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Recovery Resource Mapping: Results of a Philadelphia Recovery Home Survey

Rhonda Johnson, Nelson Martin, Timothy Sheahan, Fred Way, and William White

Abstract

Traditional approaches to identifying the needs for addiction treatment services at the community level have relied on incidence and prevalence surveys of alcohol and drug (AOD) use, AOD-related problems index data (e.g., AOD-related deaths, emergency room visits, arrests), and an analysis of existing addiction treatment service resources and utilization by modalities and levels of care. Missing from this approach is the analysis of the incidence and prevalence of recovery and the measurement of community recovery capital. This article calls for a strategy of recovery resource mapping and illustrates how such a strategy is being used in the city of Philadelphia. The discussion includes a presentation of an inaugural survey of funded and unfunded recovery homes in the city of Philadelphia.

Keywords: Recovery home, recovery support services, community recovery capital

Introduction

Service planning related to the prevention and treatment of substance use disorders has for many decades relied on an analysis of data related to alcohol- and other drug-related problems. As a country, we have methodically collected and analyzed the changing incidence and prevalence of alcohol and other drug (AOD) use as well as changes in the prevalence of AOD-related deaths, hospital emergency room admissions, arrests, diseases (e.g., HIV, Hepatitis B/C), and treatment admissions. This approach reflects traditional pathology and intervention paradigms—the assumption that solutions to AOD problems can be found within the study of the etiology, patterns, and methods of treatment of these problems. An alternative or complimentary approach—one reflecting a recovery paradigm—focuses on changes in recovery incidence (number of new people entering recovery each year) and prevalence (total number of people in recovery) and on changes in recovery support resources at the community level (White, 2005, in press).

Interest in the recovery paradigm has been sparked by a new addiction recovery advocacy movement (White, 2006, 2007b), the emergence of recovery as an organizing framework for federal, state, and local treatment policy (Clark, 2007; Kirk, 2007; Evans, 2007), and efforts to redesign addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management (White, Boyle, & Loveland, 2002). Central to the recovery paradigm is the concept of *recovery capital*. First articulated by Granfield and Cloud (1999), recovery capital is the volume and quality of resources that can be drawn upon to initiate and sustain recovery from AOD problems. These resources exist in three spheres: personal recovery capital, family recovery capital, and community recovery capital (White & Cloud, in press).

The city of Philadelphia began a recovery-focused transformation of its behavioral healthcare system in 2004 that is altering service philosophies, policies, practices, and relationships (Evans, 2007; White, 2007a). The Philadelphia Department of Behavioral Health and Mental Retardation Services' (DBH/MRS) shift towards a recovery paradigm included new approaches to assessing community needs and evaluating policies and practices. One of the explicit goals of the systems transformation process was to measure and increase community recovery capital in Philadelphia. Toward that end, DBH/MRS has begun mapping recovery resources by zip code and analyzing the relationship between problem intensity and resource availability in particular neighborhoods toward the goal of placing recovery resources in the closest possible proximity to areas experiencing the greatest impact of AOD problems.

While there is a broad spectrum of potential recovery support resources (e.g., addiction treatment programs, recovery mutual aid meetings, church-based recovery ministries, other peer-based recovery support services), focus groups that were part of the Philadelphia behavioral health systems transformation process identified sober housing as a particularly critical need. Recovery homes have been rigorously evaluated in recent years, particularly the national network of Oxford Houses, and have been found to play a significant role in successful recovery stabilization and maintenance following addiction treatment (Jason, Davis, Ferrari, & Bishop, 2001; Jason, Olson, Ferrari, & Lo Sasso, 2007).

Recovery-conducive housing needs in Philadelphia have been intensified due to overall housing shortages, a decrease in government housing programs, the gentrification of older neighborhoods, an intensification of NIMBY (not in my backyard) attitudes in some areas of the City, and an increase in clients in treatment without family support resources. Housing services are available for those in Philadelphia who are identified as chronic homeless, but addiction treatment providers report fewer resources available for the working poor and middle class seeking recovery-conducive housing. In early 2006, a decision was made by DBH/MRS to conduct a survey of recovery homes in Philadelphia as a first step in the recovery resource mapping process. This article will summarize the findings of this first recovery home survey and discuss the future of DBH's recovery resource mapping process.

Recovery Homes in Philadelphia

A first challenge in conducting any recovery home survey is defining exactly what a recovery home is and distinguishing it from related institutions, e.g., halfway houses, wet shelters, boarding homes. For example, the terms halfway house and recovery home are often used synonymously by the general public, but they actually constitute two very different types of services and living arrangements. In Philadelphia, a halfway house is a licensed, staff-directed residential drug and alcohol treatment facility that provides one of the eight levels of care outlined in the Pennsylvania Client Placement Criteria (PCPC), which is a placement tool utilizing data collected from a thorough biopsychosocial assessment to place each presenting individual in the most appropriate level of care. Recovery homes are safe, sober, and supportive living arrangements often utilized in conjunction with PCPC level 2B Intensive Outpatient Treatment or PCPC level 2A Outpatient Treatment services.

One of the key differences between a halfway house and a recovery home is that, in a halfway house, the counseling services and therapeutic interventions are provided on the premises. There are only five licensed halfway houses in the city of Philadelphia. Per diem rates within these halfway houses are comparable to that of other inpatient non-hospital residential treatment programs and are generally paid by the local single county authority. Halfway houses are required to comply with both city and local License and Inspections Department guidelines and building requirements, as well as to become "licensed" through the Pennsylvania Department of Health (DOH). The DOH license requires adherence to standards around staffing, building codes, zoning, safety regulations, and staff credentialing.

In contrast to halfway houses, there is no formal requirement for licensing recovery homes in the city of Philadelphia. The only requirement such homes have is to obtain a boarding house or rooming house license through the local License and Inspections office. The DBH/MRS-funded recovery homes must verify licensing compliance as well as proof of ownership of the property, general liability insurance, proof of utility bills, and proof of 501c3 or non-profit designation before they can receive funding. This generally requires the property owner to apply for a zoning variance to change the status of their facility from that of a "single family dwelling" to a boarding home or rooming home. Boarding homes or rooming homes generally work to house clients with behavioral health needs. Traditionally, those that set out to service the mental health population of the city continue to label themselves boarding homes and are often utilized by mental health counselors and practitioners for supportive living arrangements for their clients. Those boarding homes whose mission is to service individuals suffering from a substance use disorder have rechristened their facilities as *recovery homes*.

The Department of Health (DOH) in Pennsylvania and recovery advocacy groups such as Pro-A have created a statewide recovery house committee to create standards for licensing recovery homes. As mentioned earlier, there is currently no "license" to operate a recovery house. Each county has varying building code requirements for rooming houses or boarding houses, but these do not take into consideration the other elements that should be in place to obtain the label of "recovery house," such as proper training and education in substance abuse/mental health, daily recovery-oriented activities, availability of 12-step meetings, or connections to local addiction treatment programs. The DOH committee is making progress toward the goal of a recovery house licensure process.

Recovery Home Oversight and Quality Improvement

In FY95, the Philadelphia Coordinating Office for Drug and Alcohol Abuse Programs (CODAAP), now known as the Office of Addiction Services (OAS), began funding recovery homes for persons enrolled in state-licensed outpatient addiction treatment programs. The goal of such funding was to improve treatment outcomes by stabilizing the living environment of clients who would otherwise reside in housing situations that are not conducive to their recovery. At its inception, the CODAAP issued a request for proposals that resulted in contracting five recovery programs operated by recovering individuals. Currently, OAS funds 21 recovery homes with a total capacity of 355 individuals. These 21 homes are operated by 13 separate organizations.

These OAS-funded homes have several distinct features:

- required compliance with local housing codes,
- mandatory outpatient treatment for all residents,
- ongoing communication between the recovery home and treatment providers, case managers, and probation officers,
- required 24-hour staff coverage,
- staff participation in an accredited training program,

- random, observed urine drug screening, and
- a required set of core services including case management.

The funded homes include specialty programs for women with children, clients enrolled in methadone maintenance treatment (MMT), and clients who only speak Spanish.

The recovery-focused behavioral health care systems transformation process initiated in Philadelphia in 2004 under the leadership of Dr. Arthur Evans placed great emphasis on the development of community-based resources to support long-term recovery. It was through that initiative that interest grew in evaluating and enhancing the quality of the growing network of unfunded recovery homes in the city of Philadelphia.

In January 2007, the newly created Office of Addiction Services (OAS) created a Recovery House Unit that launched several recovery home initiatives:

- developing quality guidelines for recovery homes that address issues related to recovery orientation, length of stay policies, and relapse policies,
- designing and delivering a 10-week training program for recovery home managers and staff,
- funding recovery home mini-grants to upgrade facilities or service quality,
- hosting recovery home tours (of eight funded/unfunded homes) to orient the wider service community to the Philadelphia recovery home network, and
- providing community education and advocacy to counter NIMBY (not in my backyard) responses to proposals for new homes.

Early activity within the Recovery Housing Unit revealed a great deal of citizen misinformation and stigma regarding perceptions of recovery homes. Some citizen groups actively opposed the idea of a recovery residence in their neighborhood and worked to "block" licensing and zoning processes that would allow opening of such a home. Such actions often stemmed from misconceptions about addiction and recovery and how a recovery home would affect their neighborhood. The OAS Recovery Housing Unit began providing education and advocacy but found it needed a much clearer picture of all recovery homes in the city of Philadelphia to support these activities.

In 2007, the DBH/OAS Recovery Housing Unit conducted a recovery home survey as part of its commitment to enhance their recovery-oriented service delivery and to offer individuals increased information and choices who were seeking a local recovery home environment.

The Recovery Home Survey

The first step in the recovery home survey was to create a comprehensive list of recovery homes. This started by creating a master list from a variety of existing sources. As the survey proceeded, each recovery home owner was asked to identify other recovery homes they knew. This snowball sampling created a growing list of more than 250 privately owned, unfunded homes in addition to the 21 OAS homes that eventually participated in the survey. The survey process itself involved OAS Recovery Housing Unit representatives visiting the owner/manager and clients of each recovery home in order to:

- view and evaluate each recovery home in the city of Philadelphia,
- learn about each home's organization and services,
- elicit ongoing, voluntary collaboration with the OAS housing initiative,
- identify unmet needs of individuals who reside in recovery homes,
- communicate information to recovery home owners/managers about funding, training, technical assistance resources, and operational guidelines, and

- encourage increased communication between recovery homes and local treatment programs.

The Survey Instrument: Recovery homes were evaluated on three main dimensions: 1) quality and condition of the physical plant of the house/building, 2) quality and extent of the recovery-oriented programming within the house, and 3) level of community involvement. The rating on each of these three dimensions was decided through discussion and consensus of the survey team following each visit. The rating was based on a 5-point Likert scale, with 5 being the highest rating and 1 the lowest rating.

The physical plant assessment included evaluation of proper zoning, certificate of occupancy, the attractiveness and cleanliness of the facility, and safety compliance. The survey team focused on such details as fire safety precautions, including hard-wired fire alarm systems, fire extinguishers, display of evacuation plans, and clearly marked exit signs for emergency use. The survey team evaluated the condition of walls, doors, windows, steps, rooms, lighting, kitchens, bathrooms, and common rooms. Areas of assessment related to the overall physical condition and safety of the home would normally be reviewed by the city's License and Inspections (L&I) agency site visits, but many recovery homes fear L&I involvement and exist outside their awareness. As the OAS Recovery Housing Unit evaluated the properties, they offered technical assistance on becoming L&I compliant. The Unit also evaluated the furniture, paint color, and overall comfort of each recovery home.

The recovery home survey assessment also evaluated the extent to which each home had a recovery-focused mission and structure, a positive recovery atmosphere, and access to recovery support meetings and sober fellowship. The survey team focused on a number of dimensions that distinguish a generic boarding home or rooming house from a recovery home. The survey site visits addressed such questions as:

- Are there strong connections between the home and local addiction treatment programs, AA/NA/CA meetings, and local church and faith-based recovery support programs?
- Does the recovery home have recovery materials available to the residents, e.g., recovery-themed pamphlets, books, and movies?
- Does the recovery home have a particular specialization or focus, e.g., gender-specific services, faith-based orientation, or strong vocational orientation?
- Do recovery home residents eat meals together, pray together, or meet together regularly to discuss community issues?
- How are medications handled in the facility?

The community involvement evaluation included such factors as a positive relationship with neighbors, community support, and connections to community resources, e.g., education, employment, health care, churches, cultural events, town meetings, etc. The survey team asked:

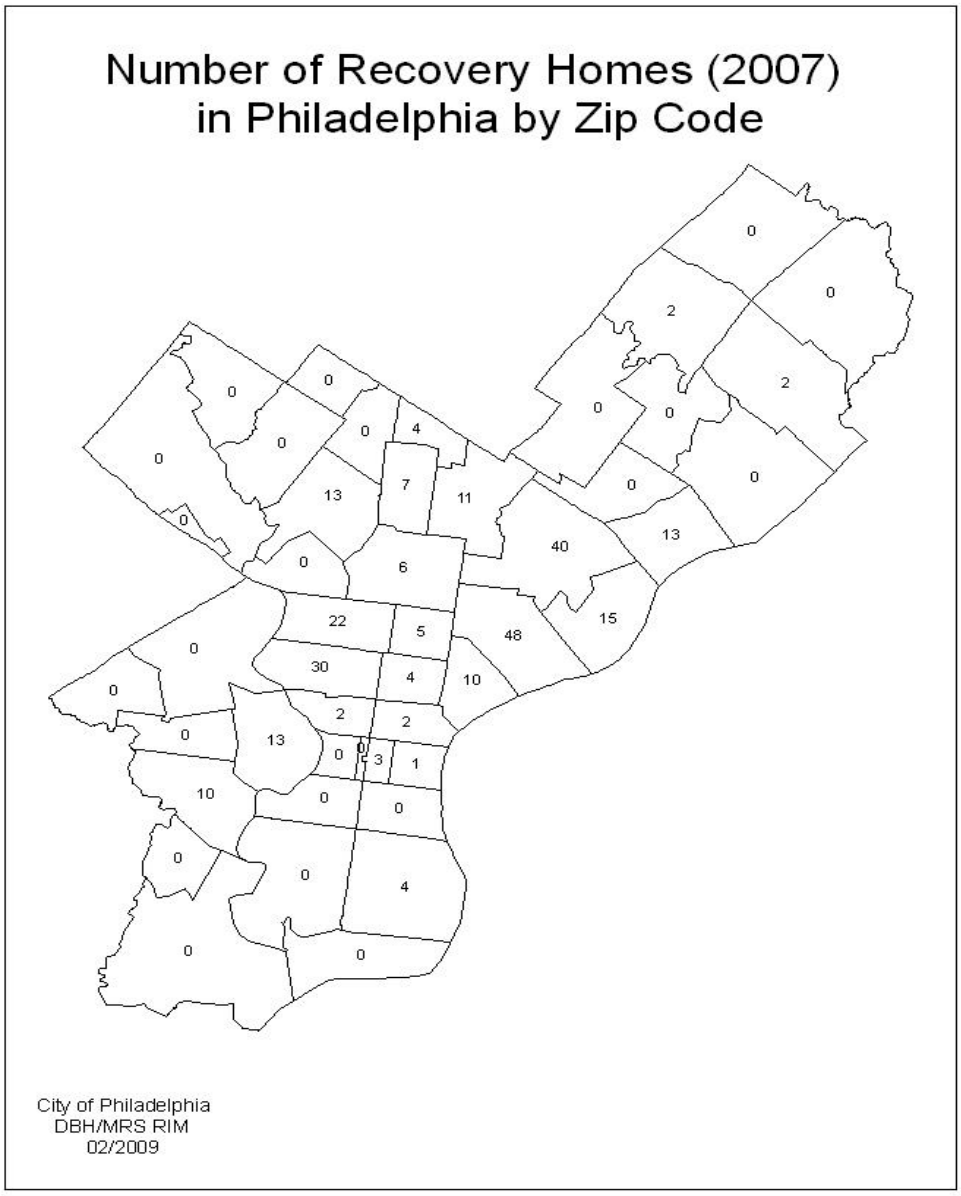
- Does the recovery home have a working relationship with the local welfare office?
- Are the neighbors aware that this is a recovery home?
- What is the degree of support or opposition from the neighborhood?
- Is the home involved in any neighborhood or community service activities as a means of "giving back," e.g., neighborhood clean-up, snow removal?
- Does the recovery home have a connection with local faith-based and religious organizations?
- What is the recovery home's connection with local education, employment, and health care resources?

Engagement in Survey Participation: Local recovery house organizations were motivated to participate in this survey process for many reasons. Most are running good, clean, structured recovery houses and have an overall desire to help others in their community. These houses welcomed the OAS Recovery Housing Unit into their homes and supported the goal of greater coordination and standardization of recovery home services. Other homes participated in the survey as a means of accessing continued technical assistance and training and in hopes of increasing their chances of future OAS funding. (The survey team explained that those houses that participated and scored among the highest in the survey would have the greatest opportunities for future funding.)

Survey Findings: The OAS Recovery Housing Unit recovery home survey confirmed two systems of recovery homes in the city of Philadelphia—one publicly funded (through OAS) and one unfunded (financially self-supported by each home's residents). The funded system consists of a network of 21 homes operated by 13 organizations that have a daily service capacity of 355 individuals. This funded network currently receives a total of $4.5 million in DBH funding per year. There are more than 250 unfunded recovery homes in Philadelphia operated by more than 80 organizations or private owners with a daily capacity of more than 1,500 individuals.

Geographical Distribution: Recovery homes are not equitably dispersed across the city of Philadelphia (See Figure 1). At present, over 50% of recovery homes are located within four zip codes, and 26 of Philadelphia County's 49 zip codes do not have any recovery homes in them. Of the 23 zip codes that contain at least one recovery home, the majority of recovery homes are clustered in 4 to 6 zip codes in North Philadelphia and the lower Northeast sections of the city, leaving Northeast Philadelphia, South Philadelphia, and West Philadelphia with very few, if any, recovery home resources.

FIGURE 1: Map of Recovery Homes by Philadelphia Zip Code



The location of recovery homes may reflect need (see later discussion), but it may also reflect varying degrees of stigma attached to alcohol and other drug problems within various Philadelphia neighborhoods. Such stigma manifests itself in many ways in regards to recovery housing. For instance, community members may "block" the zoning process at the city's License and Inspections agency or make it difficult for owners to apply for a zoning variance (to change residence from a single family dwelling to a rooming house or boarding house). Even those neighborhoods and zip codes that have been accepting of recovery homes in their area are now beginning to seek to limit the number of recovery homes on the grounds that "we have enough already." Care must be taken to avoid over-saturation of recovery homes in areas that could trigger a backlash against such services.

It will be important in the future to evaluate recovery home outcomes and to engage multiple parties in discussions about the ideal location of recovery homes. There are some basic principles that will be based on convenience, e.g., placing recovery homes in geographical

proximity to treatment centers and recovery mutual aid group meetings, but other assumptions will be more difficult to formulate. For example, should recovery homes be located in zip codes with high AOD-related casualties (to respond to those neighborhood needs), or should they be located outside such areas to increase safety and reduce recovery home resident exposure to AOD-using social cues? Most importantly, do recovery home locations enhance or inhibit access based on the degree to which they reflect or fail to reflect the natural pathways of travel and comfort of those most in need of these services?

Recovery Home Referral Sources: Recovery homes receive referrals from a wide range of sources and organizations. The primary referral sources are local addiction treatment programs, including detoxification and inpatient and outpatient treatment programs; halfway houses; hospitals; mental health programs; prisons and other components of the criminal justice system; homeless shelters; faith-based organizations; recovery mutual aid societies; and family members.

The majority of referrals received by local recovery houses come from Philadelphia's 11 detoxification facilities, 60 inpatient treatment programs, 72 outpatient treatment programs, and 4 licensed halfway houses. Counselors and aftercare providers utilize the OAS-funded recovery home network, but these homes are often filled due to limited network capacity (355 individuals) and high need for this level of support. Unfunded recovery homes now serve as a safety net to address the need for recovery housing in Philadelphia County.

Recovery Home Ratings: A total of 289 recovery homes were evaluated (22 DBH-funded homes and 267 homes not funded by DBH). Twenty-five homes were not scored due to discovery that they were not a recovery home, refusal to participate, or inability to engage the owner/manager following repeated phone calls and visits. Each home visited was given a score on each of the three scales and was then given a composite score based on the average of the three scored areas. Table 1 below illustrates a summary of the composite scores for survey homes.

Table 1: Composite Scores for Philadelphia's Funded and Unfunded Recovery Homes

Composite Scores by Type of Home	**5.0**	**4.5**	**4.0**	**3.5**	**3.0**	**2.5**	**2.0**	**1.5**	**1.0**	**Average Composite Score**
# of Funded Homes		2	11	6	3					3.95
# of Unfunded Homes			4	22	40	64	36	28	72	2.1

It can be seen that funded homes rated considerably higher than unfunded homes, and that a number of the unfunded homes were deficient in both the quality of their facilities and the available recovery support services.

Table 2 displays the average scores for each of the three areas of evaluation across funded and unfunded homes.

Table 2: Survey Scores of Philadelphia's Funded and Unfunded Recovery Homes by Dimension

Average Area Score by Type of Home	Physical Plant	Recovery Programming	Community Involvement
Funded Homes	3.9	3.79	3.79
Unfunded Homes	2.2	2.4	1.6

Funded recovery homes in Philadelphia rank high on all three dimensions evaluated in the survey, while the unfunded recovery homes need improvement in all three areas. The financial resources of the unfunded homes (provided through resident income to the owners) seem sufficient to support these homes but are not always sufficient to upgrade the physical condition of the homes. We suspect the low level of community involvement of the unfunded homes is a function of stigma and fear, as many of these homes seem to be hiding within their communities in fear that NIMBY could threaten their existence if they became too visible.

One of the most important lessons learned from the OAS Recovery Home Survey was that a nice house and nice property did not necessarily mean a good recovery program. Some very attractive facilities lacked strong recovery orientation and support, and some homes with less than ideal physical facilities exhibited very strong recovery orientation and support. Other homes needed help both in developing the recovery program and in upgrading their physical facilities. This underscored the need for different types of technical assistance to enhance the quality of the overall recovery home network.

On one occasion, the OAS Recovery Housing Unit was informed of a new recovery home about which there had been complaints of possible drug activity and police being called to the home. When a member of the Recovery Housing Unit came to the house to inquire about the program, a woman who smelled of alcohol and was visibly intoxicated answered the door. She invited the RH employee into the house and began explaining that it was a “women’s recovery house.” When the Recovery Housing Unit employee questioned this, the woman admitted, “we sometimes drink, but that’s all.” It was then explained to her that the house was not a recovery home, but more a boarding home without any “recovery” orientation. She was asked and agreed to discontinue communication and marketing to local addiction treatment programs and to stop misrepresenting the program as a “recovery home.”

Effects of Survey Process: There were several immediate effects of the survey process. First, far more recovery homes were discovered than were thought to exist before the recovery home survey began. Second, some boarding houses that promoted themselves as a recovery home to increase their business but offered no real recovery orientation were confronted about this misrepresentation and agreed to no longer list themselves as a recovery home. Third, the unit identified many of the houses that were operating substandard and illegal programs. The OAS recovery house unit’s presence and repeated visits to these programs began to implement a level of accountability and responsibility in recovery homes that had grown accustomed to operating without oversight. The OAS recovery house unit encouraged and challenged these houses to improve their programs by offering resource and technical assistance. In a few cases where recovery houses repeatedly failed to make simple safety and health regulation improvements, the OAS recovery house unit worked with local licensing and inspection agencies to close the program and get the residents transferred to more suitable safe, sober living arrangements.

The OAS recovery home survey and field research also helped increase the overall knowledge and understanding of the state of recovery housing in Philadelphia within the behavioral health care system and within the larger community. One result of this was an increase in the number of referrals to recovery homes by treatment programs and an increase in referrals from recovery homes to local treatment providers.

Future Recovery Home Surveys: A number of lessons were learned through this first survey process. Recommendations for future surveys include:

- Developing measurable benchmarks that can be used to more precisely rate the survey dimensions,
- Include level of community service as a separate dimension from community involvement,
- Systematically evaluate recovery homes’ policies related to persons enrolled in methadone maintenance treatment,

- Solicit data on the number of referrals each home received in the past 60 days that could not be accommodated due to a full house (or length of and average waiting list time), and
- Identify recovery-conducive employment resources being used by those residing in recovery homes and develop a directory of these resources.

Recovery Resource Mapping

The recovery home survey produced the most detailed picture to date of recovery home resources in the city of Philadelphia, which in itself justifies the value of such survey processes. Recovery resource mapping involves a more detailed analysis of such data. To briefly describe how recovery resource mapping can serve as a tool in recovery-focused behavioral health care system transformation efforts, we will integrate the recovery home survey data within a larger matrix of addiction/recovery-related data for the city of Philadelphia.

For purposes of illustration, Tables 3 and 4 display a sampling of key AOD problem and recovery resource indicators by Philadelphia zip code. The columns on the left display data on homicides (as a proxy for social disorganization and a potential measure of drug-related violence), drug-related deaths, drug-related arrests, and AOD-related treatment admission. The columns on the right reveal key recovery resources by zip code via the number of addiction treatment programs, recovery mutual aid meetings, and data from the recovery home survey. All of the data presented here will not be summarized or interpreted, but key examples from this table can be used to illustrate the process of recovery resource mapping.

When such data is consistently collected over time, one can begin to answer key questions like the following:

1. Is the prevalence of recovery increasing or decreasing and within which specific populations (by age, gender, ethnicity, sexual orientation, primary drug, neighborhood)?

This data can be generated by adding a small number of recovery-related questions to local or state public health surveys. Such data combined with other recovery resource mapping data can reveal if adding particular recovery support resources in an area increases long-term recovery prevalence.

2. Are recovery support resources increasing or decreasing?

The data provided in Tables 3 and 4 provides a baseline upon which such a question can be partially answered in the future. A broader mapping of recovery resources could include the location and service utilization of outreach programs, community recovery centers, and other recovery community support institutions (e.g., recovery schools, faith-based recovery ministries).

3. Are recovery support resources equitably distributed across the city?

This question addresses the issue of service accessibility and geographical obstacles to access that inhibit admissions and contribute to early dropout rates.

4. Do recovery support resources exist in the areas of the city in which they are most needed?

This can be answered by comparing the location (by zip code) of treatment programs, recovery homes, and recovery support groups with the locations (also by zip code) in which alcohol and other drug problems are most concentrated (e.g., plotting AOD-related death data, treatment admissions, drug-related arrest data, etc. by zip code).

5. What is the geographical proximity of different recovery support resources, e.g., the distance between treatment programs and recovery homes?

This analysis can get quite specific. We can identify neighborhoods that are not in high need of recovery support services and which quite appropriately have few such resources located within them (e.g., Philadelphia zip code 19153). We can find neighborhoods that have both a high need and a high level of recovery support services (e.g., Philadelphia zip code 19124). But more importantly, we can identify areas of exceptionally high need that lack particular types of critical recovery support services. For example, Philadelphia zip codes 19132 and 19143 have high rates of AOD problems and have treatment and recovery home resources, but they rank low in availability of recovery support meetings within the area. Similarly, if we look at zip code 19134, we find an area severely impacted by AOD problems, which would justify saturating this area with recovery support resources. However, if we examine the existing recovery support resources in zip code 19134 (ranking first in 4 of 5 problem indicators among all zip codes), we find a concentration of recovery support meetings (44 meetings) and recovery homes (48 homes) but only one treatment facility. The recovery home survey site visits confirmed a high rate of addiction and co-occurring mental health issues within this neighborhood, and persons in their homes often had to travel 5-10 miles away to other parts of the city to attend outpatient and intensive outpatient treatment. One recovery home from the 19134 zip code reported that they had to send their clients to an outpatient treatment program on the opposite end of the city (i.e., recovery home is in Northeast Philadelphia, outpatient program is in South Philadelphia) because "it is one of the only outpatient programs that offers good services to those who have co-occurring disorders…there are none around here." This mix of quantitative data and field reports generated through the recovery resource mapping process can help guide the future allocation of resources to where they are most needed.

Recovery Resource Mapping Steps

Recovery resource mapping provides a helpful planning tool in recovery-oriented systems transformation processes. The Philadelphia recovery home survey conducted by the Philadelphia DBH/MRS/OAS Recovery Housing Unit illustrates how such a survey can be conducted and how survey data can be analyzed to inform future policy and programming decisions. The essential steps in such recovery resource mapping processes are:

1. Identify problem and recovery measures.
2. Collect data to establish key benchmark measures.
3. Develop and implement strategies aimed at increasing key elements of community recovery capital.
4. Monitor benchmark data to measure progress or regression on key indicators of community recovery capital.

The Philadelphia DBH/MRS has a long history of analyzing drug-related indicator data but has only recently extended this data collection into a process of recovery resource mapping. We feel this mapping process, illustrated here through the recovery home survey, will prove to be an essential tool in our long-term recovery-focused systems transformation efforts.

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Table 3: Recovery Need and Recovery Resource Indicators by City of Philadelphia Zip Code: Raw Data across Zip Code Areas

Zip Code	# of Homicides In 2007	# of Deaths w/ drugs present	# of Drug-related Arrests / Poss 2007	# of Drug-related Arrests / Sales 2007	# of Unique BHSI Tx Admissions 2007	# of Unique CBH Tx admissions	# Rec. Supp. Meetings per week	# of Treatment Programs	# of Recovery Homes (2007)
1901						15			
19102	1	0	NR*	NR	5	431	0	1	0
19103	0	3	NR	NR	8	50	45	0	0
19104	14	33	627	380	141	695	40	5	13
19105						5			
19106	1	4	NR	NR	63	172	28	0	1
19107	0	6	NR	NR	50	363	47	6	3
19109						1			
19110						1			
19111	3	28	112	NR	142	296	20	2	0
19112	0	0	NR	NR	0		0	0	0
19113	0	0	NR	NR	1		0	0	0
19114	0	12	NR	NR	104	159	41	0	2
19115	1	6	NR	NR	35	71	20	0	2

1911 6	2	9	NR	NR	56	305	13	0	0
1911 7	0	0	NR	NR	0		0	0	0
1911 8	0	4	NR	NR	7	7	15	0	0
1911 9	3	9	NR	61	78	201	12	2	0
1912 0	21	17	451	129	205	471	6	1	11
1912 1	20	25	768	440	306	1102	17	3	30
1912 2	0	10	197	183	112	737	10	13	4
1912 3	4	10	114	NR	190	675	19	8	2
1912 4	15	45	654	589	647	1659	35	8	40
1912 5	1	18	250	170	175	627	28	2	10
1912 6	2	10	NR	NR	52	110	5	1	4
1912 7	0	2	NR	NR	6	28	26	0	0
1912 8	0	15	NR	NR	66	157	12	2	0
1912 9	2	5	NR	NR	23	76	5	3	0
1913 0	4	8	169	117	149	312	18	2	2
1913 1	11	15	532	184	133	450	16	4	0
1913 2	35	38	1270	973	428	1533	14	4	22
1913 3	16	19	1863	1553	269	827	20	3	5
1913 4	15	53	2111	2153	802	1998	44	1	48

1913 5	1	36	114	138	182	496	40	0	13
1913 6	2	22	221	72	131	348	9	1	0
1913 7		7	NR	NR	58	221	5	2	15
1913 8	9	17	366	211	124	332	6	1	0
1913 9	24	29	915	367	185	865	17	5	0
1914 0	25	45	1470	1096	424	1274	22	2	6
1914 1	11	17	686	282	123	285	9	2	7
1914 2	15	18	605	295	177	343	3	1	0
1914 3	33	49	998	545	277	938	16	3	10
1914 4	14	33	477	385	232	751	36	5	13
1914 5	11	16	456	249	183	501	14	1	0
1914 6	11	22	519	409	167	551	21	2	0
1914 7	6	17	169	90	90	226	21	1	0
1914 8	15	25	439	555	210	537	29	1	4
1914 9	3	18	167	60	127	345	12	0	0
1915 0	2	6	NR	38	48	99	2	0	0
1915 1	9	10	276	168	74	235	6	0	0
1915 2	3	8	NR	NR	48	142	23	1	0
1915 3	1	7	NR	NR	13	51	1	0	0

1915 4	2	16	NR	NR	65	141	14	2	0
1916 0						2			
Total	384 + 8 unknown addresses	822 + 68 unknown + 74 from out of Philadelphia	16,996	11,814	7,191	22,217	862	101	267

*** (NR=None Reported)**

Table 4: Recovery Need and Recovery Resource Indicators by City of Philadelphia Zip Code: Rankings across Zip Code Areas

Zip Code	# of Homicides In 2007	# of Deaths w/ drugs present	# of Drug-related Arrests / Poss 2007	# of Drug-related Arrests / Sales 2007	Rank for Unique BHSI Tx Admissions 2007	Rank for Unique CBH Tx Admissions	# Rec. Supp. Meetings per week	# of Treatment Programs	# of Recovery Homes (2007)
19101						45th			
19102	16th	25th	NR	NR	45th	19th	29th	8th	16th
19103	17th	24th	NR	NR	42ND	43rd	2ND	9TH	16TH
19104	9th	6th	10TH	11TH	20TH	10th	5TH	4TH	6TH
19105						47th			
19106	16th	23rd	NR	NR	33RD	33rd	9TH	9TH	15TH
19107	17th	21st	NR	NR	37TH	20th	1ST	3RD	13TH
19109						49th			
19110						49th			
19111	14th	8th	26TH	NR	19TH	27th	14TH	7TH	16TH
19112	17th	25th	NR	NR	47TH	NR	29TH	9TH	16TH
19113	17th	25th	NR	NR	46TH	NR	29TH	9TH	16TH
19114	17th	16th	NR	NR	27TH	34th	4TH	9TH	14TH
19115	16th	21st	NR	NR	39TH	41st	14TH	9TH	14TH

1911 6	15th	18th	NR	NR	35TH	26th	21ST	9TH	16TH
1911 7	17th	25th	NR	NR	47TH	NR	29TH	9TH	16TH
1911 8	17th	23rd	NR	NR	43RD	46th	19TH	9TH	16TH
1911 9	14th	18th	NR	26TH	29TH	32nd	22ND	7TH	16TH
1912 0	5th	13th	16TH	22ND	10TH	17th	25TH	8TH	7TH
1912 1	6th	9th	7TH	8TH	5TH	5th	17TH	6TH	3RD
1912 2	17th	17th	22ND	18TH	26TH	9th	23RD	1ST	12TH
1912 3	13th	17th	25TH	NR	11TH	11th	15TH	2ND	14TH
1912 4	8th	3rd	9TH	5TH	2ND	2nd	7TH	2ND	2ND
1912 5	16th	12th	20TH	19TH	16TH	12th	9TH	7TH	8TH
1912 6	15th	17th	NR	NR	36TH	38th	26TH	8TH	12TH
1912 7	17th	24th	NR	NR	44TH	44th	10TH	9TH	16TH
1912 8	17th	15th	NR	NR	31ST	35th	22ND	7TH	16TH
1912 9	15th	22nd	NR	NR	40TH	40th	26TH	6TH	16TH
1913 0	13th	19th	23RD	23RD	18TH	25th	16TH	7TH	14TH
1913 1	10th	15th	12TH	17TH	21ST	18th	18TH	5TH	16TH
1913 2	1st	4th	4TH	4TH	3RD	3rd	20TH	5TH	4TH
1913 3	7th	11th	2ND	2ND	7TH	7th	14TH	6TH	11TH
1913 4	8th	1st	1ST	1ST	1ST	1st	3RD	8TH	1ST

1913 5	16th	5th	25TH	21ST	14TH	16th	5TH	9TH	6TH
1913 6	15th	10th	21ST	25TH	22ND	21st	24TH	8TH	16TH
1913 7	17th	20th	NR	NR	34TH	31st	26TH	7TH	5TH
1913 8	11th	13th	18TH	16TH	24TH	24th	25TH	8TH	16TH
1913 9	4th	7th	6TH	12TH	12TH	6th	17TH	4TH	16TH
1914 0	3rd	3rd	3RD	3RD	4TH	4th	12TH	7TH	10TH
1914 1	10th	13th	8TH	14TH	25TH	28th	24TH	7TH	9TH
1914 2	8th	12th	11TH	13TH	15TH	23rd	27TH	8TH	16TH
1914 3	2nd	2nd	5TH	7TH	6TH	5th	18TH	6TH	8TH
1914 4	9th	6th	14TH	10TH	8TH	8th	6TH	4TH	6TH
1914 5	10th	14th	15TH	15TH	13TH	15th	20TH	8TH	16TH
1914 6	10th	10th	13TH	9TH	17TH	13th	13TH	7TH	16TH
1914 7	12th	13th	23RD	24TH	28TH	30th	13TH	8TH	16TH
1914 8	8th	9th	17TH	6TH	9TH	14th	8TH	8TH	12TH
1914 9	14th	12th	24TH	27TH	23RD	22nd	22ND	9TH	16TH
1915 0	15th	21st	NR	28TH	38TH	39th	28TH	9TH	16TH
1915 1	11th	17th	19TH	20TH	30TH	29th	25TH	9TH	16TH
1915 2	14th	19th	NR	NR	38TH	36th	11TH	8TH	16TH
1915 3	16th	20th	NR	NR	41ST	42nd	29TH	9TH	16TH

1915 4	15th	14th	NR	NR	32ND	37th	20TH	7TH	16TH
1916 0						48th			
Total	384 + 8 unknown addresses	822 + 68 unknown + 74 from out of Philadelphia	16,996	11,814	7,191		862	101	267

*** (NR=None Reported)**