Original Article

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Houston Recovery Initiative

A Rich Case Study of Building Recovery Communities One Voice at a Time

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Abstract

Recovery from alcohol and drug problems is a process of change through which an individual achieves control and improved quality of life. Recovery is a primary goal for individuals with substance use disorder as it provides hope that treatment and overall health are possible for every individual. More than 23 million Americans are in recovery from addiction to alcohol and other drugs. Recovery-oriented systems of care (ROSC) are networks of community services and peer support that help individuals and families achieve recovery from substances and improve overall health. ROSC is a strengths-based and person-centered model that leverages existing community resources to address the needs of individuals and families as they progress through the journey of recovery. The ROSC model serves as the foundation of the Houston Recovery Initiative (HRI). The purpose of this article is to describe the history, development, and infrastructure of the HRI, which is a volunteer collaboration whose main goal is to educate the community on recovery and broaden the recovery safety net for people with substance use disorder in Houston, Texas. Since 2010, the HRI has grown to include more than 200 agencies across the spectrum of treatment and recovery support services in Houston so as to provide a resource for the community. Herein, we detail efforts to grow the HRI, lessons learned, future plans, and resources needed to move the HRI forward.

Keywords: collaboration, community, peer group, recovery, recovery-oriented systems of care, strengths-based, substance use disorder

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INTRODUCTION

In 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that 21.6 million (8.2%) Americans aged 12 years or older had a substance use disorder (SUD) or dependence issue within the past 12 months (SAMHSA, 2013a). Of these, 2.6 million struggled with abuse of or dependence on alcohol and illicit drugs, 4.3 million were dependent on illicit drugs but not alcohol, and 14.7 million were dependent on or abused alcohol but not illicit drugs (SAMHSA, 2013a). This total has been fairly steady since 2002, fluctuating between 20.6 million and 22.7 million (SAMHSA, 2013a). Although many Americans struggled with SUD in 2013, only about 1.3 million (7.8%) received treatment at a specialized facility (SAMHSA, 2013b).

Specifically for the Houston–Sugar Land–Baytown area, approximately 8.9% of those 12 years and older met the criteria for SUD in 2012 (SAMHSA, 2012a). In 2006, the National Highway Traffic Safety Administration ranked Harris County first in per-capita alcohol-related deaths among 10 of the most populous counties in the nation (SAMHSA, 2012a). That same year, more than 20,000 individuals were arrested for drug offenses in Harris County. This trend has increased since 1997 (Houston Department of Health and Human Services, 2009).

Before the founding of the Houston Recovery Initiative (HRI), the resources for people with SUD in Harris County were very scattered. Andrew Tilghman, a journalist for the *Houston Chronicle*, reported that one of every seven Harris County probationers ended up in jail for failing to comply with court-ordered conditions. Probation officials said in a written statement that the primary factor affecting this recidivism rate was the lack of SUD treatment and aftercare resources. The lack of resources combined with high probation officer caseloads exacerbated this situation (Tilghman, 2005). All of these factors motivated the Texas Department of State Health Services to contact Houston recovery leaders to pilot the recovery-oriented system of care (ROSC) model to build a more recovery-oriented community.

Recovery has become one of the primary goals for behavioral healthcare. This has been a recent shift the past decade, leading treatment providers and personnel to have a positive, strengths-based outlook on the abilities of individuals with SUDs and/or mental health disorders to improve. At the same time, this viewpoint supports an individual's resiliency to escape addiction and to reach an overall wellness and better quality of life (SAMHSA, 2015).

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In 2011, SAMHSA published the following common working definition of recovery from SUDs and mental health disorders: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2012b). Life in recovery is composed of four major aspects: health, home, purpose, and community (SAMHSA, 2012b). Ultimately, there is no definitive way to reach recovery. Recovery exists in the individual and his or her personal pathway.

ROSC MODEL

The HRI is based on the ROSC model theory (Evans & White, 2013). This theory focuses on long-term recovery, community collaboration, and individual and family needs. Evans and White (2013) stated that the ROSC model represents a shift from a primary emphasis on clinical treatment of addiction to models encompassing psychological, biological, and social systems that create and sustain an individual's overall health. The idea is not to simply guide people to abstinence but to consider the whole sense of self and a better quality of life. A guiding principle of recovery is holistic care. In a ROSC, recovery encompasses a person's whole life: mind, body, spirit, and community (SAMHSA, 2012b). Therefore, ROSCs should address housing, employment, relationships, community participation, and more as well as the treatment of SUD and/or mental health disorder.

Thus, recovery refers to not only abstinence but also the promotion of the complete health of an individual and restoring affected people as contributing members of society. The HRI recognizes that there are many different ways to reach recovery and emphasizes the importance of identifying and addressing individuals' needs and treating them with care. The HRI is founded on the belief that behavioral and mental health professionals partnering with peers in recovery can create a system to educate citizens and increase recovery services through collaboration among many different individuals and organizations across the greater Houston area.

Recovery capital refers to the spectrum of internal and external resources required to help a person achieve recovery from substance use (Laudet & White, 2008). Recovery capital can include social support groups, 12-step meetings, recovery coaches, churches, sober friends, and more (Granfield & Cloud, 1999, 2001). Research has shown that increased recovery capital, particularly in the initial phase, can increase the likelihood that a person sustains recovery (Humphreys, Mankowski, Moos, & Finney, 1999). The HRI's purpose is to provide a variety of resources that can help each person increase his or her recovery capital.

A key focus of the HRI is the expansion of peer support specialists or recovery coaches in the Harris County area. A recovery coach is a person with lived experience of recovery who helps guide and motivate individuals seeking recovery (SAMHSA, 2009). A formal certification process is required for recovery coaches, which they can use to either work for pay or volunteer. Recovery coaches spend much time with their mentees and can help with education, employment, housing, social services, or other resources individuals may need.

One support group available to those who struggle with alcohol abuse or addiction is Alcoholics Anonymous, which uses a 12-step program that outlines a defined process of steps for participants to complete. A sponsor, who has personal experience in recovery, typically leads the person through the program. Recovery coaches differ from sponsors, as coaches are not obligated to follow the 12-step program. Instead, recovery coaches urge individuals to pave their own pathway to recovery (SAMHSA, 2009). This distinction ties in with the overall mission of the HRI, although the HRI does not at all discourage participation in 12-step programs.

HISTORY AND LESSONS LEARNED

Phase 1 (May 2010–April 2011)

On May 10, 2010, the first HRI meeting was convened at the Council on Alcohol and Drugs Houston, now the Council on Recovery, with 23 leaders from various organizations, including The University of Texas at Austin, the Texas Department of State Health Services, Santa Maria Hostel, and the Coalition of Behavioral Health Services. This meeting served as the beginning of the very first ROSC in Texas. Five workgroups were formed during this meeting: Treatment, Recovery Support Services, Peer Recovery Coaches, Customer Voice, and Public Policy. In the subsequent few months, the workgroups met individually at least once a month to decide on new directions to take with their specific component of recovery, whereas the overall group (including all five workgroups) met every couple weeks.

Meanwhile, new members continued to join the initiative, and on July 30, 2010, a conference, "Planning a ROSC Model for our Community," took place with more than 100 active participants. At the conference, speakers from Detroit, Chicago, and Louisiana presented on the implementation of their own ROSC models, and the HRI workgroups formally presented their ideas for building a recovery community in Houston. By the end of the day, many volunteers had eagerly signed up to support the HRI.

After receiving feedback from the July stakeholder conference and from a national team development program for ROSCs in Florida, the 23-member leadership team drew up 33 recommendations for the HRI. By the end of 2010, the group narrowed this extensive list down to six areas of focus (Gulf Coast Addiction Technology Transfer Center, 2010, 2011).

1. Customers as members of advisory boards and consumer councils: The HRI believes the voices of the individuals in recovery should be heard.
2. Peer support for people waiting for treatment: The HRI sought to capitalize on people's attitude toward recovery by offering the support and listening ear of a peer with lived experience to people who are ready but must wait for addiction services.
3. Housing: The HRI assigns a high priority to housing needs. Many times, a person's recovery journey can become

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hampered by unsteady or unmet needs for housing assistance. The HRI wants to aid individuals by making safe environments available to them.

4. Recovery community centers: Recovery-friendly facilities can offer a venue for events, 12-step meetings, meeting places for recovery coaches, and other services as needed. These facilities broaden the recovery services available to the community.
5. 12-step community involvement: Recognizing the important role of the 12-step community, the HRI leadership intentionally partnered with various 12-step groups to leverage their experience, knowledge, and influence in the field.
6. Education on the chronic care model of addiction: Education is one of the founding pillars of many advocacy efforts and was included as a priority from the outset. The HRI leaders decided to focus their educational outreach on the chronic care model of addiction and stigma-reducing language for criminal justice agencies, referral agencies, and the medical community.

These focus areas evolved the workgroups into the following: Housing, Recovery Community Centers, Peer Recovery Support, 12-Step Community, Education, and Recovery Resource Directory. Within this first year, the HRI sought to gather a plethora of community members, decipher service gaps and obstacles to recovery in Houston, and determine new directions to close these gaps. Other accomplishments during the first year included (a) the completion of the first draft of a user-friendly, client-centered directory of treatment and recovery support services in Houston and (b) the submission of a grant proposal to SAMHSA for recovery maintenance programs for women.

Phase 2 (May 2011–April 2013)

Planning and organizing for change served as pillars of the second phase. The main goals were to develop guidelines for the needed change; assess agency capacity and readiness for change; and plan policies, funding, and regulations to carry out the agenda. It was important during this phase to continue building the leadership team involved to progress the work already accomplished. As excitement for the ROSC model spread throughout the greater Houston area, the number of individuals and agencies involved grew.

Each workgroup continued to make astounding progress. The Peer Recovery Support workgroup initiated routine recovery coach training classes that included more than 60 people in the first year. Recovery coaches began to be integrated into the community, with five coaches operating in Santa Maria Hostel, a treatment center for women (http://www.santamariahostel.org). Cenikor, a drug rehabilitation and drug addiction treatment and alcohol addiction center (http://www.cenikor.org), started offering scholarships for two of their graduates each year to receive recovery coach training. The 12-Step Community workgroup organized a community meeting that was attended by more than 140 people. To prioritize housing needs, the Housing workgroup participated in a meeting with more than 150 housing service providers in Houston to include rapid rehousing and an evaluation of existing housing resources.

During this phase, the HRI created a seventh workgroup, the Adolescent ROSC group, to focus on the youth who struggle with SUD and are working to maintain a drug-free lifestyle. The adolescent ROSC group met at least once a month and rapidly grew in membership and ideas.

Phase 3 (May 2013–Present)

Phases 1 and 2 established the foundation for the HRI as a stable, long-term initiative. In this current phase, the HRI aims to address community barriers to recovery and to monitor and evaluate the outcomes of the HRI workgroups. To gain information about existing recovery services in Houston, in May 2013 the Department of State Health Services and the Council on Recovery detailed an agenda for a recovery forum as well as two community focus groups.

The first focus group was held on June 28, 2013, with nine members of the business community. It seemed important to conduct a focus group with members of this community because their views on addiction and addiction recovery were different than the views of those already invested in the recovery community. This focus group revealed that many people in the business community lack knowledge regarding what to do if a colleague is struggling with substance use and desired more education surrounding recovery, treatment, and stigma. Key questions for which the business community required answers before agreeing to support recovery initiatives were the following:

- What can you do for me?
- Why should I work with you?
- What's my risk?
- What's my reward?

Owing to these hesitations, the HRI learned from this focus group important communication strategies for involving and educating the business community about recovery. The aforementioned questions showed members of the HRI the need to incorporate these answers when discussing recovery with the business community. The HRI essentially reframed its approach to addressing the business community so recovery can be more readily received. In addition, the HRI prioritized establishing a Business Community Advisory Council to co-develop an educational plan for training individuals in the workplace on addiction and recovery. As a first step, the HRI is working toward forming quality relationships with the business community so the forthcoming plan can incorporate collaborative expertise.

The HRI held a second focus group on August 9, 2013, concerning the community with co-occurring disorders, which are simultaneous diagnoses of substance-related disorders and mental health disorders (SAMHSA, 2006). In these instances, an individual has symptoms from both disorders; rather than being a cluster of similar symptoms, the

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symptoms of one disorder are independent of the symptoms of the other diagnosis (SAMHSA, 2006). Eighteen representatives from organizations that work with co-occurring disorder populations attended the forum. This particular focus group offered great insight for the HRI and discovered that the main needs for the community centered on education. The needs identified by the group included the following:

- The need for recovery coaches to be trained both in mental health disorder and SUD
- The need to incorporate family in the recovery process for those with co-occurring disorders
- The need for agencies to collaborate to provide effective training for working with this population
- The need to destigmatize co-occurring disorders
- The need to focus on overall wellness. The members emphasized the need to integrate work on both disorders with a focus on the whole health of the person.

On the basis of the findings of this focus group, the HRI decided to develop a separate group to examine stigma within the HRI as well as in the greater Houston area. Attendees from the focus group stressed the importance of first addressing language and mannerisms internally that could lead to stigmatization of this population before addressing stigma within the community. From that subgroup, the HRI planned to organize a community training to reduce the level of stigma and discrimination experienced by people with co-occurring disorders. This training, which is still a pilot project, includes emphasis on language used to describe and discuss people with co-occurring disorders to increase people's awareness of how language can perpetuate stigma. The training is held in conjunction with the Working with Communities "First Call Training" presentation, which is discussed subsequently in the "Workgroups" subsection of this article. Two trainings have been given to various community members, one session through a local church and another at Brazos County Drug Court.

This training is expected to simultaneously allow the HRI to strengthen relationships with organizations that have a proven track record for providing peer-to-peer training, family resources, and community education. The HRI also began collaborating with dual-recovery groups to establish meetings in the Houston area to find mutually acceptable guidelines for working with individuals who have both mental health disorders and SUDs.

On August 30, 2013, the recovery forum "Broadening the Recovery Net" was held in Houston with 173 people in attendance. At the forum, public officials including the mayor of Houston and Harris County judge spoke to show support for the recovery community. The HRI also provided continuing education credits for social workers, licensed professional counselors, and licensed chemical dependency counselors. Once again, the HRI presented on the forward progress of the initiative and included presentations showing the results from both focus groups. One of the biggest messages communicated to attendees was the need to get involved to create a recovery-focused community in Houston.

After the forum, the HRI decided that future events should encourage increasing the variety of communities attending beyond members of the recovery community. This includes an expansion to people from the business, mental health, faith-based, and adolescent communities as well as others.

These focus groups and the forum helped forge long-term goals for the HRI. The workgroup leaders discovered the vast need for education about the meaning of recovery. They desired to paint a picture of the positive impact recovery can have on individuals, families, and communities. Using the feedback, the HRI has evolved to eight workgroups.

In 2015, the HRI coordinated a panel discussion with the Greater Houston Behavioral Health Affordable Care Act Initiative covering medication-assisted treatment as a path to recovery with a lecture by a local physician on medication-assisted treatment as well as personal testimonies. On September 27, 2015, the HRI hosted the Big Texas Rally for Recovery in Houston in which local, state, and national dignitaries spoke on behalf of individuals and groups dedicated to recovery. Various recovery organizations and agencies set up tables to exhibit their services and raise awareness on the possibilities of recovery. More than 200 people attended the rally, including individuals from Dallas, Abilene, San Antonio, and Austin. This rally will continue as an ongoing annual event for the state of Texas during the National Recovery Month in September (see Figure 1).

WORKGROUPS

The HRI currently has adapted into these eight workgroups: Adolescent ROSC, Behavioral Health Integration, Criminal Justice, Faith-based Recovery Advocacy, Housing, Recovery Advocacy, Recovery Community Centers, and Working with Communities. Each workgroup strives toward creating a

Date	Event
May, 2010	First ROSC meeting
July, 2010	First ROSC forum
May, 2011	Phase II began
May, 2013	Phase III began
June 28, 2013	Focus Group I
August 9, 2013	Focus Group II
August 30, 2013	Second ROSC forum
February, 2015	Created first logic model for workgroups
March, 2015	Established first official logo
April, 2015	First panel discussion on MAT
September 27, 2015	Big Texas Rally for Recovery

ROSC: Recovery Oriented Systems of Care; MAT: Medication Assisted Treatment

Figure 1. Key dates of the Houston Recovery Initiative.

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community of holistic care for individuals in recovery and, ultimately, educating the community on the positive nature of recovery (see Figure 2). A volunteer chair leads each workgroup. The events and activities of each workgroup are funded through innovative use of sponsorships because the HRI operates without a budget. These include soliciting donations from grocery stores for food for events, selling vendor tables at community events to cover costs, and collaborating with organizations to use their facilities and share resources. At the time of the publication of this article, the HRI includes more than 500 volunteer members.

In 2015, each workgroup created individualized strategic plans for the year. These plans included the problems they wished to address, the activities that were planned to address those problems, and evaluations of those activities. The strategic plans facilitate structure and accountability for the workgroups. The HRI plans to have annual evaluations and presentations by each workgroup on their successes and areas of improvement. The evaluations will include the number of attendees to events and activities, pretests and posttests created for certain trainings, and qualitative viewpoints of participants. An example of a strategic plan completed by the Recovery Advocacy workgroup is displayed in Figure 3.

The Recovery Community Centers workgroup, for instance, planned at the beginning of the year to put together a Health Fair at a park near their meeting place. However, the park closed a couple of months later, and the original plan was adapted to become a Peer Recovery Festival located at one of the city's multiservice centers. The festival was held in August as a kickoff to National Recovery Month. Close to 200 people attended the festival, and agencies sponsored free food and numerous activities. The Recovery Community Centers workgroup has also established peer recovery coaches and trainings in Houston, with more than 300 individuals trained to be recovery coaches.

The Working with Communities workgroup continued their annual resource fair, which has a different theme each year. The 2015 theme focused on families and friends in recovery, and in 2016, the fair will focus on exercise and wellness for professionals and people in recovery. They also established their first "First Call Training" that aims to educate lay members of the community on how to respond with encouragement when they encounter someone with a SUD.

Teen leadership trainings, created by the Adolescent ROSC workgroup, represent another great accomplishment of these workgroups. These trainings were created in 2013 and showed great promise as another means beyond alternative peer groups to support youth as they choose recovery. The group created a manual to share their training materials and agenda across the state of Texas.

Other workgroup activities include the first recovery education event hosted by the Recovery Advocacy workgroup at the State Capitol during the legislative session, a Webinar presentation for the Society of Public Health Education, contributions to recovery housing standards, and a cross-discipline education session about recovery within the medical community in Houston presented by the Behavioral Health Integration workgroup. Through their efforts, each workgroup has made a significant impact in the community, and these efforts will continue to expand.

Adolescent ROSC	Behavioral Health Integration	Criminal Justice	Faith-Based Recovery Advocacy
• Created Teen Leadership Trainings, which helps teens support and guide each other through recovery • Launched production of documentary, Generation Found	• Addressed cultural competencies within behavioral health • Increased training across disciplines	• Helped the Texas Department of Criminal Justice establish peer recovery training in prison system • Formulated a recovery resource guide for Texas	• Brought a national event, REEL Recovery Film Festival, to Houston • Coordinated Freedom Fest for July 4th celebrations

Housing	Recovery Advocacy	Recovery Community Centers	Working with Communities
• Designed standardized rules to classify housing as "recovery appropriate" • Set goal to educate apartment managers on recovery	• Held first recovery education event at the State Capitol during the 84th Legislative Session • Orchestrated "Our Stories Have Power"	• Established peer recovery coaches and trainings in Houston • Hosted many entertaining events for people in recovery	• Formed First Call Initiative to inform lay members how to respond to substance use issues • Organized expos and symposiums each year

Figure 2. Summary of workgroup activities.

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LEADERSHIP

The HRI was established and grew through a very organic process. The original loose structure provided an opportunity for members to take the initiative in any direction necessary for the community. Although this loose structure is necessary to start a volunteer coalition, the downside is that it may have contributed to a delay in forward progression and may have rendered evaluation a challenge. One suggestion to avoid this potential pitfall is to incorporate strategic plans earlier to aid in evaluation. This not only could serve as a guide to setting future goals but also would facilitate the acknowledgement of objectives already met. Remembering and owning small achievements alongside the large ones can indicate that change is happening and could help alleviate concerns about slow progress.

The HRI leadership team helped the group to stay relevant and inclusive of the recovery community. One of the vital characteristics of the HRI chair is his servant leadership style. Many workgroup chairs respect the lead chair because he allows members to think independently and welcomes innovative ideas. Another important element is for leadership to be inclusive of all people in the community by creating a warm environment. Inviting people from different backgrounds into the initiative allows the group to expertly lead the community at large forward to becoming more recovery friendly.

The HRI is particularly challenged by the lack of a budget, a formal 501(c)(3) designation, and formal support staff. Although the HRI has accomplished much with no funding, a budget would allow for the creation of more recovery events for the community and enable the HRI to hire a few staff members to dedicate time to the initiative. The lack of a 501(c)(3) designation requires the HRI to rely on a separate organization to serve as the financial administrator and hinders the HRI in receiving donations. With an entirely volunteer membership, all the work done must be completed in people's free time. This has forced progress to move slower than had full-time staff members been on task.

At the same time, the members of the HRI have such a strong passion for the mission to create a recovery community in Houston. This is one of the main attributes that has allowed the HRI to function. That and the high level of support from the state have been pertinent to the successes of the initiative. Without support from staff within the Texas Department of State Health Services, completing all the accomplishments thus far would have been extremely difficult.

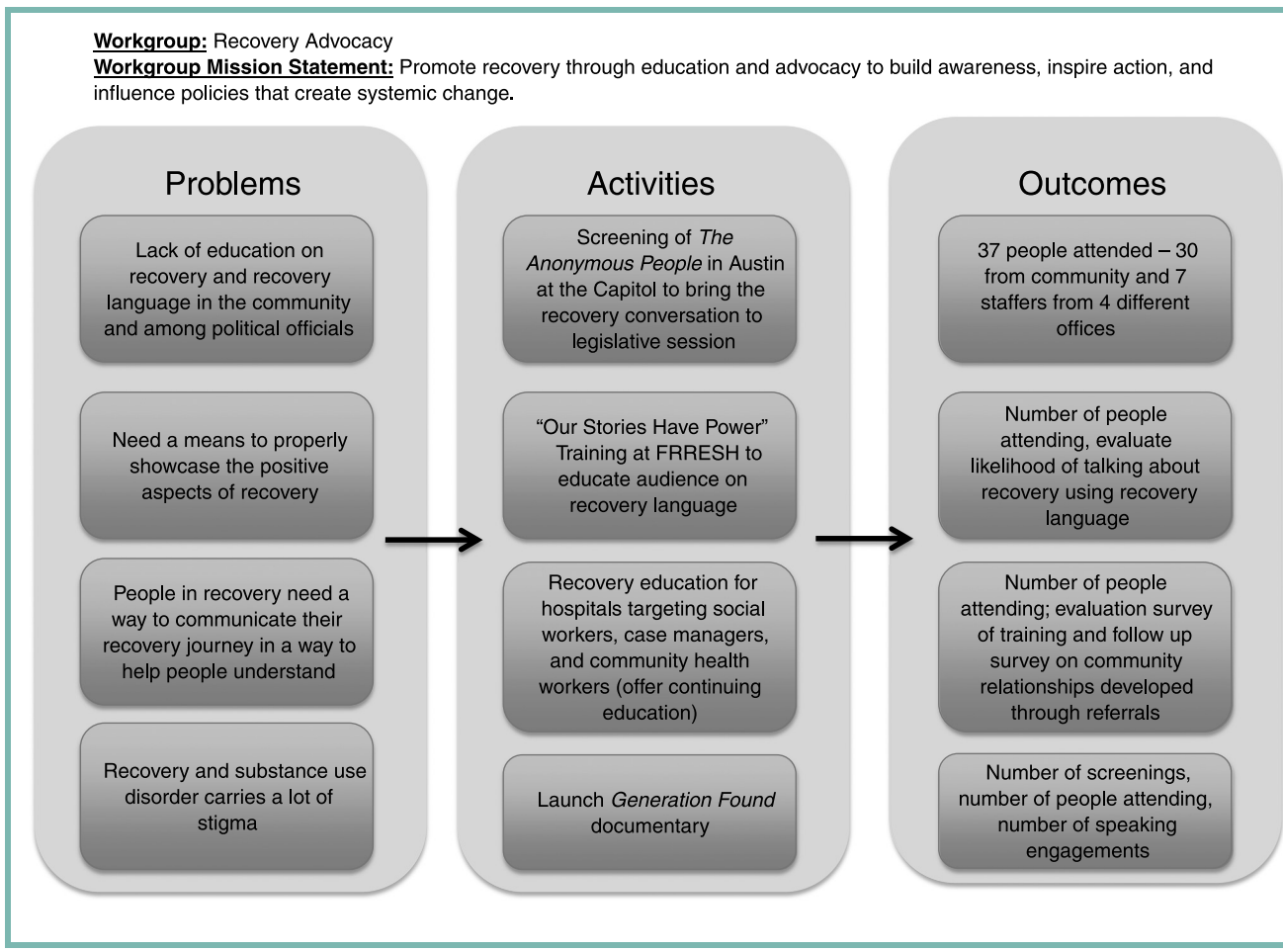

Figure 3. Example of a strategic plan.

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The new strategic plans have helped the initiative to organize efforts. The strategic plans of each workgroup and the HRI as a whole have helped keep records of the HRI's activities and evaluate them after a year's time. This provides a way to see the new areas of improvement and to recognize the good work that has been done.

FUTURE PLANS

Moving forward, the HRI will continue to develop strategic plans and garner support in the community. The HRI hopes to increase their presence in the Houston community and play a major role in recovery support services. In 2015, the HRI created a logo, recreated the Web site with a more modern design (http://www.houstonrecoveryinitiative.org), and created a one-page information sheet describing the initiative to establish a more solid identity and brand. With this foundation, the HRI plans to create more awareness of the initiative and increase the number of volunteers. The HRI wishes to provide an avenue to recovery for the 369,000 persons in Harris County with an SUD and continue working toward destigmatizing recovery.

The HRI also looks to establish a financial baseline to further support workgroups in their activities to present exhibits and recovery-related educational events around the city. The HRI plans to grow and involve other people and agencies in the movement. The HRI is building recovery communities one voice at a time.

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