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Gender-specific Recovery Support Services: Evolution of the Women’s Community Recovery Center to the Women’s Recovery Community Center

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INTRODUCTION

It was not long ago that addiction treatment and recovery was “a man’s world.” The treatment field’s organizations were directed and staffed by men, served a primarily male clientele, and utilized theories and techniques drawn exclusively from male experience. Recovery support groups were similarly male-dominated, and women seeking entrance to them faced considerable obstacles to their recovery (White, 1996).

That world changed through the efforts of pioneering women whose lives are finally being celebrated (White, 2004). In the intervening years, we have learned as a field that there are essential gender differences in almost every important dimension of addiction, treatment, and recovery (Kandall, 1996; Wechsberg, Craddock, & Hubbard, 1998; Walitzer & Dearing, 2006). These new understandings paved the way for gender-specific treatment programs and recovery support groups designed specifically to meet the needs of addicted women and their families (Schliebner, 1994; LaFave, 1999; Uziel-Miller, & Lyons, 2000; Kaskutas, 1994) and expanded the range of settings in which women with alcohol and other drug problems could be identified and served (Grella & Greenwell, 2004).

One limitation of the gender-specific service innovations of recent decades is that they have been developed inside an acute-care model of addiction treatment that is ill-suited to women with high problem severity and complexity and low levels of recovery assets. As a result, those

calling for a shift in addiction treatment from an emergency-room model of brief biopsychosocial stabilization to a model of sustained recovery support are also arguing that this new model must meet the unique recovery support needs of women and people of color (White & Sanders, 2004). This shift to models of sustained recovery management is birthing new and renewed social institutions (e.g., peer-operated recovery support centers, recovery homes) and new and renewed service roles (e.g., recovery coaches, outreach workers). In spite of these advances, we are in the earliest stages of designing institutions and roles to meet the needs of recovering women.

The purposes of this article are to briefly describe the emergence of the recovery support center as a new indigenous service institution; profile the history of and service components within the Women's Community Recovery Center in New Britain, Pennsylvania; and highlight some of the lessons learned from the Center's first 18 months of operation.

RECOVERY SUPPORT CENTERS

Over the course of their recovery from severe alcohol and other drug problems, people experience a multitude of needs that are often outside the traditional service scope of addiction treatment programs. The growing recognition of the need for non-clinical recovery support services is generating new models for delivering services to meet these needs. One such model is the recovery support center (RCC). Usually operated by a grassroots recovery advocacy organization (Valentine, White, & Taylor, 2007), the RCC resembles the social fellowship of an AA clubhouse and the service orientation of a social service drop-in center. (See www.facesandvoicesofrecovery.org for a directory of such organizations.) The Connecticut Community of Addiction Recovery (CCAR) describes its RCC as a:

"Recovery-oriented sanctuary anchored in the heart of the community. It exists 1) to put a face on addiction recovery, 2) to build "recovery capital" in individuals, families and communities and 3) to serve as a physical location where CCAR can organize the local recovery community's ability to care. (From Core Elements of A Recovery Community Center, CCAR, 2006)

The development of regional RCCs in states like Connecticut and Vermont marks a new approach to the delivery of non-clinical recovery support services. According to White and Kurtz (2006), the RCC "moves recovery from 'the church basements to main street,' provides a venue for sober socializing, a physical place for recovery development (linkage to recovery-conducive employment, recovery homes, recovery workshops, planned leisure activities, community service work), and serves as a medium for connecting people with recovery needs to people with recovery assets." RCCs also function as "an organizational/human bridge between the professional treatment community and the recovery community" (White & Kurtz, 2006, p. 32).

Because of their service orientation, it would be easy to see the emerging RCCs simply as a new level of care within the existing treatment continuum of care, but RCC leaders reject such a view. They emphasize that what they are providing is not treatment but recovery support services that are designed and delivered, not by clinically trained professionals, but by and for people in recovery. RCC leaders also emphasize that such services are part of their larger goal of developing recovery capital within local communities of recovery and the larger communities

in which they are nested—an approach that blends individual and family support models with models of community organization and cultural renewal (McCarthy, 2006; Valentine, 2006).

History of the Women’s Community Recovery Center

The Pennsylvania Recovery Organization-Achieving Community Together (PRO-ACT) program was established in 1997 as a grassroots recovery advocacy organization. Its founding goals were to mobilize members of the recovery community to reduce the stigma of addiction, to educate the public about addiction recovery, and to help shape pro-recovery public policies. In 1998, PRO-ACT received a Recovery Community Support Services Grant from the Center for Substance Abuse Treatment that provided the opportunity to expand PRO-ACT’s role within the community and begin to provide peer-driven/peer-delivered recovery support services throughout Southeastern Pennsylvania. Through a highly participatory planning process, PRO-ACT has extended the range of its service focus and developed a wide variety of recovery support services designed to help individuals and families initiate and sustain long-term recovery. Although PRO-ACT began in Bucks County, the organization has expanded its services to include the entire five-county Southeast Pennsylvania Region, with a special focus on the City of Philadelphia. The latter move has been sparked by a recovery-focused behavioral health care systems-transformation process being led by the Philadelphia Department of Behavioral Health (White, in press; see http://www.phila.gov/dbhmr/strategicplanning/spi_re_intro.html).

One of the early projects developed by PRO-ACT was Mentor Plus (2000). The Mentor Plus project matched volunteer Mentors with inmates in early recovery (“Mentees”) residing at the Bucks County Correctional Facility (BCCF). The Mentors visited their assigned Mentees once a week during the Mentees’ incarceration. The focus of these visits was the development of a recovery plan that would be implemented upon the Mentee’s release. As the program evolved, it became clear that female Mentees had a great deal more difficulty transitioning out of the institution and implementing a recovery plan than did their male counterparts. The special needs of female Mentees included safe housing, early financial assistance, recovery-conducive employment, assistance with family problems, support for continuing education, and linkage for assistance and support for co-occurring medical and psychiatric illnesses.

While these needs were being identified, another committee within PRO-ACT was exploring the Recovery Centers that were being established in Vermont and Connecticut. Out of that synergy of circumstances, PRO-ACT naively developed the idea of developing a Center that would combine the goals of providing recovery housing for women who needed it and providing within the same facility a recovery-oriented, gender-specific sanctuary for other women in the community. By this point, the Council had already had 15 years’ experience providing gender-specific programming, outreach, and support to women in a recovery community setting. In December of 2004, the Council purchased a building that had once served as a women’s college dormitory in New Britain, Pennsylvania for use as a Women’s Community Recovery Center. The Center was opened to the Community in May of 2005, after months of work establishing a steering committee, fundraising, attending zoning hearings, hiring staff, recruiting and training volunteers, and developing policies and service procedures.

Forty-eight volunteers were recruited and trained as recovery coaches, and a 12-session Life Skills program/curriculum was developed to address the barriers and needs that women seeking long-term recovery were most often experiencing. In January of 2006, with great

excitement, the first 5 women entered the house as residents. Volunteers and professional staff worked together to continue outreach to the community while providing recovery support services to the residents. During 2006, the number of residents grew as the Center moved closer to its 18-person housing capacity.

Unfortunately, meeting the demand for housing quickly dominated the Center's efforts and became what seemed to be an overwhelming task. Screening potential residents and providing recovery support for those women living in the Center became the focus for both the staff and volunteers. As this occurred, the number of women living in the community and participating in the WCRC declined. In March of 2007, the staff began an evaluation process to review the experience of the Center to-date. Peer volunteers, the staff, and the women who had participated (whether as members of the community or as residents) were involved in this evaluation process that resulted in several shifts in our approach to service delivery. In the remaining sections of this article, we will profile the women served by the Center, the core services of the Center, and the lessons we learned through this novel experiment of combining the provision of recovery housing and the delivery of non-residential recovery support services to women in the community within the same physical facility.

PROFILE OF RESIDENTS

Over the past year and a half, 28 women, aged 19-47, have lived at the Women's Community Recovery Center (WCRC). These women presented with varied educational histories (7 without high school education, 13 with high school diploma or GED, 6 with some college work, and 2 college graduates), a history of unstable employment, and significant (25 of 28) with legal involvement due to their past alcohol and other drug use. A history of multiple-drug use was the norm among residents, with only 5 of the 28 women using alcohol alone. Of the 28 residents served since January, 2006, 9 were addicted to heroin and 14 to cocaine. All residents had received some level of drug and alcohol treatment prior to entering the WCRC, and some had multiple episodes of past treatment. Twenty-one residents had been involved in support groups such as AA or NA before their admission to the WCRC. All residents had experienced more than one relapse, and many presented with chronic relapse histories.

Nineteen of the 28 residents were mothers, and another was pregnant at the time of her exit from the WCRC. These 19 mothers had a total of 47 children, and 15 of the 19 had current or past custody problems or other serious parenting issues that had brought many to the attention of Children & Youth Services. Twenty-four of the 28 residents had come from families in which at least one relative (and usually more) had a problem with alcohol and/or other drugs. Along with their family-of-origin addiction histories, most residents were actively involved, or had been involved in the past, with a significant other who had a history of alcohol or other drug dependency.

Twenty-two of the residents reported physical health problems/diagnoses prior to admission. These problems ranged from Hepatitis C (10 out of 28 residents) to such problems as hypothyroid conditions, Hodgkin's Lymphoma (in remission), diabetes, arthritis, emphysema, asthma, hypertension/high blood pressure, anemia, herniated/degenerative discs, scoliosis, knee problems, kidney stones, dental issues, back pain, and migraines. Twenty-one of the women had at least one psychiatric diagnosis, and 11 had more than one diagnosis at the time of their admission to the WCRC. The most prevalent diagnoses were depression, bipolar disorder, and anxiety disorders. Most of the residents reported prior psychiatric treatment, and

most were taking medication for their psychiatric diagnoses during residency. They were often on more than one medication, with several of the residents taking psychiatric medications and simultaneously enrolled in methadone maintenance therapy.

Several residents had experienced one or more inpatient stays at mental health treatment facilities. At the most extreme end of the scale, one resident had been hospitalized for mental health concerns a total of 8 times, with half of those admissions prompted by suicide attempts. Other residents were/are under psychiatric care to manage their mental health symptoms, with most receiving this care through a local outpatient facility or through the psychiatrist at their drug and alcohol treatment program.

The majority of residents (22 out of 28) had a history of trauma prior to their arrival at the WCRC, with reported trauma ranging from childhood or adult physical, sexual, or emotional abuse; rape; witnessing violence; the death of a child; and extreme neglect. Not only had many residents experienced sexual, physical, and/or emotional abuse or neglect as children, but many had also experienced various types of violence within their adult relationships, including physical and emotional abuse by partners, as well as rape and sexual assault by partners and/or strangers.

It can be seen from this brief profile that the women admitted to residential recovery support presented histories of great severity; complexity; chronicity; and, in spite of their recent treatment histories, great acuity. The implication of this profile for the WCRC's self-assessment of its capabilities will be discussed shortly.

WCRC SERVICES

The women staying at the WCRC are expected to pay rent, but due to their poor financial status and difficulty in obtaining employment, many of the past residents left the WCRC owing rent money. Past residents have collectively paid \$17,050 of a total of \$23,000 due for rent, owed for lengths of stay ranging from less than 2 weeks up to 40 weeks. The Center is staffed by 7 paid positions: a Women's Services Manager, a Volunteer Coordinator, a Case Manager, and four part-time Life Skills support staff. All are recovery informed—individuals in personal or family recovery or individuals with an otherwise deep understanding of the addiction recovery process.

The Center currently has more than 20 volunteers. A case manager is made available to the residents, to help them address the many problems that residents experience in navigating the traditional treatment system, and to help identify and connect the residents with other community resources. Case managers and peer volunteer recovery coaches work with the residents to develop and implement recovery plans. Service activities in general include case management, recovery coaching, social support, education and skill-building groups, and crisis management. Center programming has been expanded to include a monthly calendar, which is published and open to any woman in the community. Programming includes a lecture series, Life Skills workshops, Parenting, Craft/Cooking night, Bible Study, and presentations/discussions on health and appearance facilitated by volunteers.

Nearly all residents are enrolled in outside professionally directed addiction treatment while they live at the Center. These treatment services are provided by local provider organizations. While living at the WCRC, all residents are strongly encouraged to attend recovery support

group meetings such as AA, NA, or Women for Sobriety. WCRC residents also run their own AA meeting, open to the community, every Monday afternoon and evening at the Center, and they host a Wednesday-morning AA meeting that provides babysitting services. The degree of connection between WCRC residents and the local recovery community and local support groups has varied widely, ranging from those with very strong connections to those who have never been engaged with the local recovery community.

One of the biggest challenges Center staff and volunteers have faced is in determining how to provide true recovery support services instead of treatment services. Working with residents who present such a wide range and intensity of problems during their residence at the Center has a tendency to shift staff and volunteers out of their recovery support roles and toward counseling roles, a shift that is unintended and inappropriate. The pull toward this clinical role is particularly strong in the face of relapse. Half of the residents (14 out of 28) experienced a relapse while in residence. Such relapse events often led to the exit of the client shortly thereafter, either through transfer to a higher level of care or through the client's decision to leave against staff advice. Although many residential treatment programs will administratively discharge clients who have relapsed, WCRC staff and volunteers are willing to work with the client who relapses. While residency at the WCRC is not considered a level of treatment, the idea of working with a client who has relapsed and allowing her to remain in residence is a revolutionary one. For residents who relapsed, staff examined the situation to determine the best course of action, whether that meant facilitating referral to a higher level of care or helping the client develop a more effective relapse-prevention plan. However, residents did not always respond positively to these staff efforts.

An important consideration in planning future staffing for the Center is the fact that the Center's focus is shifting more toward a community developmental model. We see a knowledge of recovery, but not a background in clinical work, as a necessary qualification for staff.

In its two years of operation, the WCRC was able to establish a residential recovery support center, recruit and train a core cadre of volunteers, develop a set of core services, establish a sound referral base, and engender strong local community support. Perhaps even more important, 22 out of 28 women obtained employment, 12 of the 19 mothers in residence began visitation with their children, all residents were linked to the local recovery community, 8 have remained involved with WCRC services after leaving residence, and 3 are active volunteers working with other women seeking recovery.

The following three case studies further illustrate the characteristics of WCRC clients and WCRC recovery support services. (Names have been changed.)

Marie is a 36-year-old Caucasian woman, single, with one child with special needs. She has one older sibling, her parents are divorced, and her mother has remarried. Marie was referred for residence through a local counseling center. She presented as homeless and is on prescribed Methadone, as well as anti-depressant and sleeping medications. Marie is engaged in ongoing addiction and psychiatric treatment. During residence, she attended the 12-week Life Skills program, attended Twelve-Step meetings, and engaged with a Recovery Coach and a Twelve-Step Sponsor. Marie was able to regain joint custody of her son and successfully complete all of her Probation and Parole requirements. She also became gainfully employed and took herself off of Medical Assistance. She displayed patterns of taking on roles of responsibility, becoming overwhelmed, then sabotaging herself. She opted to take a career position and relocate to her parents' home, despite staff feedback about this choice. She

subsequently relapsed but was able to return to treatment quickly and re-stabilize. She is currently working part time and is actively involved in WCRC Services, Life Skills, and volunteer activity at the WCRC. She and her son live with her parents.

Faye is a 28-year-old Caucasian woman, single, with no children. She is the youngest of 5 children, and her parents remain married. She was referred for residence through a local counseling center. She presented as homeless, with a past history of treatment for ADHD, but was not taking prescribed medications. Faye was actively engaged in addiction treatment and mental health services at the time of her entry into the WCRC. During her residence, she attended programming activities, the 12-week Life Skills program, and Twelve-Step Meetings, and she also engaged with a Recovery Coach and a Twelve-Step Sponsor. She entered the WCRC with private insurance and was unemployed. Although Faye has a college degree, she took a job in retail and maintained the job throughout her stay of 18 weeks. She completed the program successfully and moved on to rent a room from a woman in the recovery community. Faye continues to be involved in ongoing activities at the WCRC. She currently works in sales and was able to pass her licensing test with support from staff. She manages her ADHD through biofeedback rather than medication. She has maintained abstinence since her discharge.

Hope is a 26-year-old Caucasian woman, single, with 2 children. She is the youngest of three children, her parents are divorced, and her father has remarried. She was referred for residence through the prison (Bucks County Correctional Facility). Hope presented as homeless, with a history of Bipolar Disorder treated with a prescribed mood stabilizer. She became actively involved in addiction treatment and mental health services through a local counseling center. During her residence, she attended all of the WCRC's service programs and became actively involved in a Twelve-Step Program. Hope also achieved employment during her residence. Through staff at the WCRC, Hope became involved with the Bucks County Opportunity Council's self sufficiency program, seeking financial assistance. She rented an apartment in the area and continues to be employed. Hope recently received scholarships to beauty school through the Bucks County Office of Corrections and the Bucks County Chamber of Commerce, and began school in June, 2007. She has maintained abstinence and continues to be actively involved in ongoing activities at the WCRC.

The following are case histories of women living in the community who have accessed and received services through the Center's Community component. (Names have been changed.)

Elizabeth is a 40-year-old woman recently arrested for her second DUI. Her longest period of abstinence was 7 years, and her last DUI was 9 years ago. She is a married mother of two teenagers and a victim of rape and sexual abuse. Elizabeth first came to the Center as a result of her DUI. She had not had positive experiences with AA. She was matched with a Recovery Coach and attended the Life Skills Series and as the Reading Group at the Center. She began to volunteer and attend AA. She found a sponsor, but relapsed on pain medication and was a victim of violence during her relapse. She was admitted to a 14-day inpatient rehab. Within one week, she was transitioned into outpatient treatment. Elizabeth met weekly with her Recovery Coach, who provided support with advocacy, support in helping connect with resources, and coaching with day-to-day problems with family and work. Elizabeth currently has nine months of recovery and growth. As she says, "The Center is a place where I am comfortable talking about things I don't talk about anywhere else—I really look forward to

meeting with my Coach. We laugh and cry together. If it hadn't been for the folks at the Center, I don't know if I could have survived the relapse.”

Cara is a 49-year-old woman facing severe liver failure. Cara connected with the Center through a local hospital. Initial involvement included home visits from the staff and volunteers from the Center. Cara had been in inpatient treatment four times during the past 10 years. She was a recently divorced mother of 2 adult children. Cara was matched with a Recovery Coach, who helped her develop a recovery plan, and she attended lectures at the Center as well. However, she stated that she did not feel that she was a part of the Center because she did not live there. Cara relapsed and died of liver failure. Her death raised many questions and provided an opportunity to look at how the Center could better respond to those living within the community.

Lisa is a 52-year-old woman with 3 adult children. She works as a waitress and is connected with a Recovery Coach. They have developed a recovery plan that includes ongoing meetings with her recovery coach. She has received outpatient counseling and attended AA meetings and Life Skills sessions at the Center. Lisa's participation at the Center has become more frequent, as she has increased the number of activities she attends. In addition, she volunteers at the Center one day per week.

LESSONS LEARNED

The WCRC was founded on the belief that gender-specific recovery support services could be combined with professionally directed treatment services to enhance long-term recovery outcomes. After two years, we still believe in the importance of such services, but we have learned many lessons about the challenges of implementing and sustaining such services. In reviewing our experiences of the past 24 months, we have identified the following as among the most important of such lessons.

The Planning Process: It is important to note that, initially, as staff and volunteers moved through the developmental stages of the WCRC, they utilized a community development and empowerment model. The key word was inclusion: inclusion of the community via volunteers and inclusion of service recipients in the refinement of services over time. The WCRC relied extensively on volunteers from the community, to form the work groups that develop rules and structure for the residents, and to develop the Life Skill-building workshop curriculum. Volunteers also met to develop committees for fundraising and décor/Center maintenance. However, as the Center evolved, staff took on more of a leadership role, and the needs of the residents overshadowed the community outreach/engagement efforts.

Staff/Volunteer Recruitment, Training, and Supervision: Effective recovery support services rest on the principle of continuity of contact in primary recovery support relationships over time. Achieving that continuity requires retention of staff and volunteers, which in turn requires a high level of technical and emotional support for their efforts. That support is best demonstrated by rigorous screening and selection, structuring orientation and ongoing training programs, ready availability for consultation on difficult situations, and regular opportunities for staff and volunteer recognition.

Volunteer Risk Management: Actions that volunteers take or fail to take can jeopardize the future of the best recovery support programs. This risk can be minimized by performing

background checks on all applicants for volunteer positions¹, training volunteers in ethical decision making, providing ethical guidelines for peer-based recovery support services, and the providing close supervision.

Role Clarity: The scope and severity of the problems experienced by women entering the WCRC made it challenging for us to remain in our non-clinical recovery support roles. This required constant reminders to staff and volunteers that we were NOT counselors or therapists and that our job was not to fix problems but to facilitate recovery initiation and maintenance. This required significant attention in training and supervision.

Gender-specific Barriers to Recovery: For many women served by the WCRC, lack of family support, multiple role demands, lack of financial resources, past criminal records, and their own identities as “outsiders” severely limited their choices and access to community services. Histories of trauma and resulting patterns of emotional volatility and relationship instability further compromised these women’s ability to achieve stable recovery. This is to say, not that recovery is impossible, but that it requires a more complex and enduring support process than we had anticipated.

Diversity: We have found that one of the most important dimensions in the delivery of recovery support services is a broad representation of pathways and styles of recovery among staff and volunteers. Ideally, people being served should be brought into contact with the full scope of such styles, including the Twelve-Step community, faith-based recovery ministries, secular programs of recovery, and people in medication-assisted recovery. That diversity should also be reflected in the age and ethnic composition of staff and volunteers.

Medication Management: We had not anticipated the number of women we would serve who would be on prescribed psychotropic medication. That discovery demanded our attention to ensuring continuity of medication access (e.g., for women medicated in jail but given no medication upon their release to enter the WCRC), procuring a safe to secure medications, establishing a medication log to track medication consumption, staff education on medications and side effects, and increased communication with prescribing physicians.

Facility Security: There were more security issues than we had anticipated, e.g., women trying to sneak out to visit boyfriends. Given the crucial importance of physical and psychological safety in the delivery of women’s services, we were forced to heighten security through the implementation of a curfew, the use of security cameras, and a key-fob system.

Relapse Management: We were unprepared for the level of problem severity (and the accompanying in-residence relapse rate) of those we served. While we supported the philosophical position that our response to women who relapsed should be one of early re-intervention and support, this was hard to operationalize. Training of staff and volunteers about the chronic nature of severe drug dependence and the principles of long-term recovery management helped us sort through the best options in the face of such relapse incidents.

Use of Community Resources: The key to the development of an effective recovery support center is aligning the power of local community resources in support of recovery initiation and

¹ A criminal background check is not intended to automatically disqualify people who have such a background (many people in long-term recovery with notable community service have such backgrounds); the background checks are intended to screen out individuals who have established patterns of predatory behavior, who may be looking for new venues through which they can exploit vulnerable individuals.

recovery maintenance. It was very important for us to establish constant and consistent communication with outside agencies, both to help our residents access the services they needed and to help us stay current on changes in our residents' status with other community agencies.

Co-location of Services: The central question the WCRC has faced is this: Can a recovery home and a recovery support center co-exist within the same physical facility? Both the need to respond to the overwhelming needs of the WCRC residents and the limits imposed by the physical design of the WCRC facility have prevented significant community participation. After careful deliberation, the WCRC has devised several changes to improve our ability to serve women living in the community. We suspect that co-location will result in doing one or the other function well, but that it will be very hard to maintain a level of excellence in service to both women in residence and women in the community.

THE EVOLUTION OF THE CENTER

In January of 2007, Dr. Stacey Conway collected and analyzed data on the Center and its residents. A Study Committee was developed to review the results and make recommendations to ensure that the Recovery Support needs of the community were being met. The major finding was that housing 18 women within the Center would not allow for the community component of the program to grow and meet the needs of community members. As a result of that finding, the Committee recommended that the WCRC:

- Change the name of the Center from “Women’s Community Recovery Center” to “Women’s Recovery Community Center,” to better reflect the mission and purpose of the facility
- Reduce the number of women living in the house to 6
- Make renovations to make the house property more appealing to members of the community
- Adjust screening protocols for potential residential candidates, to ensure that the level of services we offer meets the level of services they need
- Develop a Vision Committee, to steer the ongoing programming provided through the center
- Ensure that everyone entering the Center is personally welcomed and oriented to Center services and activities
- Develop and implement an outreach and marketing plan
- Identify additional, sustainable funding sources
- Have Information Specialists on site to provide information, advocacy, referral, and recovery support

As we think about the future of the Center, we want to re-engage and re-energize the Volunteers and then establish a diverse, 10-member Vision Committee, facilitated by Dr. Stacey Conway, to steer the direction of future programs, projects, and services available through the Community Center. Our goal is to maintain continuous improvement of the Center’s availability

to women from the community who want to access, strengthen, and sustain long-term recovery. We are continuously adjusting this pioneering model.

SUMMARY

Calls to transform addiction treatment into “recovery-oriented systems of care” are triggering new experiments in the delivery of pre-treatment, in-treatment, and post-treatment recovery support services. Two such experiments involve the proliferation of self- or staff-managed recovery homes and the rise of recovery support centers. This paper describes the attempt of the Pennsylvania Recovery Organization-Achieving Community Together (PRO-ACT) to operate a gender-specific recovery home and a recovery support center within the same facility in New Britain, Pennsylvania.

In its first two years of operation, the Women’s Community Recovery Center (WCRC) served 28 women in residence, while attempting to offer recovery support services to women in the larger community. The needs of the women in residence were so great and so complex that responding to these needs consumed the majority of staff and volunteer resources. Some of the critical lessons learned from this experience include the importance of community and consumer involvement in the planning and implementation process, the necessity for boundary management between clinically oriented treatment services and non-clinical recovery support services, the importance of volunteer training and support, and the value of assertively linking the women being served to local communities of recovery and other formal and informal resources in the community.

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