

This interview is part of *Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-Oriented System of Care*, the second in a series of monographs on recovery management published by the Great Lakes Addiction Technology Transfer Center (ATTC).



## Peer-based Recovery Support Services: The Connecticut Experience

*An Interview with Phillip Valentine*  
By William L. White, MA

### INTRODUCTION

One of the distinctive characteristics of recovery-oriented systems of care is the elevated role of peer-based recovery support services within such systems and the importance of post-treatment monitoring, sustained support, and early re-intervention. Such systems are pioneering new volunteer and paid roles under such titles as recovery coaches, recovery support specialists, personal recovery assistants, peer helpers, etc. These roles are attached to existing addiction treatment organizations or are emerging from newly conceived grassroots, recovery advocacy, and recovery support organizations. Interest in these roles and in the broader arena of non-clinical recovery support services has been spawned by two Federal programs: the Center for Substance Abuse Treatment's Recovery Community Support Program (<http://rcsp.samhsa.gov/>) and the White House-initiated Access to Recovery program (<http://atr.samhsa.gov/>). One of the most prominent recovery advocacy and support organizations in the United States is the Connecticut Community for Addiction Recovery (CCAR). In December, 2006, I conducted a wide-ranging interview with Phillip Valentine, the Executive Director of CCAR, on behalf of the Great Lakes Addiction Technology Transfer Center (Great Lakes ATTC). The following interview profiles one of the most successful grassroots recovery support organizations, outlines the kinds of services CCAR provides to support the process of long-term recovery, and describes a new potential component of the addiction treatment service continuum, the recovery community center.

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**GREAT LAKES ATTC:** Phil, briefly describe how you came to be involved in the New Recovery Advocacy Movement and the delivery of recovery support services.

**PHIL VALENTINE:** Most of the time I think the movement chose me. I received a call back in the Fall of 1998 from a dear friend of mine, Jim Wuelfing, who told me there was an interesting thing happening that I might want to check out. He was involved with NEAAR, the New England Alliance for Addiction Recovery, and told me about the work Bob Savage was doing with the Connecticut Community for Addiction Recovery (CCAR). Both organizations had just received funding from CSAT, and I applied for positions at NEAAR and CCAR. I was offered the position of Associate Director at CCAR and assumed that position in January, 1999.

**GREAT LAKES ATTC:** How would you describe CCAR's vision and mission?

**PHIL VALENTINE:** CCAR envisions a world where the power, hope, and healing of recovery from alcohol and other drug addiction are thoroughly understood and embraced. Our mission is to put a positive face on recovery through advocacy, education, and service, in order to end discrimination surrounding addiction and recovery, open new doors and remove barriers to recovery, and ensure that all people in recovery and people seeking recovery are treated with dignity and respect. When people ask me what I do, my "one-liner" is that CCAR organizes the recovery community to put a face on recovery and to build recovery capital.

**GREAT LAKES ATTC:** How is CCAR organized?

**PHIL VALENTINE:** CCAR has a central office and four recovery community centers. They evolved out of our chapters. At one time we had six chapters up and running, and their primary purpose was to put a face on recovery. From their needs and desires, we launched the recovery community centers—recovery-oriented anchors in the hearts of the communities, a place where local communities of recovery can design and deliver the supports they need to initiate and maintain their recoveries. Our CCAR staff members constitute an inner circle, and our task is to support, empower, and train the volunteers who form the next circle. Our "target audience" is our volunteers—people in all stages of recovery, family members, interns, friends, and allies. One of our "ideal" volunteers is a retired person in long-term recovery. Our target audience is not people still actively using, or even those seeking recovery or those in early recovery. They are our secondary target audience, and we reach them through our volunteer force. Staff interacts with people at all stages of need, but we're gradually working to have volunteers handle most of the direct peer support. Currently we have 10 staff and 150 trained volunteers. We use this model to multiply our efforts and get the most value for the federal, state, and local dollars we receive.

**GREAT LAKES ATTC:** What would you consider to be some of the more important milestones in the history of CCAR?

**PHIL VALENTINE:** There are so many. Receiving funding from CSAT's Recovery Community Support Program laid a financial foundation that was matched by funding from the Connecticut Department of Mental Health and Addiction Services (DMHAS). Our first "Recovery Walks!" held in 2000 was another early milestone and an idea that came from the recovery community. We had never heard of a walk in support of recovery from alcohol and other drug addiction. We did some internet research and found one walk/run for a treatment center in the DC area, so we decided that, if we held a walk and 50 people showed up, we would be successful. Seven

hundred showed up for that first walk. Last September walks for recovery were held coast to coast. That's an incredible breakthrough. Recovery is truly becoming more visible. We just held our third Legislative Day, and a few legislators revealed for the first time publicly their own personal recoveries.

We produced a couple videos that are still pertinent and powerful today, "Putting a Face on Recovery" and "The Healing Power of Recovery." We wrote the "Recovery Core Values" in collaboration with mental health recovery advocates that became the cornerstone of Tom Kirk's (DMHAS Commissioner) policy on a Recovery-Oriented System of Care, which has become a national model. Opening our first Recovery Community Center in Willimantic was an important milestone. This was in response to a high-profile series of newspaper articles in the state's largest paper, *The Hartford Courant*, labeling Willimantic "Heroin Town." We like to say that a few years later CCAR had a hand in turning Heroin Town into Recovery Town. Another milestone was starting our Recovery Housing Project that inventoried the state's independently owned, privately operated sober houses; established a coalition; wrote standards; and delivered training. The most recent milestones have been the initiation of our Telephone Recovery Support program, which perhaps we can talk about later; and our purchase of a three-story, character-laden Victorian home in Hartford for our fourth recovery community center, which will also contain our administrative offices.

**GREAT LAKES ATTC:** CCAR has developed a very close relationship with the Connecticut Department of Mental Health and Addiction Services, your state addiction agency. How has that relationship evolved over time?

**PHIL VALENTINE:** The key is that CCAR places a high emphasis on integrity, honesty, and trust. The DMHAS staff trusts us. We will tell them the truth, even if it might mean some temporary "loss" for ourselves. They know we have the best interests of the recovery community at heart. What we will not do is inflate our numbers or exaggerate what we are doing or minimize our struggles to make ourselves look good.

**GREAT LAKES ATTC:** How would you describe CCAR's relationship with the treatment community?

**PHIL VALENTINE:** CCAR has never taken an antagonistic stance with the treatment community. Early on, we were perceived as a threat—a new source of competition for limited dollars. I believe that has changed. Recently, I was meeting with a PhD researcher, and I was talking about working with treatment programs to find better solutions. He was surprised. He wanted to know why I wasn't more angry, or more active, in trying to right ALL the wrongs within the system. I replied that I know a lot of people on the front lines, and have met many counselors with huge hearts trying to move people into recovery, and that I don't have an issue with them. Yeah, there are some bad eggs; there are in every field. But for the most part, we have an incredibly dedicated workforce. Why would I take issue with them? I think it also has to do with another unwritten philosophy that is part of the CCAR culture. I say it this way, "We labor in the light of recovery instead of dwelling in the darkness of addiction." I realize the treatment industry is there; and, yes, there are instances of "harvesting the crop of the addicted for profit"; and, yes, recoverees are usually left to fend for themselves once they're done with their treatment episode. Yet the treatment industry does serve a vital purpose: it is very good at initiating recovery.

**GREAT LAKES ATTC:** Describe the recovery values and principles that CCAR helped forge for the State of Connecticut.

**PHIL VALENTINE:** The state had merged the mental health and addiction services under one new agency. CCAR got together with mental health advocates to discuss what we had in common. We agreed that we had a lot in common when we first entered the “system.” Our common concerns are centered around being treated with dignity and respect, that we shouldn’t be left to navigate the system on our own, and that the system should reward the providers that are the most recovery friendly and produce the best outcomes. We don’t care how many people a provider serves; we care if the people they serve get well. Tom Kirk used these to write Policy #83, a defining document in beginning to design the state’s Recovery-Oriented System of Care (see <http://www.dmhas.state.ct.us/policies/policy83.htm>).

**GREAT LAKES ATTC:** Describe the evolution of CCAR’s involvement in peer-based recovery support services.

**PHIL VALENTINE:** CCAR was first organized as a pure advocacy organization. Those first four-plus years we did all kinds of cool things to put a face on recovery—posters, website, video, presentations, etc. However, when a member asked a very simple but deep question, “what can I do?” we were often stretched to find something meaningful. They could tell their story (well, what does that mean?), or they could attend a Chapter meeting (and then?), etc. You catch the drift. There was also a segment of our membership that wanted to be of service. They wanted to provide support, give rides, lend a listening ear, mentor, etc., and we didn’t have those opportunities available. So when the RCSP switched from Support to Services, we resisted at first and then began to see how this could really be of benefit. We started slowly, and as we grew into the delivery of support services, they’ve become more defined.

**GREAT LAKES ATTC:** Describe the range of recovery support services being provided through CCAR.

**PHIL VALENTINE:** Our recovery support services range from telephone-based recovery support to offering peer recovery support groups. We were very hesitant to start the latter on the grounds that people should use existing resources, such as AA and NA meetings. But we found a need for an “all-recovery group.” Our all-recovery group in Willimantic draws from 20 to 50 people at each meeting. It welcomes 12-Step, Christian-based, methadone, medication-assisted, co-occurring, family members, and community members, but the main theme is to come in and talk about recovery. Such a simple concept, it’s brilliant, and it’s helped a lot of people. We also are conducting a lot of family-education and community-education activities, as well as family support groups and groups that mix family members and people in recovery. We have a comprehensive recovery housing database that allows us to know up-to-the-minute bed availability and to link people to sober living. And then there’s this whole process in the recovery community centers themselves, where people are hooked into jobs or just get support from one another. We serve a broad spectrum of people, but I think we have a special mission of serving people who don’t feel fully accepted in mainstream AA or NA. We don’t place judgments on people. We say, “You’re in recovery if you say you are. Is there some way that you think you might be able to improve your recovery, and how can we help you do that?”

**GREAT LAKES ATTC:** How would you describe the relationship between professionally directed treatment services and peer-based recovery support services?

**PHIL VALENTINE:** I’ve had a couple knee surgeries that illustrate this relationship. I trusted my doctor to perform these surgeries. They were critically needed, but when he was done he turned me over to a physical therapist. And that’s where my recovery would either succeed or

fail. If you go regularly to your physical therapy sessions and do the exercises at home like you're supposed to, you can expect your knee to be stronger than ever. Recovery from addiction is the same process. You might need professional treatment to jump-start the process, but recovery is about what happens after treatment. Recovery support services are the physical therapy of recovery.

**GREAT LAKES ATTC:** Has your expansion beyond advocacy to providing recovery support services broadened the characteristics of people who volunteer for CCAR?

**PHIL VALENTINE:** The people who are attracted to CCAR are usually wired one of two ways: they're wired to do advocacy about the big issues—to get out there and speak and fight for the cause—or they're wired for service work with individuals. Recovery support services are a tremendous way for grateful people in recovery to give back. Our advocacy work called for a vanguard of recovering people to offer themselves as living proof that long-term recovery is real. There are many people in recovery who quite frankly aren't comfortable being part of that public vanguard, but who are willing to help offer such testimony to individuals in need. Many of our volunteers know experientially that leaving treatment is like falling off a cliff with no one to catch you. They understand the need for a bridge between treatment and long-term recovery and are willing to serve as that bridge. These are the people who are making the telephone recovery support calls, facilitating groups, facilitating trainings, and getting involved with the recovery housing coalition.

**GREAT LAKES ATTC:** Describe your efforts to build a network of recovery community centers.

**PHIL VALENTINE:** As CCAR evolved, we realized that, in order for local communities of recovery to have a realistic shot at providing support services, they'd need an actual physical location. We put together a loose plan and worked it in Willimantic. The plan follows a theme from the movie *Field of Dreams*, "build it and they will come." Willimantic opened. We looked for a site for over a year before we found one in New London. Bridgeport opened after a long search. Last, we've moved into the world of ownership by purchasing a building in Hartford. Our funds are stretched to the maximum now. We'll need additional funding to open more. We've been welcomed wherever we've opened. There has been no NIMBY ("not in my back yard") experience for us (knock on wood). A lesson learned is that the Center will take on the personality of the lead organizer, and that is a good thing. We call the lead organizer a Senior Peer Services Coordinator, and running a Center is more about community organizing than anything else. I think a lot of Recovery Community Organizations lose the organizing piece; they follow a traditional treatment provider model.

**GREAT LAKES ATTC:** You have recently started providing telephone-based recovery support services to people leaving Connecticut treatment programs. Could you describe the scope of this and what you're learning from it?

**PHIL VALENTINE:** The Telephone Recovery Support premise is simple: a new recoveree receives a call once a week for 12 weeks from a trained volunteer (usually a person in recovery) to check up on their recovery. We have found, though, that after 12 weeks when we ask the recoveree if they still want to receive a phone call, most times the answer is "yes." We now have people who have been receiving calls for 50 or more weeks, and they're still in recovery. In our first full year of making these calls, CCAR volunteers and staff have made more than 3,100 outbound phone calls. We piloted the project for 90 days out of Willimantic, after meeting with Dr. Mark Godley from Chestnut Health Systems to refine our procedures (DMHAS supported this consultation through a Center of Excellence project). We tweaked the script a

bit, and the process works amazingly well. Outcomes have been ridiculously good—our last quarterly report indicated that 88 percent of our recoverees were maintaining their recovery. Volunteers love making these calls; it helps them as well. It's a win-win situation. We have trained dozens of people to make these calls out of all our locations. Anyone is eligible to receive a call—all you have to do is ask.

**GREAT LAKES ATTC:** Are all of your volunteers people in recovery?

**PHIL VALENTINE:** We thought the telephone recovery support would best be provided by people in recovery, but we have had some interns who weren't in recovery who have done a great job in this role and have gotten the same results as our recovering people. I think it's just the fact that the agency of CCAR, what we represent, is reaching out to them, and as representatives of CCAR, they really feel and understand that somebody cares for them. It may be more the institution and the relationship with the institution than the particular person who's making that call. And I don't even know if it's the institution as much as the purpose. It's the care, compassion, and love behind the call that seem to work.

**GREAT LAKES ATTC:** It's hard to estimate the power of such contact.

**PHIL VALENTINE:** Early in my recovery, I was told to get a long list of names and phone numbers of people in recovery, and I did. I was a good boy. I had probably a couple hundred names. Did I ever call anybody? No. The idea of actually using the phone numbers was foreign to me. I couldn't pick up the phone to call somebody, but when somebody called me, I would talk and talk and talk and felt very grateful for the support.

**GREAT LAKES ATTC:** What keeps the volunteers coming back?

**PHIL VALENTINE:** It's fulfilling. I sit here, and I listen to volunteers make telephone recovery support calls. I'm not ever sure who's getting the most out of it, the volunteers or those they're calling, but I see volunteers with eyes lit up, energized on the phone, really glad to hear from this person that they're doing well, praising the person for all the good things they're doing, being able to be a small part in maybe moving that person towards a life of recovery. There is nothing more rewarding in a volunteer position than playing a role in moving someone into a life in recovery.

**GREAT LAKES ATTC:** How would you distinguish between peer-based recovery support services and treatment services?

**PHIL VALENTINE:** I associate the terms "treatment" and "clinical" with being cold and sterile. I don't know if that's correct, but maybe that's been my experience. I see treatment as more sterile, professional, hospital-like, staff-focused. Treatment can be real effective in initiating recovery, where recovery support services are more focused on maintaining and enriching recovery. Recovery support services aren't bureaucratically bound—at least not yet—by mountains of rules, regulations, and paper. Recovery support services are more free and unencumbered to sustain a focus on whatever it takes to support recovery. We're trying to escape the coldness you feel when you walk into a place that seems only concerned with forms and money—the feeling that you're just one more person in the assembly line, one more of the addicts or alcoholics coming through the system. It's hard to be seen as a person in such coldness. Recovery support services are the warmth that can heat you back up. They're the antidote to people being paid to be your friend. Frontline counselors are often warm and wonderful people, but they are constrained by the burdens placed upon them.

**GREAT LAKES ATTC:** Are your recovery support services being provided by people in volunteer and paid roles?

**PHIL VALENTINE:** The vast majority of our recovery support services are provided by volunteers, and that's the way we hope to keep it. That being said, if a director of a center is a very strong, powerful personality and very visible, people will be drawn to that person for recovery coaching. What we try to do is to get such people to train others so that we can expand the pool of recovery support resources.

**GREAT LAKES ATTC:** Do you see a danger in the trend toward paid recovery coaches? Might we drift toward that same clinical coldness you described earlier?

**PHIL VALENTINE:** It's always about the heart. There's a real spiritual component. Some recovery coaches can get paid and handle it well, and others cannot. Getting paid in this role elevates the level of authority and responsibility. I worry about the ego. I worry about coaches aspiring to that kind of life-and-death influence over others. That kind of authority can mess with a person's recovery and humility. The longer I'm in recovery, the less I know. When you're a paid recovery coach for a while, you think you're starting to know all the answers, and that's just not true. There's always gonna be clients who are gonna teach you more than you teach them, and I hope we stay open to the lessons of such people. There are new ways to deal with things. The volunteer piece works in part because you have a whole network of other volunteers that you bounce things off of. With volunteers, the individual is served by a community of people—the volunteers being the welcome wagon of that community. What a difference it makes on the soccer fields! I've had six years' experience as a travel soccer coach. I wouldn't dream of getting paid. I love it, and I do it because the kids are so much fun. The sport's great. I have something to contribute. Why do we think that a recovery coach should be any different than that?

**GREAT LAKES ATTC:** Could you provide more detail on what you're doing with telephone-based recovery support services?

**PHIL VALENTINE:** Right now, we're making calls out of all four CCAR recovery community centers in Connecticut: Hartford, Bridgeport, New London, and Willimantic. In a recent quarter (July-Sept, 2006), we had 108 individuals we were calling on our rolls; 95 were in stable recovery, and only 13 had relapsed. The group as a whole included people who were 30, 60, or more than 90 days out of treatment. The services are available to anyone who requests them, even if you haven't been in treatment. Our number-one referral source is the Recovery Housing Coalition in Connecticut. The treatment providers are starting to jump more on board, so we're getting 6 to 10 referrals a day from them.

**GREAT LAKES ATTC:** You mentioned that many people want to keep up the phone contact after the standard 12-week period. How long are telephone-based services provided?

**PHIL VALENTINE:** We have people we've called now for more than a year who are still sober and still appreciating our calls.

**GREAT LAKES ATTC:** Describe a typical recovery support call.

**PHIL VALENTINE:** We have a set script, but the call really starts on this basic premise: "Hi. This is \_\_\_\_\_ from CCAR, checking in with our regular recovery support call. How are you

doing?” And then the conversation branches from there based on their responses. We use a decision tree to guide those making the calls. “I’m doing well.” “What kind of supports are you using for your recovery? Oh great. You’re in a 12-step program. Have you had a chance to get a sponsor yet?” That kind of thing. “You’re still clean, but you’re not going to any support meetings? Is there some reason why you’re not going to meetings? Can I help you find a meeting?” If we find that people have relapses, we explore options with them and try to get them re-linked to recovery support. Our complete script is available for anyone who wants it.

**GREAT LAKES ATTC:** Describe the orientation and training of those staff and volunteers who provide recovery support services through CCAR.

**PHIL VALENTINE:** We have this inner circle of ten staff people who know that the best way to multiply our efforts and be good stewards of our funding is to recruit and develop a volunteer force that is highly trained. We modeled our volunteer program on those used at the major hospitals in the New Haven area. There is a formal application, an interview, a background check, an orientation that includes the module “CCAR Ambassador 101,” and ongoing training. Our basic orientation covers such areas as crisis intervention, confidentiality, ethics, and relationship boundaries. And then we provide specialty training for the kinds of roles people want to fulfill, such as peer support group facilitation or telephone recovery support. We have a formal schedule for volunteers working, and each volunteer is evaluated at six weeks and again after six months. We spend a lot of time acknowledging and rewarding our volunteers—for example, at reward dinners—to let them know how much we appreciate the contributions they’re making. Volunteer management is not easy, and it takes a very skilled person running it.

**GREAT LAKES ATTC:** Describe the ongoing supervision of volunteers.

**PHIL VALENTINE:** Volunteer supervision is done by our peer services coordinators, with our statewide Volunteer Manager having a hand in the formal evaluations. Each volunteer is given a clear sense of what we’re evaluating them on and how they can improve. The volunteers also get together and talk with each other about situations that are coming up in the phone calls or in the peer support groups. There’s not a lot of crisis intervention. We do have situations where people referred to us may come in high or intoxicated, but we’re pretty good at responding to them. When people show up at the center high, we understand that they’re here looking for something—looking for help.

There is a second tier of supervision that’s important that involves the staff who work with and supervise the volunteers. There are always risky situations that can arise in this kind of service work. The key is how we manage it. Our staff meetings are a reporting session, in which we explore these areas of risk. We look at, “What kind of scenarios came up that you struggled with? What did you find most difficult?” We’re trying to get the coordinators to always be completely truthful, rather than hide areas of potential vulnerability.

**GREAT LAKES ATTC:** How are the telephone support services provided by CCAR being funded?

**PHIL VALENTINE:** We were fortunate in that we worked with the State and their federal Access to Recovery grant to establish our first fee-for-service. We’ve learned to cope with the complexities and the tedious work of the medical billing world. We also established a case-rate, so for every ATR eligible recoveree, we receive \$151.20 for the first 12-week block of phone calls.

**GREAT LAKES ATTC:** What are the major obstacles in implementing peer-based recovery support services?

**PHIL VALENTINE:** One of the potential obstacles is how the treatment providers respond to this growing recognition of the need for non-clinical recovery support services. There is a question of whether they'll jump in and do these services to expand their own service empires, or whether they're going to help the recovery community enhance its own capacities for support. The question is whether treatment agencies will see an "upstart" young recovery community organization as an ally or as a competitor for funds. We are very fortunate in Connecticut that our state leader, Tom Kirk, has promoted a collaborative relationship between CCAR chapters and local treatment programs.

**GREAT LAKES ATTC:** What do you see as the future of funding for peer recovery support services? Is there an ideal way to fund these services?

**PHIL VALENTINE:** Ideally, the funding will come from the recovery community itself, and I think the recovery community centers will be that vehicle through which people can, through their individual financial contributions, support local recovery support services. State and federal agencies can help seed these programs for a number of years to build a base of support, but in the long term, the recovery community itself must take ownership of these service centers. The problem is that it may take eight to ten years of development work for a center to be fully self-sustaining.

**GREAT LAKES ATTC:** What do you personally feel best about today in terms of CCAR's involvement in recovery support services?

**PHIL VALENTINE:** I'm a fisherman. I feel good that the recovery support services we provide are a net that's catching a lot of the people who wouldn't have otherwise started and sustained a recovery process. Somebody had to build and maintain that net, and I'm honored and humbled by the enormity of how we have affected people's lives. Counselors in treatment often don't get to see the fruits of their work, but we get to see people and stay involved with people and see how their lives have changed years into the recovery process. We can see how they grow and change. We get to witness the fruits of recovery.