those that convey hope, responsibility, gratitude, and solutions.
- Discuss recovery outside of the boundaries of the treatment/recovery field.
- Be persistent in your efforts, recognizing that attitude changes occur gradually over time.

Don't:

- Make assumptions about what your audience knows about addiction, treatment, and recovery.
- Exaggerate statistics or successes.
- Present the situation as "desperate." Very few people want to support a losing cause.
- Be a victim. Show the positive and responsible contributions of the treatment field and recovery move ment.
- Portray persons with addictions as scary or dangerous individuals.
- Oversimplify treatment as a quick solution. Instead, show treatment and recovery as a long-term process.
- Use stigmatizing language (other than to explain why the language is stigmatizing).
- Use jargon or terms the audience may not understand. Explain what terms such as "treatment" and "recovery" entail.
- Preach or condescend to your audience.
- Violate anyone's privacy or anonymity.
- Bring up debates that should be settled within the field.

■ Support Services Planning Record

Embracing Wellness, Embracing Change - Carmen Vasquez

This is a format for developing your plan and keeping all your personal notes throughout the planning process. You can copy this or type up your own, providing more or less space, as needed, for writing your notes.

1. Members

Name	Address	Phone/fax/mail
A.		
B.		
C.		
Etc.		

2. Communications Network

How we will communicate with each other:

How often we will communicate and meet (weekly, monthly, daily, etc.):

Other organizations we need to communicate with and how we will do it:

■ Meeting Dates

(Continued on next page)

- **Skills, knowledge, techniques we need to develop and/or practice; person affected or responsible; plans for acquiring:**

- **Tasks we expect to accomplish:**

Task 1:

Estimated time frame: **Person responsible for task:**

Task 2:

Estimated time frame: **Person responsible for task:**

Task 3:

Estimated time frame: **Person responsible for task:**

Task 4:

Estimated time frame: **Person responsible for task:**

- **What do we need to accomplish each task?** (Be sure to include what you need from each team member, as well as out sources, such as contacts, skills, money, ideas, etc.)

■ Personal Responsibility Plan

Becoming Well and Creating Change - Carmen Vazquez

My Personal Action Plan

I agreed to be responsible for:

What I need to accomplish this task (resources, information, etc.) and where I can obtain these items or help.

- **Who will I ask to help me? What will they be responsible for?**

- **When will we meet? What is our time frame for completion?**

- **I have offered or agreed to provide support to _____ in connection with the following task:**

- **My responsibilities include:**

- **Time frame:**

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■ Cultivating Champions for Your Peer-Driven Support Services

Friends in High Places: Networking and Stakeholder Development - Susan Hailman

Cultivating Champions

Motivating a potential stakeholder to become an involved champion for your project is a process of cultivation. It involves convincing separate individuals of the benefits they will derive, personally or organizationally, from becoming involved in your initiative, and then giving them a way to contribute. Choose as champions people who can add their stamp of approval to your project. Through this participation with you, they "buy in" to what you are doing.

Each time they contribute, your group should recognize them for their contribution. Any results that come to your organization from their effort should be shared with them enthusiastically. For example, you might get the president of a large civic organiztion to announce what you are doing and ask people to remember you if anyone they know has a problem with drugs or alcohol. Or, the president might direct you to affluent members with time or money to donate.

Through your careful cultivation, you can develop a team of champions who are concerned about your recovery community work and want your organization to grow and be sustained because they recognize the contribution you are making to the community. The champions on the team can help you tackle diversifying your funding base, marketing your program, developing volunteer leadership, and collaborating with other community organizations.

Who might be your champions?

Every stakeholder of your organization is a potential champion for your effort. To make your list of potential champions, also think about:

- Representatives of organizations that have partnered with you
- People whose names get mentioned in the news that might be interested in the purposes of your community
- People who care about having a healthy community
- Members of boards in your community
- People who believe recovery support services are very important.

Where do potential champions come from?

They are all around you in the community, but you have to seek them out. This is easier when you remember that people like to be asked to help worthy causes. You can begin by asking them to tell you the names of other possible champions. Then, it is easier to ask them to become a champion themselves.

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You need to recruit people who are affiliated with organizations in the community. But don't overlook the potential champions in your own recovery community organization and in other grassroots organizations. Here's a list of the types of people you might recruit:

- Grassroots leaders
- Business leaders
- Civic leaders
- Leaders of health organizations
- Religious leaders
- Educators
- Recipients of your services
- Recipients' families
- People who volunteer in the community
- Representatives of organizations that have partnered with your group
- Neighbors—don't overlook the people next door
- People active in local politics

Using champions

- Champions can be used strategically to influence policymakers or funders to support your program.
- Champions can be used to recruit new members or volunteers.
- Champions can do some of the "real work" of your organization as board or advisory council members, helping to fundraise, plan, and develop policy.
- Champions can increase public awareness and support of your organization through formal and informal presentations and word of mouth.
- Champions can widen your organization's web of support through their professional and personal contacts and their willingness to open doors to new relationships for you.

✔ **Remember**:

Stakeholders may get an enormous amount of personal satisfaction out of doing something for a program that is doing something that is good for the community, and that is what you are doing.

What do stakeholders need to know?

As you are getting started providing peer-driven services, they will need to know such these things about your recovery organization as:

- What is its vision?
- Who is "at the table?"
- What methods are you using to meet your goals?
- Who is eligible to be a member? To receive services?
- How and where and when are your services offered?

Other things they will want to know after you get farther along. . .

- What else do you need?
- Who could provide complementary services?

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- Who controls the money?
- What do you tell the community about your program?
- Who gets credit for what you do?W
- How is your work evaluated?
- How do you/we know it works?

Remember . . . Giving stakeholders the opportunity to provide input, and using their input to make the program better, builds their support and "buy-in" for your project. Building opportunities for their involvement builds stronger ties to potential funders, partners, volunteers, and the community you serve.

Stakeholder Success Tips

- **Create stakeholder ownership.** The more interested and involved stakeholders are, the more they will invest in your program.
- **Seek advice.** In addition to time, money, and donated goods, stakeholders can also give you their best thinking, a contribution we tend to overlook!
- **Share information.** Interested and involved stakeholders know how what they do helps you fulfill your program's mission and vision.
- **Tap into stakeholder networks.** When people have good experiences as your stakeholders, they will help you win new stakeholders. They may have contacts you do not.
- **Know what motivates.** Focus on what motivates the stakeholder to invest in your program. Adapt to their changing interests, needs, and availability to maintain a long-term relationship with them.
- **Show appreciation.** Stakeholders need recognition and appreciation for their contributions.
- **Do what you say**. Maintain integrity and accountability with your stakeholders or they'll go elsewhere.

■ Some Tips for Handling Turf Battles and Competition

Friends in High Places: Networking and Stakeholder Development - Susan Hailman

Turf Battles and Competition Among Collaborating Groups

When your recovery community organization starts to collaborate with another organization, both organizations will experience change. During the early days of collaboration, especially, be on the lookout for the following "normal" fallout, and be prepared to act to correct the problems that come up.

1. Loss of direction or focus
2. Loss of leadership or struggles for leadership
3. The "founding member" syndrome
4. Unequal involvement and recognition of members
5. Poor planning efforts
6. Negative publicity
7. Failure of planned projects
8. Burnout or unrealistic demands on members
9. Bureaucratic structure
10. Turf battles and competition

Turf battles can occur when there is actual or perceived competition among organizations for funding, clients, volunteers, or visibility. Differing value systems or professional philosophies, personality conflicts among leaders, and past negative experiences can set up competitive situations.

Competition is natural and a fact of life. But competitive turf battles that lead to conflict can have adverse consequences for participants in collaborations. Here are some suggestions for reducing conflict over turf:

- Arrange opportunities for the organizations to talk about their differences. The cause of conflict may be simple misunderstandings.
- Facilitate a session to mediate differences or arrange a compromise. For example, two organizations working in the addiction field may realize they have different goals that are complementary, not overlapping.
- Use the opportunity, when one organization changes leadership, to improve the relationship.
- Explore possibilities of collaborative programming and apply for grants specifically earmarked for efforts the two groups can perform together.
- Look for areas of agreement and opportunities for limited cooperation to pave the route to resolution.
- Assist groups to focus on "common ground" within the collaboration and on the collaboration's goals. Not all turf battles have be played out within the collaboration.
- Bring in a professional facilitator or mediator to hold sessions to build trust and reduce conflict.

■ Winner's Circle Code of Ethics

Peer-Driven Recovery Re-Entry Supports - Robert Carty & Jerome Collins

Since some of the steps are culturally inappropriate and therefore difficult to accept, members of the Winners' Circle have developed this Code of Ethics for use in their recovery support program. It is used much the way 12-step members use the 12 Steps and 12 traditions.

- We acknowledge our common goal to lead a sober, drug- and crime-free lifestyle.
- We share in group decision-making as well as in responsibility for the actions of other members.
- We become members and sponsors to assist new members in their recovery process.
- We recognize and reward success, and confront inappropriate behavior.
- We are accountable to each other and responsible for the goals of the Winner's Circle over other personal business.
- We respect the confidential nature of the Winner's Circle and hold in confidence information about the personal business of others.
- We recognize personal responsibility to openly share our issues, wants, needs, ideas, and knowledge with other members.
- We celebrate the importance of each member to our collective result.
- We accept the belief that we have a particular area of our life that is not addressed in traditional 12-step support groups.
- We ask for guidance, we seek counsel, we do not isolate, nor discount personal responsibilities for our own actions.
- We are self-supporting to the best of our abilities. Our leaders are trusted servants. They do not govern.
- We are committed to recovery, freedom, sobriety and spiritual growth. We are a community.
- We are committed to building strong families through love, protection and spiritual values.
- We reach beyond any ethnic, spiritual or gender barriers to demonstrate the dynamics of collective unity.
- We influence our community with pro-social behavior and deeds which demonstrate good citizenship.
- We continue to develop a positive regard for authority figures.
- We separate ourselves from past resentments.

■ Peer-Driven Services as Part of a Recovery Management Model

William White

If peer-driven recovery support services and recovery management models were in place, how would today's clinical practices within addiction treatment change? William White asked this question and answered it in his luncheon address. In his vision of what treatment would look like if the new system and model already existed, he said changes in practice would take result in twelve areas.

1. The Service Organization

An organization providing recovery support services:

- Integrates resources of multiple formal and indigenous institutions into a process of recovery management in which the primary physician has a role.
- Establishes partnerships with indigenous resources, such as mutual aid groups, churches, and cultural revitalization movements.
- Relinks treatment to the community.

2. Identification and Engagement

- Population-based identification strategies; mass screening
- Assertive community outreach
- Proactive waiting list management
- Low thresholds of service engagement
- Seamless movement between levels of care
- Monitoring and re-engagement

3. Screening and Assessment

Screening and assessment procedures will change:

- From an intake function to a continual function
- From categorical assessment to global assessment
- From a focus on deficits to a focus on strengths
- To provide stage-appropriate recovery support services:
  - □ Continual assessment of support needs
  - □ A support services menu

4. Redefinition of "Client"

- From "identified patient" to family and intimate social network surrounding the "client"
- Client defines who the "family" is
- The community as the "client:" Focus on the physical, social, cultural ecology of recovery, e.g., creating recovery sanctuaries

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5. Service Goals

- Optimal long-term outcome
- Focus on client-defined goals versus symptom suppression
- From "treatment plans" to "recovery plans"

6. Service Technologies and Emphasis

- Disease management technologies include:
  - □ Engagement (relationship building)
  - □ Stage-appropriate recovery education and coaching
  - □ Mentoring
  - □ Organizing and linking to recovery supports
  - □ Feedback
  - □ Early reintervention

7. Service Intensity and Duration

- Longer period of service involvement
- Expanded continuum of care with lower intensity recovery support services
- Eliminate concept of "aftercare." All care is continuing care.

8. Service Locus

- Shift from office-based to neighborhood and home-based delivery of services
- Question: "How do we get an individual into treatment?" is reframed: "How do we get recovery into the physical and cultural world of the individual?"

9. Service Relationship

- From domination to partnership model
- Continuity of contact in a primary service relationship
- Selecting a recovery specialist
- From counselor to ally and consultant
- New roles:
  - □ Recovery coaches

10. Evaluation

- From single episode evaluation to study of treatment and recovery careers
- Planned synergism: potent service sequences and combinations

11. Consumer Involvement

- Consumer involvement in:
  - The direction of service
  - Policies
  - Personal goal-setting
  - Delivery
  - Evaluation
- Focus on self-management
- Consumer-led support services
- Consumers as volunteers and employees

12. Advocacy

- Traditional model: Advocacy limited to intsitutional interests
- Recovery model:
  - Community education (stigma reduction)
  - Activism to heighten responsiveness of service institutions
  - Community resource development
  - Activist/community organization approach to unmet needs