Guidance 35
Recovery Management Practices

Contract Reference: *Sections A.1.1 and C.1.2.6*

Authority: *Sections 394.453(1)(c), 394.4573, 394.9082 F.S.*

Frequency: *Ongoing*

Due Date: *Ongoing*

Purpose: The purpose of this document is to provide directions and recommendations for implementation of Recovery Management practices in Network Service Providers. These practices are accomplished using Florida's Recovery-Oriented System of Care (ROSC) Framework. This document provides best practice standards to transform delivery of care to one that focuses on sustainable wellness and recovery.

I. DEFINITIONS

A. Peer Specialist: As defined in s. 397.311 (31), F.S.

B. Recovery: As defined in s. 397.311(38), F.S.

Through key stakeholder engagement, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed the following working definition of recovery.[1]

Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

This definition describes recovery as a process, not an end state. Complete symptom remission is neither a prerequisite of recovery nor a necessary process outcome. Recovery can have many pathways including professional clinical treatment and use of medications; family, school, and faith-based supports; peer support; and other approaches. Four major dimensions support a life in recovery:

1. Health: Learning to overcome, manage, or more successfully live with symptoms; and making healthy choices that support one's physical and emotional wellbeing.
2. Home: A safe, stable place to live.
3. Purpose: Meaningful daily activities such as work, school, volunteer activities, or creative endeavors; an increased ability to lead a self-directed life; and meaningful engagement in society.
4. Community: Relationships and social networks providing support, friendship, love, and hope.

c. **Recovery Management (RM):** A philosophical framework for organizing treatment services to provide pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality-of-life enhancement for individuals and families affected by behavioral health disorders. [2]

D. Recovery-Oriented: Recognizes that each person must be the agent of and the central participant in their own recovery journey. All services and supports need to be organized to

[1] (Recovery, 2010)

[2] White, W. (2008). Recovery management and recovery-oriented systems of care. Chicago: Great Lakes Addiction Technology Transfer Center, Northeast Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services

support the developmental stages of this process.

E. Recovery-Oriented System of Care (ROSC): A value-driven framework to guide transformation of a behavioral health system of care. The framework structures behavioral health systems to involve a network of clinical, nonclinical services, and supports that sustain long-term, community-based recovery. Formal and informal service networks are developed and mobilized to sustain long-term recovery for individuals and families impacted by behavioral health disorders. ROSC reflects variations in each community's vision, institutions, resources, and priorities. The "system" is not a treatment agency but a macro-level organization of a community, a state, or a nation.

F. Recovery Capital: Recovery capital is the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery.

G. Recovery Support: As defined in s 397.311(41), F.S.

H. Support Services: As defined in s. 394.67(16)(c), F.S.

II. ROSC OVERVIEW

A. Priority Areas

1. **Collaborative Service Relationship** indicated by a mutual service relationship between the provider and the service recipient shifts from a hierarchy model to the shared decision-making process and best practices that support the service recipients.
2. **Cross-system Partnerships** indicated by strategically leveraging resources and working across sectors to achieve common goals.
3. **Community Integration** indicated by assertively connecting service recipients to natural community-based resources to promote development of interest, skills, and supportive relationships.
4. **Community Health and Wellness** indicated by a focus on prevention, early intervention, wellness and increased recovery capital through targeted community education, strategic partnership development, and improved connections between system and local communities.
5. **Peer-based Recovery Support** indicated by increasing access to peer-based recovery support services.

B. Goals of a Recovery-Oriented System of Care

1. Promote good quality of life, community health, and wellness for all.
2. Prevent the development of behavioral health conditions.
3. Intervene earlier in the progression of illnesses.
4. Reduce the risk caused by substance use disorders and mental health conditions on individuals, families, and communities.
5. Provide the resources to assist people with behavioral health conditions to achieve and sustain their wellness and build meaningful lives for themselves in their communities.

C. Best Practice Standards as Defined in Table 1

D. Performance Domains for Quality Improvement Monitoring

The practices below are aligned with the Department's Recovery Oriented Quality Improvement Monitoring process and protocols produced by Florida Certification Board.

1. **Meeting Basic Needs** indicated by assessment, planning and delivery of all services to first address basic needs.
2. **Comprehensive Services** indicated by treatment and recovery supports that provide for a variety of treatment and recovery support modalities.

3. **Medications and Medication- Assisted Treatment** where applicable, indicated by the provision of information on psychotropic medication and medication-assisted treatment (MAT).
4. **Strength Based Approach** indicated by treatment delivery and planning that are fundamentally oriented toward an individual's strengths rather than deficits.
5. **Customization and Choice** indicated by the planning and delivery of all services and supports designed to address the unique circumstances, history, needs, expressed preferences, and capabilities of individuals receiving services.
6. **Opportunity to Engage in Self-Determination** indicated by the level of involvement of the individual determining treatment approaches and other recovery-oriented services.
7. **Network Supports and Community Engagement** indicated by active efforts in the planning and delivery of services to involve environmental supports in the individual's treatment and overall recovery that promotes community integration.

The Department's goal is to transform its publicly funded behavioral health services to a more recovery-oriented system. The Department also acknowledges regional and community variances in terms of visions, institutions, resources, and priorities. Due to these variations, transformation practices discussed here are not prescriptive of best practice standards, and the Department does not expect that all practices will be executed in every region or community. Specific regional best practices will be directed by each Managing Entity in consultation with the Department and key stakeholders. **Table 1** includes a list of best practice standards and changes in practice.

Table 1 ROSC Implementation Crosswalk		
Best Practice Standards	**Performance Domains for Quality Improvement**	**Potential Practice Changes**
Assessment: *Greater use of global and strength-based assessment instruments and interview protocol; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stages of recovery.*	**Meeting Basic Needs**	**Conduct Global Assessments:** *Use holistic, contextually appropriate assessments, use strengths-based assessment procedures and interview protocols; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stage of recovery. Focus the assessment on multiple life domains rather than primarily on the presenting problems.*
Clinical Care: *Greater accountability for delivery of services that are evidence-based, socially considerate and appropriate, and trauma informed; greater integration of professional counseling and peer-based recovery support services; considerable emphasis on understanding and modifying everyone's recovery environment; use of formal recovery circles (recovery support network development).* **Service Dose and Duration:** *Dose and duration of total services will increase while the number and duration of acute care episodes will decline; emphasis shifts from crisis stabilization to ongoing recovery coaching; great value placed in continuity of contact in a primary recovery support relationship over time.* **Post-treatment Checkups and Support:** *Emphasis on recovery resource development (e.g., supporting alumni groups and expansion of local recovery support groups); assertive linkage to communities of recovery; face-to-face, telephone-based, or internet-based post-treatment monitoring and support; stage-appropriate recovery education; and, when needed, early re-intervention.*	**Comprehensive Services**	**Promote Retention:** *Enhance rates of service retention and reduce rates of service disengagement and administrative discharge by utilizing outreach workers, enhancing peer-based recovery support services in the treatment context, providing contextually appropriate services, providing a menu of service options so that care is individualized, and incorporating family members and other important allies as desired. Develop assertive approaches to helping people remain connected to natural community-based supports.* **Expand the Focus of Services and Supports:** *Expand the focus beyond sobriety, symptom management, or biopsychosocial stabilization, to assisting individuals with building lives in the community and promoting community health. Focus on what people and communities want to become rather than what we want them to stop doing.* *Strengthen the family and community contexts so that individuals have increased access to natural supports, which sustain recovery and wellness beyond their involvement in a treatment episode. Facilitate the development of recovery maintenance skills rather than only recovery initiation skills. Provide clinical services that are recovery-focused, evidence-based, developmentally appropriate, socially considerate and appropriate, trauma-informed and integrated with a broad spectrum of non-clinical recovery support services. Provide prevention supports that strengthen individual, family and community protective factors and reduce risk factors for substance use.* **Ensure a Sufficient Continuum of Care with Appropriate Dose/Duration of Services:** *Provide doses of treatment services across levels of care that are associated with positive recovery outcomes. Facilitate continuity of contact in a primary recovery-support relationship over time and across levels of care.* **Develop Strong Cross-system Partnerships to Achieve Common Goals:** *Build meaningful collaborations across systems such as criminal justice, behavioral health, child welfare, housing, public health, education, transportation to strategically leverage resources and achieve intersecting goals.* **Increase Service Access:** *Assure rapid access to treatment with minimal wait times. During unavoidable wait times, engage people through peer-based supports within treatment. Ensure that there are no limitations to accessing treatment based on past utilization and/or outcomes.*

Table 1 ROSC Implementation Crosswalk		
Best Practice Standards	**Performance Domains for Quality Improvement**	**Potential Practice Changes**
Clinical Care: *Greater accountability for delivery of services that are evidence-based, socially considerate and appropriate, and trauma informed; greater integration of professional counseling and peer-based recovery support services; considerable emphasis on understanding and modifying each individual's recovery environment; use of formal recovery circles (recovery support network development).*	**MAT**	**Conduct Global Assessments:** *Use holistic, contextually appropriate assessments, use strengths-based assessment procedures and interview protocols; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stage of recovery. Focus the assessment on multiple life domains rather than primarily on the presenting problems.* **Promote Health Activation:** *Shift towards philosophy of choice rather than prescription of pathways and styles of recovery/support, greater individual authority and decision making within the service relationship, emphasis on empowering individuals to self-manage their own recoveries and identify their personal life and treatment goals. Similarly, empower the community to identify their strengths that can be mobilized to promote wellness.*
Assessment: *Greater use of global and strength-based assessment instruments and interview protocol; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stages of recovery.* **Service Relationship:** *Service relationships are less hierarchical with the counselor serving more as an ongoing recovery consultant than professional expert; more a stance of "How can I help you?" than "This is what you must do."*	**Strengths Based Approach**	**Facilitate Individualized, Person-Centered Service Planning:** *Ensure that treatment and recovery/wellness planning processes are individualized, directed by the person/family, and are grounded in the broader life goals that people have for themselves rather than clinical goals.* **Promote Health Activation:** *Shift towards philosophy of choice rather than prescription of pathways and styles of recovery/support, greater individual authority and decision making within the service relationship, emphasis on empowering individuals to self-manage their own recoveries and identify their personal life and treatment goals. Similarly, empower the community to identify their strengths that can be mobilized to promote wellness.*
Role of Individual: *Shift toward philosophy of choice rather than prescription of pathways and styles of recovery; greater individual authority and decision-making within the service relationship; emphasis on empowering individuals to self-manage their own recoveries.* **Service Relationship:** *Service relationships are less hierarchical with the counselor serving more as an ongoing recovery consultant than professional expert; more a stance of "How can I help you?" than "This is what you must do."*	**Customization and Choice**	**Promote Health Activation:** *Shift towards philosophy of choice rather than prescription of pathways and styles of recovery/support, greater individual authority and decision making within the service relationship, emphasis on empowering individuals to self-manage their own recoveries and identify their personal life and treatment goals. Similarly, empower the community to identify their strengths that can be mobilized to promote wellness.* **Promote Collaborative Service Relationships:** *Shift the relationship with individuals and community members from a hierarchical expert-person served model to a partnership/consultant model. The helping stance changes from "This is what you must do." to "How can I help you?"* **Expand the Focus of Services and Supports:** *Expand the focus beyond sobriety, symptom management, or biopsychosocial stabilization, to assisting individuals with building lives in the community and promoting community health. Focus on what people and communities want to become rather than what we want them to stop doing.* *Strengthen the family and community contexts so that individuals have increased access to natural supports, which sustain recovery and wellness beyond their involvement in a treatment episode. Facilitate the development of recovery maintenance skills rather than only recovery initiation skills. Provide clinical services that are recovery-focused, evidence- based, developmentally appropriate, socially considerate and appropriate, trauma-informed and integrated with a broad spectrum of non-clinical recovery support services. Provide prevention supports that strengthen individual, family and community protective factors and reduce risk factors for substance use.*

Table 1 ROSC Implementation Crosswalk		
Best Practice Standards	**Performance Domains for Quality Improvement**	**Potential Practice Changes**
Engagement *Greater focus on early identification via outreach and community education; emphasis on removing personal and environmental obstacles to recovery; shift in responsibility for motivation to change from the individual to service provider; loosening of admission criteria; renewed focus on the quality of the service relationship.* **Retention:** *Increased focus on service retention and decreasing premature service disengagement; use of peers, outreach workers, recovery coaches, and advocates to reduce rates of individual disengagement and administrative discharge.* **Attitude Toward Re-admission:** *Returning individuals are welcomed (not shamed); emphasis on transmitting principles and strategies of chronic disease management; focus on enhancement of recovery maintenance skills rather than recycling through standard programs focused on recovery initiation; emphasis on enhancing peer-based recovery supports and minimizing need for high-intensity professional services.*	**Opportunity to Engage in Self-Determination**	**Facilitate Individualized, Person-Centered Service Planning:** *Ensure that treatment and recovery/wellness planning processes are individualized, directed by the person/family, and are grounded in the broader life goals that people have for themselves rather than clinical goals.* **Peer-based Recovery Support Services:** *Expand the availability of non-clinical, formal (paid) and informal (non-paid) peer-based recovery support services and integrate them with professional and peer-based services.*
Service Delivery Sites: *Emphasis on transfer of learning from institutional to natural environments; greater emphasis on home-based and neighborhood-based service delivery; greater use of community organization skills to build or help revitalize indigenous recovery supports where they are absent or weak.* **Service Relationship:** *Service relationships are less hierarchical with counselor serving more as ongoing recovery consultant than professional expert; more a stance of "How can I help you?" than "This is what you must do."* **Attitude toward Re-admission:** *Returning individuals are welcomed (not shamed); emphasis on transmitting principles and strategies of chronic disease management; focus on enhancement of recovery maintenance skills rather than recycling through standard programs focused on recovery initiation; emphasis on enhancing peer-based recovery supports and minimizing need for high-intensity professional services.*	**Network Supports and Community Integration**	**Promote Community Integration:** *Facilitate community integration by supporting people in identifying their personal dreams, goals, and preferences for their life. Connect them to relevant resources and walk alongside them to develop the interest, skills and relationships that will enable them to enhance their life. Collaborate with community specific recovery-support organizations (e.g., faith community); assertively link people to local communities of recovery; participate in local recovery education/celebration events in the larger community and advocate on issues that affect long-term recovery in the community (e.g., issues of stigma and discrimination). Mobilize and increase collaboration amongst diverse community resources. Partner with the community in a manner that values and integrates the knowledge, expertise, and strengths of community members.* **Promote Collaborative Service Relationships:** *Shift the relationship with individuals and community members from a hierarchical expert-patient model to a partnership/consultant model. The helping stance changes from "This is what you must do." to "How can I help you?"* **Conduct Strength-Based Community Asset Mapping:** *Support prevention efforts that use a strategic approach to assess the strengths and assets within communities, rather than focus primarily on needs assessments, gaps, and identified problems.* **Assertively Engage All Community Members:** *Promote prevention, early engagement, and intervention via outreach and community education. For those in need of intervention, emphasize removing personal and environmental obstacles to recovery through meeting basic needs; ensure that the responsibility for motivation to change shifts from individuals to service providers; use inclusive admission criteria rather than emphasis on exclusionary criteria.* **Broaden Service Delivery Sites:** *Increase the delivery of community integrated neighborhood and home-based services and expand recovery support services in high-need areas. Utilize and link people to existing community-based resources rather than duplicating efforts and recreating resources within segregated, institutional environments. Assist people in developing a network of natural recovery supports in order to increase their recovery capital.*

III. MANAGING ENTITY RESPONSIBILITIES

Each Managing Entity shall demonstrate progress toward implementation of a ROSC framework within its service areas. The Managing Entity shall:

A. Incorporate specific Best Practice Standards and Potential Practice Changes in **Table 1** into Network Service Provider subcontracts and monitor compliance with the Performance Domains for Quality Improvement Monitoring aligned with the specific standards and changes selected.

B. Incorporate concepts designed to bolster the role of peer support and ROSC concepts with Network Service Providers.

C. Require subcontracted Network Service Providers who employ peers working with adults in direct recovery-support service roles to:

1. Use the Reaching for their Dreams Using Recovery Capital as a foundation to inform the individualized recovery planning process by developing goals among applicable domains.
2. Receive standardized supervision of peer-based support services training for peer supervisors. At minimum, standardized peer supervision training must cover the following core competencies:
    - **a.** Role and core competencies of peer specialists.
    - **b.** Navigating self-disclosure.
    - **c.** Strengths-based and person-centered service practices.
    - **d.** Boundaries and ethics for peer specialists.
    - **e.** Integration of peer specialists.
    - **f.** Effective supervision skills for peer specialists.
    - **g.** Supporting professional growth and development opportunities.

D. Support programmatic changes to include prevention and early intervention.

E. Promote adoption of sustainable recovery-oriented practices.

F. Analyze and assess current Managing Entity administrative, fiscal, policy, monitoring, and evaluation functions to align with recovery-oriented concepts using the Best Practices Standards in **Table 1**.

G. Identify opportunities to promote the expansion of peer-based recovery support services and recovery communities, enhance the role of peers in the workforce, and support development of peer-run organizations in their network.

H. Require subcontracted Network Service Providers providing direct services to complete the Self-Assessment Planning Tool (SAPT) process every two years, incorporating data collection from the Recovery Self-Assessment (RSA) tools, Person in Recovery, Provider, and where applicable, Family Members versions. Resources for evaluating and implementing recovery-oriented services are available at: 2018 Provider Self-Assessment Planning Tool - ROSC Adaptation

Recovery Self-Assessment | Yale Program for Recovery and Community Health

I. Annually provide technical assistance to Network Service Providers for improvement among all domains and shall include development of individualized action plans.

Annually provide a regional summary report that includes data to demonstrate the extent to which services use the characteristics of recovery-oriented best-practices. This report shall also include a regional action plan to address opportunities for improvements and demonstrate progress towards identified goals and be sent to the regional office.

J. Require direct Network Service Providers who deliver person-specific services to complete Recovery Management Curriculum Modules 1 through 7 on Recovery Management best practices in employee orientation or within one year of employment and refresher trainings as needed, available at Recovery Oriented System of Care (ROSC) | Florida DCF Require attestation of training completion for Network Service Provider employees. Managing Entities are permitted to create their own attestation forms.

1. Pre and post-test may be provided to measure adoption of training content among Network Service Provider employees.

K. Use the Recovery Oriented Quality Improvement Monitoring Blueprint, available at Recovery-Oriented Quality Improvement Monitoring Blueprint (June 2020)

1. Conduct Recovery-Oriented Quality Improvement monitoring as a component of routine on-site monitoring of Network Service Providers who deliver individual-specific services.
2. Network Service Providers delivering services through an evidence-based model that requires the use of specific assessment tools are exempt from Recovery-Oriented Quality Improvement monitoring, including Evidence Based Practice teams established through Guidance Document 37.
3. Include findings from the monitoring in a final report that shall include all elements of the site visit, facility tour, policy and procedure review, person served interviews, surveys, service chart scoring outcomes, staff interviews, and where applicable, review of peer specialist staff job description(s).
4. In consultation with the Department, provide follow-up training and technical assistance on enhancing recovery management approaches and practices to monitor providers with a cumulative average score of less than 4.0 across all domains.
5. Reports shall be submitted to the Network Service Provider and the Department's regional office within 30 days of the site visit.

L. Pursuant to section 394.9082(6)(x), F.S., Promote the use of person-first language and trauma-informed responsive care among providers, peer organizations, and family members, including, but not limited to, through training and sharing best practices. For purposes of this paragraph, the term "person-first language" means language used which emphasizes the patient as a person rather than that patient's disability, illness, or condition.

1. Managing Entities shall promote the adoption of person-first language and trauma-informed, responsive care across provider networks. Managing Entities shall demonstrate ongoing efforts to advance awareness and adoption and monitor compliance through documentation, training records, policy reviews, and other quality improvement activities. Supportive trainings and resources may be located using the link below for Florida Alcohol and Drug Addiction Association's (FADAA) Person-Centered Responsive Care Center.

IV. RESOURCES

Managing Entities and Network Service Providers are encouraged to research the following recovery-oriented promising practices as examples of effective implementation:

Recovery Support Bridgers/Navigators - Certified Recovery Peer Specialists (CRPS) are utilized to assist individuals in successfully transitioning back into the community following discharge from a Hospital Emergency Department, Jail, State Mental Health Treatment Facility (SMHTF), Crisis Stabilization Unit (CSU) or Detoxification facility. The CRPS engages the individual while still inpatient or incarcerated and provides support and information on discharge options. They participate in discharge planning and assist the person in identifying community-based service and support needs and build self- directed recovery tools, such as a Wellness Recovery Action Plan (WRAP). The CRPS then supports the individual as they transition to the community. More information on WRAP may be accessed at: http://mentalhealthrecovery.com/

Care Transition Programs® - This intervention utilizes a Transition Coach to preferably meet an individual in the acute care setting to engage them and their family (as appropriate) and sets up in-home follow up visits and phone calls designated to increase self-management skills, personal goal attainment, and provide continuity across the transition.[3] More information on the Care Transition Programs may be accessed at: Community-based Care Transitions Program | CMS

Behavioral Health Homes - The SAMHSA – Health Resources and Services Administration Center for Integrated Health Solutions has proposed a set of core clinical features of a behavioral health home that serves people with mental health and substance use disorders, with the belief that application of these features will help organizations succeed as health homes. This resource may be accessed at: CIHS_Health_Homes_Core_Clinical_Features.pdf

Reducing Avoidable Readmissions Effectively (RARE) - The RARE Campaign in Minnesota was established to improve the quality of care for persons transitioning across care systems and to reduce avoidable readmissions by 20%. Five areas were identified as a focus of these efforts:

- Person-served/Family Engagement and Activation,
- Medication Management,
- Comprehensive Transition Planning,
- Care Transition Support, and
- Transition Communication

For more details, the RARE Campaign published recommendations on actions to address the above areas of focus, which can be accessed at: Reducing avoidable hospital readmissions effectively: a statewide campaign - PubMed

Wraparound[4] **-** Wraparound is an intensive, individualized care planning and management process for individuals with complex needs, most typically children, youth, and their families. The Wraparound approach provides a structured, holistic, and highly individualized team planning process which includes meeting the needs of the entire family. The philosophy of care begins with the principal of "voice and choice", which stipulates the child and family perspective and drives the planning. The values further stipulate that care be community-based and socially considerate and appropriate. The staff to family ratio typically does not exceed one Wraparound facilitator to ten families. More information on Wraparound may be accessed at: http://nwi.pdx.edu/.

Related Articles:

- Philadelphia Behavioral Health Services Transformation Practice Guidelines for Recovery and Resilience Oriented Treatment.
- Philadelphia Dept. of Behavioral Health and Intellectual Disabilities Services and Achara Consulting Inc. (2017). Peer Support Toolkit. Philadelphia, PA: DBHIDS.
- Davidson, L.; Tondora, J.; Ridgway, P.; & Rowe, M. (2012). Inventory of transformation characteristics for recovery-oriented systems of care. New Haven, CT: Yale University Program for Recovery and Community Health.
- Winarski, J., Dow., M, Hendry, P., & Robinson, P. (2018). Self-Assessment/Planning Tool for Implementing Recovery-Oriented Services (SAPT) Adapted for Florida's Recovery Oriented System of Care Initiative (ROSC). Tampa, FL: Louis de la Parte Florida Mental Health Institute, University of South Florida.

[3] See, http://caretransitions.org/about-the-care-transitions-intervention/, site accessed October 14, 2015

[4] IOM (Institute of Medicine). 2010. The healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington, DC: The National Academies Press

- Recovery concept finds common ground in mental health and addiction, Co-occurrences Newsletter of the Minnesota Co-Occurring State Incentive Grant Project.
- Recovery in Mental Health & Addiction, Davidson and White, Recovery to Practice Issue No. 14
- Kelly, J. & White, W. (Late 2010) Addiction recovery management: Theory, science and practice. New York: Springer Science.
- Monographs published by Great Lakes Addiction Technology Transfer Center, available at William White Papers- Papers by Category
    - Recovery Management
    - Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation
    - Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices
    - Practice Guidelines for Resilience and Recovery Oriented Treatment, Philadelphia Department of Behavioral Health and Intellectual Disability Services

Relevant Websites and Links: Recovery Supports To Scale Technical Assistance | SAMHSA

https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf

Achara Consulting: Home - Achara Consulting

Recovery Management Creating a Recovery-Oriented System of Care

Peer-based Recovery Support Microsoft Word - Peer-Based Recovery Support Services _body only_.doc

Practice Guidelines for Resilience and Recovery Oriented Treatment, Philadelphia Department of Behavioral Health and Intellectual Disability Services. Practice Guidelines - DBHIDS